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Federal Register

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Presidential Documents

Title 3—

The President

Proclamation 7845 of November 9, 2004

World Freedom Day, 2004

By the President of the United States of America

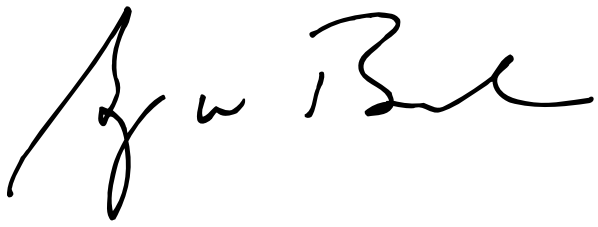
A Proclamation

Fifteen years ago, the people of East and West Germany tore down the Berlin Wall, and freedom triumphed over Communism. The dismantling of the Berlin Wall reunited Germany and helped spread freedom across Central and Eastern Europe. With free elections and the spread of democratic values, these countries won their liberty, and their people became free. These democracies today contribute to a strong Europe, and the United States values their friendship and their partnership.

On World Freedom Day, we recognize all of those who fought for liberty and helped end the oppression of Central and Eastern Europe. We stand by those who today are enjoying the blessings of liberty. And we reaffirm our commitment to extending peace and freedom in the world.

NOW, THEREFORE, I, GEORGE W. BUSH, President of the United States of America, by virtue of the authority vested in me by the Constitution and laws of the United States, do hereby proclaim November 9, 2004, as World Freedom Day. I call upon the people of the United States to observe this day with appropriate ceremonies and activities and to reaffirm their dedication to freedom and democracy.

IN WITNESS WHEREOF, I have hereunto set my hand this ninth day of November, in the year of our Lord two thousand four, and of the Independence of the United States of America the two hundred and twenty-ninth.



[FR Doc. 04–25438
Filed 11–12–04; 8:45 am]
Billing code 3195–01–P

Rules and Regulations

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DEPARTMENT OF AGRICULTURE

Rural Housing Service

Rural Business-Cooperative Service

Rural Utilities Service

Farm Service Agency

7 CFR Parts 1775, 1777, 1778, 1780, 1942, 3570, and 4274

RIN 0572–AB96

Definition Clarification of State Nonmetropolitan Median Household Income (SNMHI)

AGENCY: Rural Housing Service, Rural Business-Cooperative Service, Rural Utilities Service, and Farm Service Agency, USDA.

ACTION: Final rule.

SUMMARY: The Rural Housing Service (RHS), Rural Business-Cooperative Service (RBS), and the Rural Utilities Service (RUS), agencies delivering the United States Department of Agriculture's Rural Development housing, business, and utilities programs, amend their regulations to reflect the clarification of the definition of Statewide Nonmetropolitan Median Household Income, which shall be defined as ''the median household income of the state's nonmetropolitan counties and portions of metropolitan counties outside of cities, towns or places of 50,000 or more population.'' This modification will enable Rural Development to more effectively serve communities across rural America. The loan and grant eligibility or priority scoring will be positively impacted for Rural Development Housing, Business, and Utilities Programs.

DATES: *Effective Date:*

7 CFR part 1775—November 15, 2004.
7 CFR part 1777—December 15, 2004.
7 CFR part 1778—November 15, 2004.
7 CFR part 1780—November 15, 2004.
7 CFR part 1942—November 15, 2004.
7 CFR part 3570—November 15, 2004.
7 CFR part 4274—November 15, 2004.

FOR FURTHER INFORMATION CONTACT: Linda Scott, Loan Specialist, Water Programs Division, Rural Utilities Service, U.S. Department of Agriculture, 1400 Independence Avenue, SW., Room 2235–S, Stop 1570, Washington, DC 20250–1570. Telephone (202) 720–9639. E-Mail: *Linda.Scott@usda.gov.*

SUPPLEMENTARY INFORMATION:

Executive Order 12866

This rule has been determined to be not significant for the purposes of Executive Order 12866 and, therefore, has not been reviewed by the Office of Management and Budget (OMB).

Catalog of Federal Domestic Assistance

The programs described by this rule are listed in the Catalog of Federal Domestic Assistance Programs under numbers 10.760—Water and Waste Disposal Systems for Rural Communities; 10.761—Technical Assistance and Training Grants; 10.762 ''Solid Waste Management Grants; 10.763—Emergency Community Water Assistance Grants; 10.766—Community Facilities Loans and Grants; 10.767—Intermediary Relending Program; and 10.770—Water and Waste Disposal Loans and Grants (Section 306C). This catalog is available on a subscription basis from the Superintendent of Documents, the United States Government Printing Office, Washington, DC, 20402–9325, telephone number (202) 512–1800.

Executive Order 12372

The programs described by this rule that are subject to the requirements of Executive Order 12372, ''Intergovernmental Review of Federal Programs,'' as implemented under USDA's regulations at 7 CFR part 3015, are 10.760—Water and Waste Disposal Systems for Rural Communities; 10.763—Emergency Community Water Assistance Grants; 10.766—Community Facilities Loans and Grants; 10.767—Intermediary Relending Program; and 10.770—Water and Waste Disposal Loans and Grants (Section 306C).

Executive Order 12988

This rule has been reviewed under Executive Order 12988, Civil Justice Reform. RUS has determined that this rule meets the applicable standards provided in section 3 of the Executive Order. In addition all State and local laws and regulations that are in conflict with this rule will be preempted; no retroactive effect will be given to the rule; and, in accordance with Section 212(e) of the Department of Agriculture Reorganization Act of 1994 (7 U.S.C. 6912(e)) administrative appeal procedures, if any are required, must be exhausted prior to initiating any action against the Department or its agencies.

Regulatory Flexibility Act Certification

This rule has been reviewed with regard to the requirements of the Regulatory Flexibility Act (5 U.S.C. 601–612). The undersigned has determined and certified by signature of this document that this rule will not have a significant economic impact on a substantial number of small entities since this rulemaking action does not involve a new or expanded program.

Information Collection and Recordkeeping Requirements

This rule contains no new reporting or recordkeeping burdens under OMB control numbers 0572–0109, 0572–0110, 0572–0112, 0572–0121, 0575–0015, 0575–0173, and 0570–0021 that would require approval under the Paperwork Reduction Act of 1995 (44 U.S.C. chapter 35).

National Environmental Policy Act Certification

The Administrator of RUS has determined that this rule will not significantly affect the quality of the human environment as defined by the National Environmental Policy Act of 1969 (42 U.S.C. 4321 *et seq.*). Therefore, this action does not require an environmental impact statement or assessment.

Unfunded Mandates

This rule contains no Federal mandates (under the regulatory provision of title II of the Unfunded Mandates Reform Act of 1995) for State, local, and tribal governments or the private sector. Thus this rule is not subject to the requirements of section 202 and 205 of the Unfunded Mandates Reform Act of 1995.

Executive Order 13132, Federalism

The policies contained in this rule do not have any substantial direct effect on states, on the relationship between the National Government and the States, or on the distribution of power and responsibilities among the various levels of government. Nor does this rule impose substantial direct compliance costs on State and local governments. Therefore, consultation with states is not required.

Background

The purpose of this final rule is to create a standard definition of Statewide Nonmetropolitan Median Household Income (SNMHI) that is more representative of the rural areas in a State. With respect to Rural Utilities Service Water and Environmental Programs (WEP), the definition will be used in priority scoring for WEP Technical Assistance and Training Grants (7 CFR part 1775), Section 306C Water and Waste Disposal Loans and Grants (7 CFR part 1777), and Emergency and Imminent Community Water Assistance Grants (7 CFR part 1778), and for loan and grant eligibility determinations for Water and Waste Loans and Grants (7 CFR part 1780). For the Rural Housing Service Community Facilities (CF) and Rural Business-Cooperative Service Intermediary Relending Programs (IRP), the standard definition will be used in priority scoring for the Community Facilities Loan Program (7 CFR part 1942), Community Facilities Grant Program (7 CFR part 3570) and the Intermediary Relending Program (7 CFR part 4274). Standardizing the definition of SNMHI will allow for more efficient administration of these loan and grant programs consistent with the purposes of the Consolidated Farm and Rural Development Act (codified at 7 U.S.C. 1921 *et. seq.*). With respect to 7 CFR parts 1775, 1778, and 1780, 1942, 3570 and 4274, the rule will be effective upon publication in the **Federal Register**. For 7 CFR part 1777, the rule will be effective 30 days after such publication.

Pursuant to 44 U.S.C. 3504(e)(3), 31 U.S.C. 1104(d) and Executive Order No. 10253 (June 11, 1951), the Office of Management and Budget (OMB) defines Metropolitan Statistical Areas (MSA), Micropolitan Statistical Areas, Combined Statistical Areas, and New England City and Town Areas for use in Federal statistical activities. Once each decade, OMB performs a comprehensive review of statistical area standards and definitions, and publishes a list which includes counties where MSAs are located, with periodic updates between decennial censuses based on Census Bureau data.

As a consequence of the 2000 census, the definitions of metropolitan areas were revised, resulting in larger geographical areas being considered metropolitan. These enlarged metropolitan areas include areas which are rural areas under the definition of ''rural areas'' in section 343 (13) of the Consolidated Farm and Rural Development Act (7 U.S.C. 1991 *et seq*). The expansion of the generally more affluent metropolitan areas and their consequent removal from the computation of nonmetropolitan income in the SNMHI caused the SNMHI to increase proportionately less than the increase in median household income experienced by rural communities in the metropolitan areas. While the income characteristics of the rural communities in the metropolitan areas and their need for WEP, CF and IRP assistance may not have changed, the proportionately lesser increase in SNMHI makes it less likely that a rural community in a metropolitan area can successfully compete for such assistance.

The inclusion of these rural areas within the enlarged metropolitan areas, and the consequent effect on the SNMHI, affects the eligibility of some WEP applicants for grant and lower interest rate loans. Based upon a review of applications on hand, and using the 2000 census median household income data for nonmetropolitan counties, there was an approximately 25 percent reduction in the number of communities eligible for grants, and a 50 percent reduction in the number of communities eligible for reduced interest rates. Additionally, priority scoring for all WEP programs is affected by the comparison of an area's income with the SNMHI.

The inclusion of these rural areas within the enlarged metropolitan areas did not affect the eligibility of these rural areas for CF and IRP assistance. However, applicants for CF and IRP assistance (*see* 7 CFR 1942,1(c)(2)(iii)(C)(2) for CF and 7 CFR 4274.344(c) for IRP) receive priority points in application selection criteria based on a comparison of the area's income with the SNMHI. The assignment of priority points may be negatively affected by the comparison of these rural areas within the enlarged metropolitan areas with the SNMHI.

The SNMHI calculations resulting from this definition modification will greatly reduce the negative impacts to numerous rural communities, and will enable such communities to continue to be eligible and receive priority points for WEP, CF and IRP loan and grant programs.

A proposed rule was published in the **Federal Register** on Monday, August 9, 2004, at 69 FR 48174. The comment period lasted 30 days and ended on September 8, 2004. Five comments were received. Each of the five comments supported the definition clarification of State Nonmetropolitan Median Household Income (SNMHI). Four of these favorable comments were from local towns, and one was from an engineering and architectural firm.

List of Subjects

7 CFR Part 1775

Business and industry; Community development; Community facilities; Grant program—housing and community development; Reporting and recordkeeping requirements; Rural areas; Waste treatment and disposal; Water supply; Watersheds.

7 CFR Part 1777

Community development; Community facilities; Grant programs—housing and community development; Loan programs—housing and community development; Reporting and recordkeeping requirements; Rural areas; Waste treatment and disposal; Water supply; Watersheds.

7 CFR Part 1778

Community development; Community facilities; Grant programs—housing and community development; Reporting and recordkeeping requirements; Rural areas; Waste treatment and disposal; Water supply; Watersheds.

7 CFR Part 1780

Community development; Community facilities; Grant programs—housing and community development; Loan programs—housing and community development; Reporting and recordkeeping requirements; Rural areas; Waste treatment and disposal; Water supply; Watersheds.

7 CFR Part 1942

Community development; Community facilities; Loan program—Housing and community development; Loan security; Reporting and recordkeeping requirements; Rural Areas; Waste treatment and disposal—Domestic; Water supply—Domestic.

7 CFR Part 3570

Accounting; Administrative practice and procedure; Conflicts of interests; Environmental impact statements; Foreclosure; Fair Housing; Grant programs—Housing and community

development; Loan programs—Housing and community development; Rural areas; Subsidies.

7 CFR Part 4274

Community development; Economic development; Loan programs—business; Reporting and recordkeeping requirements; Rural areas.

■ For reasons set forth in the preamble, RUS amends 7 CFR chapters XVII, XVIII, and XVIV as set forth below:

CHAPTER XVII—RURAL UTILITIES SERVICE, DEPARTMENT OF AGRICULTURE

PART 1775—TECHNICAL ASSISTANCE AND TRAINING GRANTS

■ 1. The authority citation for part 1775 continues to read as follows:

Authority: 5 U.S.C. 301; 7 U.S.C. 1989; 16 U.S.C. 1005.

■ 2. Amend § 1775.4 by adding a definition for ''Statewide Nonmetropolitan Median Household Income'' in alphabetical order to read as follows:

§ 1775.4 Definitions.

* * * * *

Statewide Nonmetropolitan Median Household Income (SNMHI). Median household income of the State's nonmetropolitan counties and portions of metropolitan counties outside of cities, towns or places of 50,000 or more population.

PART 1777—SECTION 306C WWD LOANS AND GRANTS

■ 3. The authority citation for part 1777 continues to read as follows:

Authority: 5 U.S.C. 301; 7 U.S.C. 1989; 16 U.S.C. 1005.

■ 4. Amend § 1777.4 by adding a definition for ''Statewide Nonmetropolitan Median Household Income'' in alphabetical order to read as follows:

§ 1777.4 Definitions.

* * * * *

Statewide Nonmetropolitan Median Household Income (SNMHI). Median household income of the State's nonmetropolitan counties and portions of metropolitan counties outside of cities, towns or places of 50,000 or more population.

PART 1778—EMERGENCY AND IMMINENT COMMUNITY WATER ASSISTANCE GRANTS

■ 5. The authority citation for part 1778 continues to read as follows:

Authority: 5 U.S.C. 301; 7 U.S.C. 1989; 16 U.S.C. 1005.

■ 6. Amend § 1778.4 by adding a definition for ''Statewide Nonmetropolitan Median Household Income'' in alphabetical order to read as follows:

§ 1778.4 Definitions.

* * * * *

Statewide Nonmetropolitan Median Household Income (SNMHI). Median household income of the State's nonmetropolitan counties and portions of metropolitan counties outside of cities, towns or places of 50,000 or more population.

PART 1780—WATER AND WASTE LOANS AND GRANTS

Subpart A—General Policies and Requirements

■ 7. The authority citation for part 1780 continues to read as follows:

Authority: 5 U.S.C. 301; 7 U.S.C. 1989; 16 U.S.C. 1005.

■ 8. Amend § 1780.3 (a) by revising the definition for ''Statewide Nonmetropolitan Median Household Income'' to read as follows:

§ 1780.3 Definitions and grammatical rules of construction.

(a) * * *

Statewide nonmetropolitan median household income means the median household income of the State's nonmetropolitan counties and portions of metropolitan counties outside of cities, towns or places of 50,000 or more population.

* * * * *

CHAPTER XVIII—RURAL HOUSING SERVICE, RURAL BUSINESS—COOPERATIVE SERVICE, RURAL UTILITIES SERVICE, AND FARM SERVICE AGENCY, DEPARTMENT OF AGRICULTURE

PART 1942—ASSOCIATIONS

Subpart A—Community Facility Loans

■ 9. The authority citation for part 1942 continues to read:

Authority: 5 U.S.C. 301; 7 U.S.C. 1989.

■ 10. Amend subpart A by adding a new § 1942.21 to read as follows:

§ 1942.21 Statewide Nonmetropolitan Median Household Income.

Statewide Nonmetropolitan Median Household Income means the median household income of the State's nonmetropolitan counties and portions of metropolitan counties outside of cities, towns or places, of 50,000 or more population.

CHAPTER XXXV—RURAL HOUSING SERVICE, DEPARTMENT OF AGRICULTURE

PART 3570—COMMUNITY PROGRAMS

Subpart B—Community Facilities Grant Program

■ 11. The authority citation for part 3570 continues to read:

Authority: 5 U.S.C. 301; 7 U.S.C. 1989.

■ 12. Amend § 3570.53 by revising the definition for ''State nonmetropolitan median household income'' to read as follows:

§ 3570.53 Definitions.

* * * * *

State nonmetropolitan median household income. The median household income of the State's nonmetropolitan counties and portions of metropolitan counties outside of cities, towns or places of 50,000 or more population.

* * * * *

CHAPTER XLII—RURAL BUSINESS—COOPERATIVE SERVICE AND RURAL UTILITIES SERVICE, DEPARTMENT OF AGRICULTURE

PART 4274—DIRECT AND INSURED LOANMAKING

Subpart D—Intermediary Relending Program (IRP)

■ 13. The authority citation for part 4274 continues to read:

Authority: 5 U.S.C. 301; 7 U.S.C. 1932 note; 7 U.S.C. 1989.

■ 14. Amend § 4274.302 (a) by adding a definition for ''Statewide Nonmetropolitan Median Household Income'' in alphabetical order to read as follows:

§ 4274.302 Definitions and abbreviations.

(a) * * *.

Statewide Nonmetropolitan Median Household Income (SNMHI). Median household income of the State's nonmetropolitan counties and portions of metropolitan counties outside of cities, towns or places of 50,000 or more population.

* * * * *

Dated: November 5, 2004.

Gilbert G. Gonzalez,

Under Secretary, Rural Development.

[FR Doc. 04–25245 Filed 11–12–04; 8:45 am]

BILLING CODE 3410–15–P

DEPARTMENT OF AGRICULTURE

Rural Housing Service

Rural Business-Cooperative Service

Rural Utilities Service

Farm Service Agency

7 CFR Part 1955

RIN 0560–AG78

2002 Farm Bill Regulations—General Credit Provisions; Correction

AGENCIES: Rural Housing Service, Rural Business-Cooperative Service, Rural Utilities Services, and Farm Service Agency, USDA.

ACTION: Final rule; correcting amendment.

SUMMARY: This document corrects the final regulations published in the **Federal Register** on February 18, 2003, implementing certain provisions of the Farm Security and Rural Investment Act of 2002 (2002 Act).

DATES: *Effective Date:* February 18, 2003.

FOR FURTHER INFORMATION CONTACT: Constance Beckwith, Senior Loan Officer, USDA/FSA/DAFLP/LSPMD/STOP 0523, Washington DC 20250–0523; telephone 202–720–9769; Facsimile: 202–690–1196; E-mail: *constance_beckwith@wdc.usda.gov.* Persons with disabilities who require alternative means for communication (Braille, large print, audio tape, etc.) should contact the USDA Target Center at (202) 720–2600 (voice and TDD).

SUPPLEMENTARY INFORMATION:

Background

Section 5310 of the 2002 Act changed the definition of qualified beginning farmer or rancher by increasing the acres of land that these applicants could own to a maximum of 30 (instead of 25) percent of the average farm or ranch size in the county.

Need for Correction

As published, the final regulations amended the definition of ''Beginning farmer or rancher'' in 7 CFR 762.102, 1941.4 and 1943.4 to comply with the requirements of the 2002 Act. The definition of ''Beginning farmer or rancher'' is also included in 7 CFR 1955.103; however, the necessary amendment was inadvertently not included in the February 18, 2003, final rule.

List of Subjects in 7 CFR Part 1955

Government acquired property, Sale of government acquired property, Surplus government property.

■ Accordingly, chapter XVIII, title 7, Code of Federal Regulations is corrected as follows:

PART 1955—PROPERTY MANAGEMENT

■ 1. The authority citation for part 1955 continues to read as follows:

Authority: 5 U.S.C. 301; 7 U.S.C. 1989, 42 U.S.C. 1480.

Subpart C—Disposal of Inventory Property

■ 2. Amend § 1955.103 by removing the number ''25'' from the first sentence of paragraph (5) of the definition ''Beginning farmer or rancher'' and adding in its place the number ''30.''

Dated: November 5, 2004.

Gilbert Gonzales,

Acting Under Secretary for Rural Development.

Dated: November 3, 2004.

J.B. Penn,

Under Secretary for Farm and Foreign Agricultural Services.

[FR Doc. 04–25285 Filed 11–12–04; 8:45 am]

BILLING CODE 3410–05–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2004–18996; Directorate Identifier 2004–NM–40–AD; Amendment 39–13865; AD 2004–23–10]

RIN 2120–AA64

Airworthiness Directives; Boeing Model 737–700 and –800 Series Airplanes

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: The FAA is adopting a new airworthiness directive (AD) for certain Boeing Model 737–700 and -800 series airplanes. This AD requires doing an initial inspection for pitting and cracks of the lower skin panel at the lap joint; trimming the inner skin; installing exterior doublers; replacing the fuselage skin assembly; doing repetitive supplemental inspections; and repairing if necessary; as applicable. This AD is prompted by a report indicating that localized pitting in the lower skin panels was found during production on a limited number of airplanes. We are issuing this AD to detect and correct premature fatigue cracking at certain lap splice locations and consequent rapid decompression of the airplane.

DATES: This AD becomes effective December 20, 2004.

The incorporation by reference of a certain publication listed in the AD is approved by the Director of the Federal Register as of December 20, 2004.

ADDRESSES: For service information identified in this AD, contact Boeing Commercial Airplanes, P.O. Box 3707, Seattle, Washington 98124–2207. You can examine this information at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call (202) 741–6030, or go to: *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.*

You can examine the contents of this AD docket on the Internet at http://dms.dot.gov, or at the Docket Management Facility, U.S. Department of Transportation, 400 Seventh Street, SW., room PL–401, on the plaza level of the Nassif Building, Washington, DC.

FOR FURTHER INFORMATION CONTACT: *Technical information:* Sue Lucier, Aerospace Engineer, Airframe Branch, ANM–120S, FAA, Seattle Aircraft Certification Office, 1601 Lind Avenue, SW., Renton, Washington 98055–4056; telephone (425) 917–6438; fax (425) 917–6590.

Plain language information: Marcia Walters, *marcia.walters@faa.gov.*

Examining the Docket

The AD docket contains the proposed AD, comments, and any final disposition. You can examine the AD docket on the Internet at *http://dms.dot.gov,* or in person at the Docket Management Facility office between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The Docket Management Facility office (telephone (800) 647–5227) is located on the plaza level of the Nassif Building at the DOT street address stated in the **ADDRESSES** section.

SUPPLEMENTARY INFORMATION: The FAA proposed to amend 14 CFR Part 39 with an AD for certain Boeing Model 737–700 and –800 series airplanes. That action, published in the **Federal Register** on September 3, 2004 (69 FR 53855), proposed to require doing an initial inspection for pitting and cracks of the lower skin panel at the lap joint; trimming the inner skin; installing exterior doublers; replacing the fuselage skin assembly; doing repetitive

supplemental inspections; and repairing if necessary; as applicable.

Comments

We provided the public the opportunity to participate in the development of this AD. No comments have been submitted on the proposed AD or on the determination of the cost to the public.

Conclusion

We have carefully reviewed the available data and determined that air safety and the public interest require adopting the AD as proposed.

Costs of Compliance

This AD will affect about 4 airplanes worldwide and 2 airplanes of U.S. registry. The following table provides the estimated costs to comply with this AD.

The average labor rate is $65 per work hour. The cost impact of the AD on U.S. operators is estimated to be $83,855.

TABLE.—COST IMPACT

For airplanes listed in the referenced service bulletin as group	Work hours	Parts cost	Per airplane cost
1	Inspection: 2	None	$130
	Modification: 38	105	2,575
2	Inspection: 2	None	130
	Modification: 30	104	2,054
3	Inspection: 2	None	130
	Modification: 42	106	2,836
4	Repair: 920	16,200	76,000

Regulatory Findings

We have determined that this AD will not have federalism implications under Executive Order 13132. This AD will not have a substantial direct effect on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government.

For the reasons discussed above, I certify that this AD:

(1) Is not a ''significant regulatory action'' under Executive Order 12866;

(2) Is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and

(3) Will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

We prepared a regulatory evaluation of the estimated costs to comply with this AD. See the **ADDRESSES** section for a location to examine the regulatory evaluation.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

■ Accordingly, under the authority delegated to me by the Administrator, the FAA amends 14 CFR part 39 as follows:

PART 39—AIRWORTHINESS DIRECTIVES

■ 1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

■ 2. The FAA amends § 39.13 by adding the following new airworthiness directive (AD):

2004–23–10 Boeing: Amendment 39–13865. Docket No. FAA–2004–18996; Directorate Identifier 2004–NM–40–AD.

Effective Date

(a) This AD becomes effective December 20, 2004.

Affected ADs

(b) None.

Applicability

(c) This AD applies to Boeing Model 737–700 and -800 series airplanes, certificated in any category; having variable and serial numbers listed in Table 1 of this AD.

TABLE 1.—APPLICABLE VARIABLE AND SERIAL NUMBERS.

Variable number	Serial number	Group
YA004	27837	1
YA005	27836	2
YA201	28004	4
YC003	27977	3

Unsafe Condition

(d) This AD was prompted by a report indicating that localized pitting in the lower skin panels was found during production on a limited number of airplanes. We are issuing this AD to detect and correct premature fatigue cracking at certain lap splice locations and consequent rapid decompression of the airplane.

Compliance

(e) You are responsible for having the actions required by this AD performed within the compliance times specified, unless the actions have already been done.

Initial Inspection and/or Repair

(f) At the applicable times specified in Table 1 of paragraph 1.E., ''Compliance,'' of Boeing Special Attention Service Bulletin 737–53–1256, dated September 18, 2003, do the applicable actions specified in Table 2 of this AD in accordance with the Accomplishment Instructions of the service bulletin.

TABLE 2.—INITIAL INSPECTION AND/OR REPAIR

For airplanes identified in the service bulletin as—	Requirements—
(1) Groups 1, 2, and 3	Do an external ultrasonic inspection for pitting and cracks of the lower skin panel at the lap joint.
(2) Groups 1 and 2	Trim the inner skin and install two exterior doublers (including related investigative actions).
(3) Group 3	Install three exterior doublers.
(4) Group 4	Replace the fuselage skin assembly with a new assembly.

Repetitive Inspections

(g) For Groups 1, 2, and 3 airplanes identified in Boeing Special Attention Service Bulletin 737–53–1256, dated September 18, 2003: At the applicable times specified in Table 2 of paragraph 1.E., ''Compliance,'' of the service bulletin, do the repetitive supplemental inspections of the lower skins and external doublers for discrepancies in accordance with the Accomplishment Instructions of the service bulletin.

Corrective Action

(h) If any discrepancy is found during any action required by this AD, before further flight, repair per a method approved by the Manager, Seattle Aircraft Certification Office (ACO), FAA; or per data meeting the type certification basis of the airplane approved by a Boeing Company Designated Engineering Representative (DER) who has been authorized by the Manager, Seattle ACO, to make such findings. For a repair method to be approved, the approval must specifically reference this AD.

Alternative Methods of Compliance (AMOCs)

(i)(1) The Manager, Seattle ACO, FAA, has the authority to approve AMOCs for this AD, if requested in accordance with the procedures found in 14 CFR 39.19.

(2) An AMOC that provides an acceptable level of safety may be used for any repair required by this AD, if it is approved by a Boeing Company DER who has been authorized by the Manager, Seattle ACO, to make those findings. For a repair method to be approved, the approval must specifically refer to this AD.

Material Incorporated by Reference

(j) You must use Boeing Special Attention Service Bulletin 737–53–1256, dated September 18, 2003, to perform the actions that are required by this AD, unless the AD specifies otherwise. The Director of the Federal Register approves the incorporation by reference of this document in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. For copies of the service information, contact Boeing Commercial Airplanes, P.O. Box 3707, Seattle, Washington 98124–2207. For information on the availability of this material at the National Archives and Records Administration (NARA), call (202) 741–6030, or go to *http://www.archives.gov/federal_ register/code_of_federal_regulations/ibr_locations.html.* You may view the AD docket at the Docket Management Facility, U.S. Department of Transportation, 400 Seventh Street SW, room PL–401, Nassif Building, Washington, DC.

Issued in Renton, Washington, on November 1, 2004.

Kalene C. Yanamura,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 04–24936 Filed 11–12–04; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2004–18994; Directorate Identifier 2003–NM–210–AD; Amendment 39–13866; AD 2004–23–11]

RIN 2120–AA64

Airworthiness Directives; McDonnell Douglas Model DC–9–14 and DC–9–15 Airplanes; and Model DC–9–20, DC–9–30, DC–9–40, and DC–9–50 Series Airplanes

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: The FAA is adopting a new airworthiness directive (AD) for certain McDonnell Douglas Model DC–9–14 and DC–9–15 airplanes; and Model DC–9–20, DC–9–30, DC–9–40, and DC–9–50 series airplanes. This AD requires repetitive high frequency eddy current inspections to detect cracks in the vertical radius of the upper cap of the center wing rear spar, and repair if necessary. This AD is prompted by reports of cracks in the upper cap of the center wing rear spar that resulted from stress corrosion. We are issuing this AD to detect and correct cracking of the left or right upper cap of the center rear spar, which would cause a possible fuel leak and structural failure of the upper cap, and result in reduced structural integrity of the airplane.

DATES: This AD becomes effective December 20, 2004.

The incorporation by reference of a certain publication listed in the AD is approved by the Director of the Federal Register as of December 20, 2004.

ADDRESSES: For service information identified in this AD, contact Boeing Commercial Airplanes, Long Beach Division, 3855 Lakewood Boulevard, Long Beach, California 90846, Attention: Data and Service Management, Dept. C1–L5A (D800–0024). You can examine this information at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call (202) 741–6030, or go to: *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.*

You can examine the contents of this AD docket on the Internet at *http://dms.dot.gov,* or at the Docket Management Facility, U.S. Department of Transportation, 400 Seventh Street, SW., room PL–401, on the plaza level of the Nassif Building, Washington, DC.

FOR FURTHER INFORMATION CONTACT:

Technical information: Wahib Mina, Aerospace Engineer, Airframe Branch, ANM–120L, FAA, Los Angeles Aircraft Certification Office, 3960 Paramount Boulevard, Lakewood, California 90712–4137; telephone (562) 627–5324; fax (562) 627–5210.

Plain language information: Marcia Walters, *marcia.walters@faa.gov.*

Examining the Docket

The AD docket contains the proposed AD, comments, and any final disposition. You can examine the AD docket on the Internet at *http://dms.dot.gov,* or in person at the Docket Management Facility office between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The Docket Management Facility office (telephone (800) 647–5227) is located on the plaza level of the Nassif Building at the DOT street address stated in the **ADDRESSES** section.

SUPPLEMENTARY INFORMATION: The FAA proposed to amend 14 CFR part 39 with an AD for certain McDonnell Douglas Model DC–9–14 and DC–9–15 airplanes; and Model DC–9–20, DC–9–30, DC–9–40, and DC–9–50 series airplanes. That action, published in the **Federal Register** on September 3, 2004 (69 FR 53853), proposed to require repetitive high frequency eddy current inspections to detect cracks in the vertical radius of the upper cap of the center wing rear spar, and repair if necessary.

Comments

We provided the public the opportunity to participate in the development of this AD. No comments have been submitted on the proposed AD or on the determination of the cost to the public.

Explanation of Change Made to the Final Rule

We have updated the manufacturer name from McDonnell Douglas to Boeing for Service Bulletin DC9–57–223, dated July 21, 2003, which is referenced in this AD as the appropriate source of service information for the required actions. This change is necessary to adhere to the Office of the Federal Register's guidelines for materials incorporated by reference.

Conclusion

We have carefully reviewed the available data and determined that air safety and the public interest require adopting the AD with the change described previously. We have determined that this change will neither increase the economic burden on any

operator nor increase the scope of the AD.

Costs of Compliance

This AD affects about 396 airplanes of U.S. registry and 963 airplanes worldwide. The required inspection will take about 3 work hours per airplane, per inspection cycle, at an average labor rate of $65 per work hour. Based on these figures, the estimated cost of the AD for U.S operators is $77,220, or $195 per airplane, per inspection cycle.

Regulatory Findings

We have determined that this AD will not have federalism implications under Executive Order 13132. This AD will not have a substantial direct effect on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government.

For the reasons discussed above, I certify that this AD:

(1) Is not a ''significant regulatory action'' under Executive Order 12866;

(2) Is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and

(3) Will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

We prepared a regulatory evaluation of the estimated costs to comply with this AD. *See* the **ADDRESSES** section for a location to examine the regulatory evaluation.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

■ Accordingly, under the authority delegated to me by the Administrator, the FAA amends 14 CFR part 39 as follows:

PART 39—AIRWORTHINESS DIRECTIVES

■ 1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

■ 2. The FAA amends § 39.13 by adding the following new airworthiness directive (AD):

2004–23–11 McDonnell Douglas: Amendment 39–13866. Docket No. FAA–2004–18994; Directorate Identifier 2003–NM–210–AD.

Effective Date

(A) This AD becomes effective December 20, 2004.

Affected ADs

(b) None.

Applicability

(c) This AD applies to certain McDonnell Douglas Model DC–9–14, DC–9–15, DC–9–21, DC–9–31, DC–9–32, DC–9–32 (VC–9C), DC–9–32F, DC–9–33F, DC–9–34, DC–9–34F, DC–9–32F (C–9A, C–9B), DC–9–41, and DC–9–51 airplanes, certificated in any category; as listed in Boeing Service Bulletin DC9–57–223, dated July 21, 2003.

Unsafe Condition

(d) This AD was prompted by reports of cracks in the upper cap of the center wing rear spar that resulted from stress corrosion. We are issuing this AD to detect and correct cracking of the left or right upper cap of the center rear spar, which could cause a possible fuel leak and structural failure of the upper cap, and result in reduced structural integrity of the airplane.

Compliance

(e) You are responsible for having the actions required by this AD performed within the compliance times specified, unless the actions have already been done.

Inspection

(f) At the later of the times specified in paragraph (f)(1) or (f)(2) of this AD: Do a high frequency eddy current inspection to detect cracks in the vertical radius of the upper cap of the center wing rear spar, in accordance with the Accomplishment Instructions of Boeing Service Bulletin DC9–57–223, dated July 21, 2003.

(1) Before the accumulation of 25,000 total flight cycles.

(2) Within 15,000 flight cycles or 5 years after the effective date of this AD, whichever occurs first.

Corrective Action

(g)(1) If no crack is found, then repeat the inspection thereafter at intervals not to exceed 15,000 flight cycles or 5 years, whichever occurs first.

(2) If any crack is found, before further flight, repair per a method approved by the Manager, Los Angeles Aircraft Certification Office (ACO), FAA. For a repair method to be approved by the Manager, Los Angeles ACO, as required by this paragraph, the Manager's approval letter must specifically refer to this AD.

Alternative Methods of Compliance (AMOCs)

(h) The Manager, Los Angeles ACO, FAA, has the authority to approve AMOCs for this AD, if requested in accordance with the procedures found in 14 CFR 39.19.

Material Incorporated by Reference

(i) You must use Boeing Service Bulletin DC9–57–223, dated July 21, 2003, to perform the actions that are required by this AD, unless the AD specifies otherwise. The Director of the Federal Register approves the incorporation by reference of this document in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. For copies of the service information, contact Boeing Commercial Airplanes, Long Beach Division, 3855 Lakewood Boulevard, Long Beach, California 90846, Attention: Data and Service Management, Dept. CI–L5A (D800–0024). For information on the availability of this material at the National Archives and Records Administration (NARA), call (202) 741–6030, or go to *http://www.archives.gov/federal_register/code_of_ federal_regulations/ibr_locations.html.* You may view the AD docket at the Docket Management Facility, U.S. Department of Transportation, 400 Seventh Street, SW., room PL–401, Nassif Building, Washington, DC.

Issued in Renton, Washington, on November 1, 2004.

Kalene C. Yanamura,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 04–24934 Filed 11–12–04; 8:45 am]

BILLING CODE 4910–13–M

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 2002–NM–153–AD; Amendment 39–13859; AD 2004–23–04]

RIN 2120–AA64

Airworthiness Directives; Airbus Model A319 and A320 Series Airplanes

AGENCY: Federal Aviation Administration, DOT.

ACTION: Final rule.

SUMMARY: This amendment adopts a new airworthiness directive (AD), applicable to certain Airbus Model A319 and A320 series airplanes, that requires a modification and replacement affecting all fuel tanks. All affected airplanes require the installation of fuses in the wiring of the fuel quantity indicating probes of all fuel tanks. Some affected airplanes also require replacement of the high-level sensors of the additional center tanks (ACTs) with new sensors. For all affected airplanes, these actions are necessary to prevent overheating of the fuel probes due to a short circuit. For some affected airplanes, these actions are necessary to prevent fuel leakage due to inadequate space for thermal expansion within the ACTs. Such conditions could result in fuel vapors or fuel contacting an ignition source and/or consequent fire/explosion in the center fuel tanks. These actions are intended to address the identified unsafe condition.

DATES: Effective December 20, 2004.

The incorporation by reference of certain publications listed in the

regulations is approved by the Director of the Federal Register as of December 20, 2004.

ADDRESSES: The service information referenced in this AD may be obtained from Airbus, 1 Rond Point Maurice Bellonte, 31707 Blagnac Cedex, France. This information may be examined at the Federal Aviation Administration (FAA), Transport Airplane Directorate, Rules Docket, 1601 Lind Avenue, SW., Renton, Washington; or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call (202) 741–6030, or go to: *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.*

FOR FURTHER INFORMATION CONTACT: Dan Rodina, Aerospace Engineer, International Branch, ANM–116, FAA, Transport Airplane Directorate, 1601 Lind Avenue SW., Renton, Washington 98055–4056; telephone (425) 227–2125; fax (425) 227–1149.

Relationship of This AD to SFAR 88

The FAA has examined the underlying safety issues involved in recent fuel tank explosions on several large transport airplanes, including the adequacy of existing regulations, the service history of airplanes subject to those regulations, and existing maintenance practices for fuel tank systems. As a result of those findings, we issued a regulation titled ''Transport Airplane Fuel Tank System Design Review, Flammability Reduction and Maintenance and Inspection Requirements'' (67 FR 23086, May 7, 2001). In addition to new airworthiness standards for transport airplanes and new maintenance requirements, this rule included Special Federal Aviation Regulation No. 88 (SFAR 88).

Among other actions, SFAR 88 requires certain type design (*i.e.*, type certificate (TC) and supplemental type certificate (STC)) holders to substantiate that their fuel tank systems can prevent ignition sources in the fuel tanks. This requirement applies to type design holders for large turbine-powered transport airplanes and for subsequent modifications to those airplanes. It requires them to perform design reviews and to develop design changes and maintenance procedures if their designs do not meet the new fuel tank safety standards. As explained in the preamble to the rule, we intended to adopt airworthiness directives to mandate any changes found necessary to address unsafe conditions identified as a result of these reviews.

In evaluating these design reviews, we have established four criteria intended to define the unsafe conditions associated with fuel tank systems that require corrective actions. The percentage of operating time during which fuel tanks are exposed to flammable conditions is one of these criteria. The other three criteria address the failure types under evaluation: single failures, single failures in combination with another latent condition(s), and in-service failure experience. For all four criteria, the evaluations included consideration of previous actions taken that may mitigate the need for further action.

Based on this process, we have determined that the actions identified in this AD are necessary to reduce the potential of ignition sources inside fuel tanks, which, in combination with flammable fuel vapors, could result in fuel tank explosions and consequent loss of the airplane.

Proposed AD

A proposal to amend part 39 of the Federal Aviation Regulations (14 CFR part 39) to include an airworthiness directive (AD) that is applicable to certain Airbus Model A319 and A320 series airplanes was published in the **Federal Register** on November 17, 2003 (68 FR 64823). That action proposed to require a modification and replacement affecting the center and wing fuel tanks. All affected airplanes would require modification of the wiring of the fuel quantity indicating probes of the center and wing fuel tanks. Some affected airplanes would also require replacement of the high-level sensors of the additional center fuel tank with new, improved sensors.

Comments

Interested persons have been afforded an opportunity to participate in the making of this amendment. Due consideration has been given to the comments received.

Supportive Comments

One commenter supports the proposed AD; one commenter supports the intent of the proposed AD.

Requests To Extend Compliance Time

One commenter notes a large disparity between the two limitations in the proposed accomplishment time of ''Within 4,000 flight hours or 30 months after the effective date of the AD, whichever is first.'' The commenter suggests that the FAA consider changing the timeline to flight hours or a calendar month, which is more closely tied to actual airplane utilization. The commenter adds that utilization of these airplanes could be as high as 9,000 flight hours during the proposed 30-month compliance time. The commenter asks that the compliance time be changed to 9,000 flight hours or 30 months, whichever is first. Another commenter also recommends that the compliance time be changed to 9,000 flight hours or 30 months, whichever is first, and provided no justification for the recommendation.

A third commenter states that, based on airplane utilization, the flight-hour threshold will occur first, and result in a 14-month schedule for completion. The commenter adds that, based on the instructions outlined in Airbus Service Bulletin A320–28–1087, accomplishment of the actions is possible only during a base maintenance visit. The commenter notes that the compliance limits will penalize operators with long-to-medium-range missions. The commenter recommends that the compliance time be extended to 5,500 flight hours or 30 months after the effective date of the AD, whichever occurs first. The commenter states that this will allow operators to utilize routine base maintenance visit opportunities where appropriate tooling, ground equipment, and qualified skill set are available.

A fourth commenter states that including a flight-hour limit in the compliance time suggests that the failure mode being addressed by the mandatory activity is sensitive to flight hours in service. The commenter notes that the failure mode addressed by Service Bulletin A320–28–1087 (wiring insulation breakdown/damage) is primarily related to calendar age. The commenter adds that, while the flight-hour limit may have value, it is not the crucial parameter. The commenter's in-service airplanes average about eight hours of flying per day, which means that the 4,000-flight-hour limit would require that the actions be done on all affected airplanes within about 500 days. This period is 55 percent of the calendar time afforded by the compliance time, and is less than the C-check interval. The commenter states that doing the actions on all airplanes within 4,000 flight hours would put an additional burden and cost on its operation. The commenter suggests extending the compliance time to 6,000 flight hours, which will not compromise the level of safety.

We do not agree with the commenters. In developing an appropriate compliance time for this action, we considered the safety implications, operators' normal maintenance schedules, and the compliance time

recommended by the airplane manufacturer for the timely accomplishment of the required actions. The compliance time is based on airplane utilization overall. In addition, operators provided no data to support that a compliance time extension will ensure safety. In consideration of these items, we have determined that compliance within 4,000 flight hours or 30 months after the effective date of this AD, whichever is first, will provide an acceptable level of safety and is an appropriate interval of time wherein the required actions can be accomplished during scheduled maintenance intervals for the majority of affected operators. However, according to the provisions of paragraph (b) of this AD, we may approve requests to adjust the compliance time if the request includes data that justify that a different compliance time would provide an acceptable level of safety. No change to the AD is made in this regard.

Request To Delay Issuance of the Proposed AD

One commenter states that it previously elected not to do the actions required by the proposed AD on affected airplanes (reference Service Bulletin A320–28–1087, Revision 02). This was because the Direction Générale de l'Aviation Civile (DGAC), which is the airworthiness authority for France, found the Special Federal Aviation Regulation No. 88 (''SFAR 88,'' Amendment 21–78, and subsequent Amendments 21–82 and 21–83) compliance solution proposal submitted by Airbus to be sufficient for compliance with French airworthiness directive 2002–220(B) R1, dated October 15, 2003; although further discussions with the FAA and the DGAC were necessary. These discussions were expected to include the possibility of a requirement to install transient suppression units. Correspondence between the commenter and Airbus confirmed that, in the event that transient suppression units were specified in future rulemaking, the fused adapter/connection installation specified in the service bulletin would be revised. The commenter adds that, according to its cost model, the proposed AD would cost over $500,000 for its fleet. The commenter objects to spending the money if the solution is only interim, with introduction of transient suppression units to follow. The commenter strongly encourages a permanent solution to be introduced and regulated, and is not aware of any in-service data that would suggest that airplane safety could be compromised by delaying the interim solution until introduction of a permanent solution.

We do not agree with the commenter that an alternate solution is necessary, as the modification required by the proposed AD is not an interim action. We have examined the underlying safety issues involved in fuel tank explosions on several transport airplanes. As a result of those findings, we issued a regulation titled ''Transport Airplane Fuel Tank System Design Review, Flammability Reduction and Maintenance and Inspection Requirements.'' In addition to new airworthiness standards for transport airplanes and new maintenance requirements, this rule included SFAR No. 88. Among other actions, SFAR 88 requires certain type design holders to perform design reviews, and to develop design changes and maintenance procedures if necessary. We intend to adopt ADs to mandate any changes found necessary to address unsafe conditions identified during these reviews. Based on this process, we have determined that the modification required by this AD is necessary to address the identified unsafe condition.

Request To Clarify Summary Section

One commenter states that the Summary section of the proposed AD has significant inaccuracies due to the assimilation of two independent unsafe conditions, as identified in the referenced French airworthiness directive. The unsafe conditions require mandatory action, which is achieved by applying the two service bulletins referenced in the proposed AD. The commenter notes that the reason there are two service bulletins, and only one French airworthiness directive, is to minimize the cost impact on the three airplanes requiring correction of both unsafe conditions.

Additionally, the commenter states that the Summary section does not properly distinguish between additional center tanks (ACTs) and center wing tanks, which could lead to misinterpretation of any corrective action necessary. The commenter notes that Airbus Service Bulletin A320–28–1086, Revision 01, dated October 23, 2002 (cited in the proposed AD as an appropriate source of service information for accomplishment of certain actions), affects the ACTs on the three airplanes specified above only. The commenter adds that the identified modifications reposition the high-level sensors to ensure there is a minimum of two percent expansion space in the applicable ACT, and correct a non-compliance to Joint Aviation Regulation (JAR) 25.969. This non-compliance issue could result in fuel overflowing from the ACT to the left wing surge tank in the event of thermal expansion of the fuel in the ACT. The commenter also adds that the bracket that the high-level sensor is attached to, not the high-level sensor, is the part that has been improved.

The commenter also states that Airbus Service Bulletin A320–28–1087, Revision 02, dated June 10, 2003 (cited in the proposed AD as an appropriate source of service information for accomplishment of certain actions), affects all fuel tanks (all wing tanks and all ACTs), on the affected airplanes. The modification identified is to install fuses in the fuel quantity indicating (FQI) harnesses at or near the fuel tank walls, which corrects a non-compliance with JAR 25.981. This non-compliance issue could result in the ignition of flammable fuel vapors in a fuel tank in the event of a short circuit between the FQI wiring and an unprotected 28-volt supply.

In conclusion, the commenter states that the Summary section should clearly distinguish between these two unsafe conditions and should provide certain wording to more clearly define the two unsafe conditions.

We agree with the commenter and have changed the applicable sections in this AD, for clarification, to separate the two unsafe conditions.

Request To Change Paragraph (a) of This AD

In following up on his request to distinguish the two unsafe conditions, the commenter requests the following changes, which would include a new paragraph (b):

''(a) Within 4,000 flight hours or 30 months after the effective date of this AD, whichever is first: Do the applicable actions specified in paragraph (a)(1) of this AD. Accomplishment of the modification before the effective date of this AD per Airbus Service Bulletin A320–28–1087, dated July 17, 2001, or Revision 01, dated March 3, 2003; is acceptable for compliance with the corresponding action specified in paragraph (a)(1) of this AD.

(1) For airplanes defined in Airbus Service Bulletin A320–28–1087, Revision 02, dated June 10, 2003: Modify the wiring of the fuel quantity indicating probes of all the fuel tanks by doing all the actions specified in paragraphs 3.A. through 3.D. (including operational testing and any applicable repair) of the Accomplishment Instructions of the service bulletin. Any applicable repair must be done before further flight.

(b) Within 4,000 flight hours or 30 months after the effective date of this

AD, whichever is first: Do the applicable actions specified in paragraph (b)(1) of this AD. Accomplishment of the replacement before the effective date of this AD per Airbus Service Bulletin A320–28–1086, dated November 30, 1999; as applicable; is considered acceptable for compliance with the corresponding action specified in paragraph (b)(1) of this AD.

(1) For airplanes defined in Airbus Service Bulletin A320–28–1086, Revision 01, dated October 23, 2002: Prior to or concurrent with accomplishment of paragraph (a)(1) of this AD, replace the high-level sensors of the additional center fuel tanks by doing all the actions specified in paragraphs 3.A through 3.D. (including operational testing and any applicable repair) of the Accomplishment Instructions of the service bulletin. Do the actions per the service bulletin. Any applicable repair must be done before further flight.'' The commenter provided no justification for the requested changes.

After reviewing the commenter's suggested changes to paragraph (a) of the proposed AD, we find that specifying ''all the fuel tanks'' instead of ''the center and wing fuel tanks,'' is the only significant change. We also find that moving the service bulletin references around, as suggested by the commenter, does not clarify the requirements of that paragraph. Therefore, we have changed the wording in paragraph (a)(1) of this AD to specify ''all the fuel tanks,'' for clarification; we made no further changes to paragraph (a) of this AD.

Request To Clarify Certain Sections in the Preamble

The same commenter reiterates certain wording regarding compliance with JAR 25.989, as specified in the Discussion section of the proposed AD, and notes that the wording is incorrect. The commenter states that the referenced testing is specific to some ACTs that can be fitted only to Model A319 series airplanes with Airbus Modification 28238 installed, and does not relate to other ACTs fitted to Models A319 and A320 series airplanes, or to center (wing) tanks. The commenter adds that the correct reference is JAR 25.969, not 25.989. The commenter notes that the high-level sensor is not improved and has no regulatory deficiency, and adds that it is the bracket that the sensor is attached to that is improved to provide the required expansion space. In addition, the commenter states that there is no connection between changing the high-level sensor position and the overheating of the FQI fuel probes in the event of an external 28-volt short circuit to the FQI fuel probe wiring. The commenter adds that there is no risk of the high-level sensor overheating in the event of an external 28-volt short circuit to its wiring.

The commenter also states that there is no risk of fuel spillage resulting from inadequate expansion space, which could result in fuel vapors or fuel contacting an ignition source, and/or consequent fire/explosion in the center fuel tank. Any fuel spillage will be contained within the fuel vent system until the left wing surge tank is overfilled and subsequent limited fuel spillage from the surge tank through a flame arrestor could occur. The commenter adds that in the event of fuel spillage from the surge tank, and in the presence of an ignition source on the ground, a ground fire could be ignited. In the event of a ground fire, the flame arrestor installed for this purpose will eventually protect the fuel tank.

The commenter notes that the section titled **ADDRESSES** incorrectly identifies the airplane manufacturer as ''Airbus Industrie.'' The airplane manufacturer should be identified as ''Airbus.''

The same commenter states that the Explanation of Relevant Service Information section in the preamble of the proposed AD is unclear in identifying which tanks apply to Service Bulletin A320–28–1087, Revision 02. The commenter states that the text should read, ''Airbus has issued Service Bulletin A320–28–1087, Revision 02, which describes procedures for modification of the wiring of the FQI probes of all fuel tanks.'' The modification includes the following:

- Installation of fused plug connectors for the FQI probes of the wing tanks; and
- Installation of fused adapters between the external wiring harness and the in-tank wiring of the connectors on the ACT and center wing fuel tank walls.

The commenter notes that the term ''center tank'' is imprecise, as it could be interpreted to mean the center wing tank and not the ACT. This could lead to the exclusion of necessary corrective action for some fuel tanks. The fact that the modification is applicable to all fuel tanks is explicitly described by using the word ''all.''

We acknowledge and agree with the commenter's remarks on the preamble of the proposed AD; however, most of the sections referred to are not restated in this final rule. The name of the airplane manufacturer specified in the **''ADDRESSES''** section has been changed to Airbus. No other change to the AD is made in this regard.

Inadequate Technical Information Provided in the Service Bulletins

One commenter states that it is apparent that the information in the service bulletins lacks adequate technical detail for the commenter to form an opinion relative to the content. The commenter adds that Service Bulletin A320–28–1087 specifies adding fused connectors/adapters to protect the fuel gauging lines from hot shorts to 28 volt direct current that enter the fuel tanks. However, there is no information regarding compliance with Advisory Circular (AC) 25.981, which provides guidance for the overall safe design of fuel systems under certain conditions. The commenter notes that compliance with the AC may require a different design approach, in which case issuance of the proposed AD, although improving the level of safety, would be premature and would cause an unnecessary financial burden for operators. The commenter is unable to render a sound technical opinion as to the accuracy of the proposed AD, due to insufficient data.

We appreciate the commenter's concerns; however, it is not standard practice to provide technical details for design changes in service bulletins. The modification required by this AD is intended to prevent excessive currents from entering the FQI probes. Investigations have shown that a short of 28-volt direct current to the probes could cause certain parts of the probe to heat up to a temperature in excess of 200 degrees centigrade. Additionally, all FQI probe wiring installed on Model A319 series airplanes is co-routed with 28-volt direct current. The service bulletin was issued to provide procedures to modify the airplane to the approved type design. We do not agree that this AD is premature. In this case, we find that to withdraw this AD and initiate new proposed rulemaking (providing for public opportunity to comment) would significantly delay the rulemaking process and would be inappropriate in light of the identified unsafe condition. We have determined that issuance of this AD is appropriate and warranted.

Request To Revise Cost Impact Section

One commenter states that there are presently no airplanes registered in the U.S. for which Service Bulletin A320–28–1086 applies (Models A319–115 and A319–133 series airplanes). The commenter requests that the Cost Impact section of the proposed AD be revised to provide, for future imported

airplanes, accomplishment of the proposed actions through a Certificate of Airworthiness.

We do not agree to provide for accomplishment of the proposed actions through a Certificate of Airworthiness for future imported Models A319–115 and A319–133 series airplanes. We do agree that those airplanes are not U.S.-registered; therefore, we have added a new paragraph to the Cost Impact section to provide the estimated costs for those airplanes should the airplanes be imported and placed on the U.S. Register in the future.

Conclusion

After careful review of the available data, including the comments noted above, the FAA has determined that air safety and the public interest require the adoption of the rule with the changes described previously. We have determined that these changes will neither increase the economic burden on any operator nor increase the scope of the AD.

Cost Impact

We estimate that 468 Model A319–111, –112, –113, –114, –131, and –132 and Model A320 series airplanes of U.S. registry will be affected by this AD.

It will take between 10 and 22 work hours per airplane to accomplish the modification, at an average labor rate of $65 per work hour. Required parts will cost between $670 and $5,750 per airplane. Based on these figures, the cost impact of the modification required by this AD on U.S. operators is estimated to be between $617,760 and $3,360,240, or between $1,320 and $7,180 per airplane.

If an operator is required to replace the high-level sensors, it will take about 80 work hours, at an average labor rate of $65 per work hour. Required parts are free of charge. Based on these figures, the cost impact of the replacement required by this AD is estimated to be $5,200 per airplane.

The cost impact figures discussed above are based on assumptions that no operator has yet accomplished any of the requirements of this AD action, and that no operator would accomplish those actions in the future if this AD were not adopted. The cost impact figures discussed in AD rulemaking actions represent only the time necessary to perform the specific actions actually required by the AD. These figures typically do not include incidental costs, such as the time required to gain access and close up, planning time, or time necessitated by other administrative actions.

Currently, there are no affected A319–115 and A319–133 series airplanes on the U.S. Register. However, if an affected airplane is imported and placed on the U.S. Register in the future, the required modification would take between 10 and 22 work hours per airplane, at an average labor rate of $65 per work hour. Required parts will cost between $670 and $5,750 per airplane. Based on these figures, we estimate the cost of this AD to be between $1,320 and $7,180 per airplane.

Regulatory Impact

The regulations adopted herein will not have a substantial direct effect on the States, on the relationship between the national Government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, it is determined that this final rule does not have federalism implications under Executive Order 13132.

For the reasons discussed above, I certify that this action (1) is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and (3) will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act. A final evaluation has been prepared for this action and it is contained in the Rules Docket. A copy of it may be obtained from the Rules Docket at the location provided under the caption ''**ADDRESSES.**''

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

■ Accordingly, pursuant to the authority delegated to me by the Administrator, the Federal Aviation Administration amends part 39 of the Federal Aviation Regulations (14 CFR part 39) as follows:

PART 39—AIRWORTHINESS DIRECTIVES

■ 1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

■ 2. Section 39.13 is amended by adding the following new airworthiness directive:

2004–23–04 Airbus: Amendment 39–13859. Docket 2002-NM–153√AD.

Applicability: Model A319 and A320 series airplanes, certificated in any category; as listed in Airbus Service Bulletin A320–28–1087, Revision 02, dated June 10, 2003; and Airbus Service Bulletin A320–28–1086, Revision 01, dated October 23, 2002.

Compliance: Required as indicated, unless accomplished previously.

To prevent overheating of the fuel probes due to a short circuit, and fuel leakage due to inadequate space for thermal expansion within the additional center tanks, which could result in fuel vapors or fuel contacting an ignition source, accomplish the following:

Modification/Replacement

(a) Within 4,000 flight hours or 30 months after the effective date of this AD, whichever is first: Do the applicable actions specified in paragraphs (a)(1) and (a)(2) of this AD. Accomplishment of the modification before the effective date of this AD per Airbus Service Bulletin A320–28–1087, dated July 17, 2001; or Revision 01, dated March 3, 2003; or accomplishment of the replacement before the effective date of this AD per Airbus Service Bulletin A320–28–1086, dated November 30, 1999; as applicable; is considered acceptable for compliance with the corresponding action specified in paragraph (a)(1) or (a)(2) of this AD.

(1) For airplanes defined in Airbus Service Bulletin A320–28–1087, Revision 02, dated June 10, 2003: Modify the wiring of the fuel quantity indicating probes of all the fuel tanks by doing all the actions specified in paragraphs 3.A. through 3.D. (including operational testing and any applicable repair) of the Accomplishment Instructions of the service bulletin. Do the actions per the service bulletin. Any applicable repair must be done before further flight.

(2) For airplanes defined in Airbus Service Bulletin A320–28–1086, Revision 01, dated October 23, 2002: Prior to or concurrent with accomplishment of paragraph (a)(1) of this AD, replace the high-level sensors of the additional center fuel tanks by doing all the actions specified in paragraphs 3.A through 3.D. (including operational testing and any applicable repair) of the Accomplishment Instructions of the service bulletin. Do the actions per the service bulletin. Any applicable repair must be done before further flight.

Alternative Methods of Compliance

(b) In accordance with 14 CFR 39.19, the Manager, International Branch, ANM–116, FAA, Transport Airplane Directorate, is authorized to approve alternative methods of compliance for this AD.

Incorporation by Reference

(c) Unless otherwise specified in this AD, the actions shall be done in accordance with Airbus Service Bulletin A320–28–1086, Revision 01, dated October 23, 2002; or Airbus Service Bulletin A320–28–1087, Revision 02, dated June 10, 2003; as applicable. This incorporation by reference was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. For copies, contact Airbus, 1 Rond Point Maurice Bellonte, 31707 Blagnac Cedex, France. Inspect copies at the FAA, Transport Airplane Directorate,

1601 Lind Avenue, SW., Renton, Washington; or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call (202) 741–6030, or go to: *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.*

Note 1: The subject of this AD is addressed in French airworthiness directive 2002–220(B) R1, dated October 15, 2003.

Effective Date

(d) This amendment becomes effective on December 20, 2004.

Issued in Renton, Washington, on November 1, 2004.

Ali Bahrami,

Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 04–24933 Filed 11–12–04; 8:45 am]

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DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 2002–NM–97–AD; Amendment 39–13863; AD 2004–23–08]

RIN 2120–AA64

Airworthiness Directives; Airbus Model A300 B4–600R and A300 F4–600R Series Airplanes

AGENCY: Federal Aviation Administration, DOT.

ACTION: Final rule.

SUMMARY: This amendment supersedes an existing airworthiness directive (AD), applicable to Airbus Model A300 B4–600R and A300 F4–600R series airplanes, that currently requires a one-time detailed inspection for damage of the center tank fuel pumps and fuel pump canisters, and replacement of damaged fuel pumps and fuel pump canisters with new or serviceable parts. That AD also requires repetitive detailed inspections of the fuel pumps and repetitive eddy current inspections of the fuel pump canisters, and replacement of damaged fuel pumps and fuel pump canisters with new or serviceable parts. This amendment mandates modification of the canisters of the center tank fuel pumps, which would terminate the repetitive inspections required by the existing AD. The actions specified by this AD are intended to prevent damage to the fuel pump and fuel pump canister, which could result in loss of flame trap capability and could provide a fuel ignition source in the center fuel tank. This action is intended to address the identified unsafe condition.

DATES: Effective December 20, 2004.

The incorporation by reference of Airbus Service Bulletin A300–28–6069, Revision 01, dated May 28, 2002; and Airbus Service Bulletin A300–28–6061, Revision 04, dated August 1, 2002; as listed in the regulations, is approved by the Director of the Federal Register as of December 20, 2004.

The incorporation by reference of Airbus All Operators Telex (AOT) 28–09, dated November 28, 1998, as listed in the regulations, was approved previously by the Director of the Federal Register as of December 28, 1998 (63 FR 70639, December 22, 1998).

The incorporation by reference of Airbus Alert Service Bulletin A300–28A6061, dated February 19, 1999, as listed in the regulations, was approved previously by the Director of the Federal Register as of February 8, 2000 (65 FR 213, January 4, 2000).

ADDRESSES: The service information referenced in this AD may be obtained from Airbus Industrie, 1 Rond Point Maurice Bellonte, 31707 Blagnac Cedex, France. This information may be examined at the Federal Aviation Administration (FAA), Transport Airplane Directorate, Rules Docket, 1601 Lind Avenue, SW., Renton, Washington; or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call (202) 741–6030, or go to: *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.*

FOR FURTHER INFORMATION CONTACT: Tim Backman, Aerospace Engineer, International Branch, ANM–116, FAA, Transport Airplane Directorate, 1601 Lind Avenue, SW., Renton, Washington 98055–4056; telephone (425) 227–2797; fax (425) 227–1149.

SUPPLEMENTARY INFORMATION: A proposal to amend part 39 of the Federal Aviation Regulations (14 CFR part 39) by superseding AD 99–27–07, amendment 39–11488 (65 FR 213, January 4, 2000), which is applicable to all Airbus Model A300 B4–600R and A300 F4–600R series airplanes, was published in the **Federal Register** on September 9, 2003 (68 FR 53058). The action proposed to continue to require a one-time visual inspection for damage of the center tank fuel pumps and fuel pump canisters, and replacement of damaged fuel pumps and fuel pump canisters with new or serviceable parts. The action also proposed to continue to require repetitive detailed inspections for damage of the fuel pumps and repetitive eddy current inspections of the fuel pump canisters, and replacement of damaged fuel pumps and fuel pump canisters with new or serviceable parts. The action also proposed to mandate modification of the canisters of the center tank fuel pumps, which would terminate the repetitive inspections required by the existing AD.

Comments

Interested persons have been afforded an opportunity to participate in the making of this amendment. Due consideration has been given to the comments received.

Request To Change Compliance Time

One commenter requests that the compliance time for the terminating action (modification) specified in paragraph (d) of the proposed AD be changed to ''Prior to the accumulation of 5,000 total hours, time-in-service, or within 18 months after the effective date of this AD, whichever occurs later.'' The commenter notes that an equivalent level of safety is maintained by this change, as the change will still require the modification to be done prior to the first inspection required by AD 99–27–07. The commenter adds that this change will minimize the hardship of implementing the proposed AD.

The FAA does not agree, as repetitive inspections for cracks are not equivalent to replacement of the canisters of the center tank fuel pumps with improved canisters for continued operational safety. Cracked canisters continue to be detected during the mandated inspections, but in view of the potential unsafe condition, we find that modification of the canisters by installation of reinforced canisters that are not subject to cracking must be done. In addition, inclusion of a 5,000 flight hour compliance time could allow certain low-time airplanes an additional year before accomplishment of the canister replacement. We do not find it necessary to change the AD in this regard. However, the commenter may request approval of an alternative method of compliance from the FAA, in accordance with paragraph (g)(1) of this AD, if technical justification, substantiation of need, and a satisfactory retrofit status of the commenter's fleet with the new canister are provided.

Clarification of Terminating Action

One commenter states that paragraph (d) of the proposed AD (New Requirements of This AD) specifies that accomplishment of Airbus Service Bulletin A300–28–6069, Revision 01, dated May 28, 2002 (modification of the canisters of the center tank fuel pumps)

ends the repetitive inspections required by paragraph (b) of the proposed AD. The commenter adds that initial accomplishment of the paragraph (b) inspection would terminate the repetitive inspections required by paragraph (a) of the proposed AD. The commenter notes that, as written, the proposed AD seems to require the initial accomplishment of the inspection required by paragraph (b) to terminate the repetitive inspections. The commenter asks for clarification of the intent of the AD.

As requested, we provide the following clarification: The AD does require accomplishment of the initial inspection required by paragraph (b) of this AD to terminate the repetitive inspections required by paragraph (a) of this AD. The repetitive inspections specified in paragraphs (a) and (b) of the AD are required by AD 99–27–07 (Restatement of Requirements of AD 99–27–07), and continue to be required by this AD until the terminating action is done. The new requirements that mandate modification of the canisters of the center tank fuel pumps, as specified in paragraph (d) of this AD, terminate those repetitive inspections.

Request To Change Terminating Action to Optional

One commenter states that AD 99–27–07 addresses the unsafe condition identified by that rule, and adds that the proposed AD does not provide justification for mandating the terminating action. The commenter provides the following reasons for changing the terminating action in the proposed AD to an optional action.

- The proposed AD does not specifically identify an additional unsafe condition, so there is no need to add further financial burden for operators without justifiable cause.
- Operators favor the use of terminating action in lieu of repetitive inspections; however, where either solution offers the same level of safety, this decision becomes a matter of economics.
- There is no safety benefit identified for the terminating action, so the decision to continue to inspect, or implement the terminating action, should remain at the option of the operator.

The commenter adds that there is no reasonable basis for the 18-month compliance time for the terminating action, as it appears arbitrary. Due to the current economic conditions of the airline industry, operators should be given the option of replacing the canister with the improved design, or continuing the scheduled inspections and replacing the canister only if a crack is found during the inspection. The commenter adds that the scheduled inspections, when done in accordance with AD 99–27–07, will provide a level of safety equivalent to that provided by the proposed AD.

We do not agree. The unsafe condition specified in AD 99–27–07 has not been corrected; therefore, an additional unsafe condition does not need to be added to this AD, as there has been no final fix until now. Although we acknowledge the commenter's concerns regarding further financial burden on operators, the FAA, in conjunction with the Direction Générale de l'Aviation Civile (DGAC), which is the airworthiness authority for France, is mandating the terminating action based on the determination that, in this case, long-term continued operational safety would be better assured by a modification to remove the source of the problem, rather than by continued repetitive inspections. We consider the existing canisters of the center fuel tank to be a safety issue of sufficient significance to warrant modification of the canisters. Relying on continued repetitive inspections as an option to the modification does not ensure that affected airplanes will receive appropriately modified canisters in a timely manner, or at all.

The fuel pump canister is intended to contain or trap any potential fuel pump ignition sources and consequent flames in the canister, and keep them from entering the fuel tank. A crack in the fuel pump canister has the potential to eliminate the canister fire trap capability and provide an ignition source to the center tank fuel pump. The new, improved canisters have been strengthened by thicker and re-profiled webs, the fuel aperture corner radius has been increased, the non-return valve has been strengthened, and the attachment fasteners have been increased from four to six inches. A canister locating pin (foolproofing pin) is also installed by this modification, which will prevent the installation of unmodified fuel booster-pump canisters. Accordingly, no change to the AD is made in this regard.

Request To Change Cost Analysis

The same commenter states that the proposed AD lacks adequate cost analysis. The commenter states that the cost of the canister is omitted, and specifies the cost as $4,660 per canister. The commenter adds that the actual cost of the proposed AD, using actual industry wages and the omitted cost for parts, would be $10,548 per airplane or $886,032; not the $76,660 cost calculated by the FAA.

After considering the data presented by the commenter, we agree that the parts cost for the canisters was omitted. The cost of each canister is $4,660. The cost impact information, below, has been revised to indicate this higher amount.

Economic Analysis

The same commenter states that it appreciates the FAA economic analysis for using work time estimates consistent with industry experience; however, the FAA labor rate remains much lower than actual industry costs. The commenter adds that the average airline industry labor rate is currently $98 per work hour.

We point out that our estimate of $65 per work hour is the current burdened labor rate established for use by the Office of Aviation Policy, Plans, and Management Analysis. (The burdened labor rate includes the actual labor cost, overhead, and other related costs.) Because the labor rate used in our calculations accounts for the variations in costs among those in the airline industry, we consider that $65 per work hour is appropriate. Accordingly, no change to the AD is made in this regard.

Explanation of Change Made to Proposed AD

We have clarified the inspection requirement contained in the proposed AD. Whereas the proposed AD specifies a visual inspection, we have revised this final rule to clarify that our intent is to require a detailed inspection. Additionally, a new note has been added to the final rule to define that inspection.

Conclusion

We have carefully reviewed the available data, including the comments that have been submitted, and determined that air safety and the public interest require adopting the AD with the changes described previously. We have determined that these changes will neither significantly increase the economic burden on any operator nor increase the scope of the AD.

Cost Impact

This AD will affect about 84 airplanes of U.S. registry.

The inspections that are required by AD 99–27–07 take about 2 work hours per airplane to accomplish, at an average labor rate of $65 per work hour. Based on these figures, the cost impact of the currently required actions is estimated to be $130 per airplane, per inspection cycle.

The inspections required by AD 99–27–07 were applicable to about 67 airplanes. Based on the figures discussed above, the cost impact of the current requirements of that AD on U.S. operators is estimated to be $8,710.

In this AD, the inspections are applicable to about 17 additional airplanes. Based on the figures discussed above, the new costs to U.S. operators that will be imposed by this AD are estimated to be $2,210.

The new modification required by this AD action will take about 11 work hours per airplane to accomplish, at an average labor rate of $65 per work hour. Required parts will cost about $9,620 per airplane. Based on these figures, the cost impact of the modification on U.S. operators is estimated to be $868,140, or $10,335 per airplane.

The cost impact figures discussed above are based on assumptions that no operator has yet accomplished any of the requirements of this AD action, and that no operator would accomplish those actions in the future if this AD were not adopted. The cost impact figures discussed in AD rulemaking actions represent only the time necessary to perform the specific actions actually required by the AD. These figures typically do not include incidental costs, such as the time required to gain access and close up, planning time, or time necessitated by other administrative actions.

Regulatory Impact

The regulations adopted herein will not have a substantial direct effect on the States, on the relationship between the national Government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, it is determined that this final rule does not have federalism implications under Executive Order 13132.

For the reasons discussed above, I certify that this action (1) is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and (3) will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act. A final evaluation has been prepared for this action and it is contained in the Rules Docket. A copy of it may be obtained from the Rules Docket at the location provided under the caption **ADDRESSES**.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

■ Accordingly, pursuant to the authority delegated to me by the Administrator, the Federal Aviation Administration amends part 39 of the Federal Aviation Regulations (14 CFR part 39) as follows:

PART 39—AIRWORTHINESS DIRECTIVES

■ 1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

■ 2. Section 39.13 is amended by removing amendment 39–11488 (65 FR 213, January 4, 2000), and by adding a new airworthiness directive (AD), amendment 39–13863, to read as follows:

2004–23–08 Airbus: Amendment 39–13863. Docket 2002–NM–97–AD. Supersedes AD 99–27–07, Amendment 39–11488.

Applicability: Model A300 B4–600R and A300 F4–600R series airplanes, certificated in any category, on which Airbus Modification 4801 (trim tank system) has been accomplished.

Compliance: Required as indicated, unless accomplished previously.

To prevent damage to the fuel pump and fuel pump canister, which could result in loss of flame trap capability and could provide a fuel ignition source in the center fuel tank, accomplish the following:

Restatement of Requirements of AD 99–27–07

Inspections

(a) Prior to the accumulation of 5,000 total hours, time-in-service or within 250 hours time-in-service after February 8, 2000 (the effective date of AD 99–27–07, amendment 39–11488), whichever occurs later, perform a detailed inspection for damage of the center tank fuel pumps and fuel pump canisters, in accordance with Airbus All Operators Telex (AOT) 28–09, dated November 28, 1998. Repeat the inspection prior to the accumulation of 12,000 total hours time-in-service, or within 250 hours time-in-service after accomplishment of the initial inspection, whichever occurs later. Thereafter, repeat the inspection at intervals not to exceed 250 hours time-in-service, until accomplishment of the initial inspection required by paragraph (b) of this AD.

Note 1: For the purposes of this AD, a detailed inspection is: ''An intensive examination of a specific item, installation, or assembly to detect damage, failure, or irregularity. Available lighting is normally supplemented with a direct source of good lighting at an intensity deemed appropriate. Inspection aids such as mirror, magnifying lenses, etc., may be necessary. Surface cleaning and elaborate procedures may be required.''

(b) At the applicable time specified in paragraph (b)(1), (b)(2), or (b)(3) of this AD: Perform a detailed inspection to detect damage of the center tank fuel pumps and perform an eddy current inspection to detect damage of the fuel pump canisters, in accordance with Airbus Alert Service Bulletin A300–28A6061, dated February 19, 1999; or Airbus Service Bulletin A300–28–6061, Revision 04, dated August 1, 2002. Repeat the inspections thereafter at intervals not to exceed 1,500 flight cycles, until accomplishment of paragraph (d) of this AD. Accomplishment of the initial inspections required by this paragraph constitutes terminating action for the requirements of paragraph (a) of this AD.

(1) For airplanes that have accumulated 11,000 or more total flight cycles as of February 8, 2000: Inspect within 300 flight cycles after February 8, 2000.

(2) For airplanes that have accumulated 8,500 or more total flight cycles, but fewer than 11,000 total flight cycles, as of February 8, 2000: Inspect within 750 flight cycles after February 8, 2000.

(3) For airplanes that have accumulated fewer than 8,500 total flight cycles as of February 8, 2000: Inspect prior to the accumulation of 7,000 flight cycles, or within 1,500 flight cycles after February 8, 2000, whichever occurs later.

Corrective Action

(c) If any damage is detected during any inspection required by this AD, prior to further flight, replace the damaged fuel pump or fuel pump canister with a new or serviceable part in accordance with Airbus Alert Service Bulletin A300–28A6061, dated February 19, 1999; or Airbus Service Bulletin A300–28–6061, Revision 04, dated August 1, 2002.

New Requirements of This AD

Modification

(d) Within 18 months after the effective date of this AD: Modify the canisters of the center tank fuel pumps (including an operational test) by doing all the actions per paragraphs 3.A., 3.B., 3.C., and 3.D. of the Accomplishment Instructions of Airbus Service Bulletin A300–28–6069, Revision 01, dated May 28, 2002. Accomplishment of this modification ends the repetitive inspections required by paragraph (b) of this AD.

(e) Accomplishment of the modification before the effective date of this AD per Airbus Service Bulletin A300–28–6069, dated September 4, 2001, is acceptable for compliance with the modification required by paragraph (d) of this AD.

Alternative Methods of Compliance

(f)(1) In accordance with 14 CFR 39.19, the Manager, International Branch, ANM–116, FAA, is authorized to approve alternative methods of compliance for this AD.

(2) Alternative methods of compliance, approved previously in accordance with AD 99–27–07, amendment 39–11488, are approved as alternative methods of compliance with the applicable actions in this AD.

Incorporation by Reference

(g) The actions shall be done in accordance with the applicable service information listed in Table 1 of this AD, unless the AD specifies otherwise.

TABLE 1.—MATERIALS INCORPORATED BY REFERENCE

Airbus service information	Revision level	Date
All Operators Telex 28–09	Original	November 28, 1998.
Alert Service Bulletin A300–28A6061	Original	February 19, 1999.
Service Bulletin, A300–28–6061	04	August 1, 2002.
Service Bulletin, A300–28–6069	01	May 28, 2002.

(1) The incorporation by reference of Airbus Service Bulletin A300–28–6069, Revision 01, dated May 28, 2002; and Airbus Service Bulletin A300–28–6061, Revision 04, dated August 1, 2002; is approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51.

(2) The incorporation by reference of Airbus All Operators Telex (AOT) 28–09, dated November 28, 1998, was approved previously by the Director of the Federal Register as of December 28, 1998 (63 FR 70639, December 22, 1998).

(3) The incorporation by reference of Airbus Alert Service Bulletin A300–28A6061, dated February 19, 1999, was approved previously by the Director of the Federal Register as of February 8, 2000 (65 FR 213, January 4, 2000).

(4) Copies may be obtained from Airbus, 1 Rond Point Maurice Bellonte, 31707 Blagnac Cedex, France. Copies may be inspected at the FAA, Transport Airplane Directorate, 1601 Lind Avenue, SW., Renton, Washington; or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call (202) 741–6030, or go to: *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.*

Note 2: The subject of this AD is addressed in French airworthiness directive 2002–132(B), dated March 20, 2002.

Effective Date

(h) This amendment becomes effective on December 20, 2004.

Issued in Renton, Washington, on November 1, 2004.

Ali Bahrami,

Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 04–24930 Filed 11–12–04; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 2000–NM–169–AD; Amendment 39–13860; AD 2004–23–05]

RIN 2120–AA64

Airworthiness Directives; McDonnell Douglas Model DC–9–81 (MD–81), DC–9–82 (MD–82), DC–9–83 (MD–83), DC–9–87 (MD–87), and Model MD–88 Airplanes

AGENCY: Federal Aviation Administration, DOT.

ACTION: Final rule.

SUMMARY: This amendment adopts a new airworthiness directive (AD), applicable to certain McDonnell Douglas airplanes, that requires reversing the ground stud installation of the main battery, and installing a new nameplate on the cover of the battery. This action is necessary to prevent damage to equipment or possible fire in the electrical/electronics equipment compartment due to electrical arcing between the ground stud of the main battery and adjacent structure. This action is intended to address the identified unsafe condition.

DATES: Effective December 20, 2004.

The incorporation by reference of a certain publication listed in the regulations is approved by the Director of the Federal Register as of December 20, 2004.

ADDRESSES: The service information referenced in this AD may be obtained from Boeing Commercial Airplanes, Long Beach Division, 3855 Lakewood Boulevard, Long Beach, California 90846, Attention: Data and Service Management, Dept. C1–L5A (D800–0024). This information may be examined at the Federal Aviation Administration (FAA), Transport Airplane Directorate, Rules Docket, 1601 Lind Avenue, SW., Renton, Washington; or at the FAA, Los Angeles Aircraft Certification Office, 3960 Paramount Boulevard, Lakewood, California; or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call (202) 741–6030, or go to: *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.*

FOR FURTHER INFORMATION CONTACT: Elvin Wheeler, Aerospace Engineer, Systems and Equipment Branch, ANM–130L, FAA, Los Angeles Aircraft Certification Office, 3960 Paramount Boulevard, Lakewood, California 90712–4137; telephone (562) 627–5344; fax (562) 627–5210.

SUPPLEMENTARY INFORMATION: A proposal to amend part 39 of the Federal Aviation Regulations (14 CFR part 39) to include an airworthiness directive (AD) that is applicable to certain McDonnell Douglas airplanes was published in the **Federal Register** on June 18, 2003 (68 FR 36518). That action proposed to require reversing the ground stud installation of the main battery, and installing a new nameplate on the cover of the battery.

Comments

Interested persons have been afforded an opportunity to participate in the making of this amendment. Due consideration has been given to the comments received.

Support for Proposed AD

One commenter supports the proposed AD.

Request To Allow Equivalent Nameplates

One commenter requests that we allow operators to use equivalent nameplates in lieu of the original equipment manufacturer (OEM) nameplates. The commenter states that, in an effort to reduce costs, many operators manufacture equivalent nameplates with identical information, which they install at the location(s) specified in the applicable service bulletin(s) referenced in the proposed AD.

We acknowledge the operator's desire to minimize cost; however, we do not consider it appropriate to include various provisions in an AD to accommodate individual operators' unique methods for complying with the AD. However, according to paragraph (c) of this AD, operators may request to use a unique nameplate as an alternative method of compliance. We have not changed this final rule regarding this issue.

Request To Revise the Cost Impact Figures

The same commenter states that, while the proposed AD specifies two work hours for the proposed actions, the referenced service bulletin specifies three work hours for those actions. The commenter asserts that the figure specified in the referenced service bulletin more accurately reflects the time necessary to accomplish those actions.

From this comment, we infer that the commenter is requesting that we revise the Cost Impact section of the proposed AD. We do not agree. As stated in the preamble of the proposed AD, the cost impact figures discussed in AD rulemaking actions represent only the time necessary to perform the specific actions actually required by the AD. Those figures typically do not include incidental costs, such as the time required to gain access and close up, planning time, or time necessitated by other administrative actions. The work-hour figure listed in the referenced service bulletin includes time for access and close up. However, as we explain below, we have revised the labor rate used in the proposed AD.

Conclusion

After careful review of the available data, including the comments noted above, the FAA has determined that air safety and the public interest require the adoption of the rule with the change previously described. The FAA has determined that this change will neither increase the economic burden on any operator nor increase the scope of the AD.

Labor Rate Increase

After the proposed AD was issued, we reviewed the figures we have used over the past several years to calculate AD costs to operators. To account for various inflationary costs in the airline industry, we find it necessary to increase the labor rate used in these calculations from $60 per work hour to $65 per work hour. The cost impact information, below, reflects this increase in the specified hourly labor rate.

Cost Impact

There are approximately 1,224 Model DC–9–81 (MD–81), DC–9–82 (MD–82), DC–9–83 (MD–83), DC–9–87 (MD–87), and Model MD–88 airplanes of the affected design in the worldwide fleet. The FAA estimates that 600 airplanes of U.S. registry will be affected by this AD, that it will take approximately 2 work hours per airplane to accomplish the required actions, and that the average labor rate is $65 per work hour. Required parts will cost approximately $38 per airplane. Based on these figures, the cost impact of the AD on U.S. operators is estimated to be $100,800, or $168 per airplane.

The cost impact figure discussed above is based on assumptions that no operator has yet accomplished any of the requirements of this AD action, and that no operator would accomplish those actions in the future if this AD were not adopted. The cost impact figures discussed in AD rulemaking actions represent only the time necessary to perform the specific actions actually required by the AD. These figures typically do not include incidental costs, such as the time required to gain access and close up, planning time, or time necessitated by other administrative actions. The manufacturer may cover the cost of parts associated with this proposed AD, subject to warranty conditions. Manufacturer warranty remedies also may be available for labor costs associated with this proposed AD. As a result, the costs attributable to the proposed AD may be less than stated above.

Regulatory Impact

The regulations adopted herein will not have a substantial direct effect on the States, on the relationship between the national Government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, it is determined that this final rule does not have federalism implications under Executive Order 13132.

For the reasons discussed above, I certify that this action (1) is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and (3) will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act. A final evaluation has been prepared for this action and it is contained in the Rules Docket. A copy of it may be obtained from the Rules Docket at the location provided under the caption **ADDRESSES**.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

■ Accordingly, pursuant to the authority delegated to me by the Administrator, the Federal Aviation Administration amends part 39 of the Federal Aviation Regulations (14 CFR part 39) as follows:

PART 39—AIRWORTHINESS DIRECTIVES

■ 1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

■ 2. Section 39.13 is amended by adding the following new airworthiness directive:

2004–23–05 McDonnell Douglas: Amendment 39–13860. Docket 2000–NM–169–AD.

Applicability: Model DC–9–81 (MD–81), DC–9–82 (MD–82), DC–9–83 (MD–83), DC–9–87 (MD–87), and Model MD–88 airplanes, as listed in McDonnell Douglas Alert Service Bulletin MD80–24A159, Revision 01, dated January 24, 2000; certificated in any category.

Compliance: Required as indicated, unless accomplished previously.

To prevent damage to equipment or possible fire in the electrical/electronics equipment compartment due to electrical arcing between the ground stud of the main battery and adjacent structure; accomplish the following:

Required Actions

(a) Within 1 year after the effective date of this AD, reverse the installation of the ground stud for the main battery and install a new nameplate on the cover of the battery; in accordance with McDonnell Douglas Alert Service Bulletin MD80–24A159, Revision 01, dated January 24, 2000.

Credit for Previously Accomplished Actions

(b) Accomplishment of the actions specified in paragraph (a) of this AD before the effective date of this AD, in accordance with McDonnell Douglas Service Bulletin MD80–24A159, dated March 15, 1996, is considered to be an acceptable method of compliance with paragraph (a) of this AD.

Alternative Methods of Compliance

(c) In accordance with 14 CFR 39.19, the Manager, Los Angeles Aircraft Certification Office, FAA, is authorized to approve alternative methods of compliance for this AD.

Incorporation by Reference

(d) The actions shall be done in accordance with McDonnell Douglas Alert Service Bulletin MD80–24A159, Revision 01, dated January 24, 2000. This incorporation by reference was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. Copies may be obtained from Boeing Commercial Airplanes, Long Beach Division, 3855 Lakewood Boulevard, Long Beach, California 90846, Attention: Data and Service Management, Dept. C1–L5A (D800–0024). Copies may be inspected at the FAA, Transport Airplane Directorate, 1601 Lind Avenue, SW., Renton, Washington; or at the FAA, Los Angeles Aircraft Certification Office, 3960 Paramount Boulevard, Lakewood, California; or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call (202) 741–6030, or go to: *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.*

Effective Date

(e) This amendment becomes effective on December 20, 2004.

Issued in Renton, Washington, on November 1, 2004.

Ali Bahrami,

Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 04–24932 Filed 11–12–04; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 2002–NM–324–AD; Amendment 39–13862; AD 2004–23–07]

RIN 2120–AA64

Airworthiness Directives; Boeing Model 737–100, –200, –300, –400, and –500 Series Airplanes

AGENCY: Federal Aviation Administration, DOT.

ACTION: Final rule.

SUMMARY: This amendment supersedes an existing airworthiness directive (AD), applicable to certain Boeing Model 737 series airplanes, that currently requires modification of certain fuselage support structure for the number 2 galley. This amendment requires modification of the same support structure using new methods based on new calculations. This amendment also expands the applicability of the existing AD to include additional airplanes. The actions specified by this AD are intended to prevent the galley from shifting, which could limit access to the galley door during emergencies, and result in injury to passengers and flightcrew. This action is intended to address the identified unsafe condition.

DATES: Effective December 20, 2004.

The incorporation by reference of certain publications listed in the regulations is approved by the Director of the Federal Register as of December 20, 2004.

ADDRESSES: The service information referenced in this AD may be obtained from Boeing Commercial Airplanes, P.O. Box 3707, Seattle, Washington 98124–2207. This information may be examined at the Federal Aviation Administration (FAA), Transport Airplane Directorate, Rules Docket, 1601 Lind Avenue, SW., Renton, Washington; or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call (202) 741–6030, or go to: *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.*

FOR FURTHER INFORMATION CONTACT: Keith Ladderud, Aerospace Engineer, ANM–150S, FAA, Seattle Aircraft Certification Office, 1601 Lind Avenue, SW., Renton, Washington 98055–4056; telephone (425) 917–6435; fax (425) 917–6590.

SUPPLEMENTARY INFORMATION: A proposal to amend part 39 of the Federal Aviation Regulations (14 CFR part 39) by superseding AD 95–02–08, amendment 39–9127 (60 FR 8295, February 14, 1995), which is applicable to certain Boeing Model 737 series airplanes, was published in the **Federal Register** on May 7, 2004 (69 FR 25505). The action proposed to require modification of certain fuselage support structure for the number 2 galley. The action also proposed to expand the applicability of the existing AD to include additional airplanes.

Comments

Interested persons have been afforded an opportunity to participate in the making of this amendment. Due consideration has been given to the comments received.

Requests To Add an Option To Reduce the Weight Limit of the Galley as an Alternative to the Modification

One commenter states that the wording in the proposed AD and the referenced service bulletin is such that, if the allowable operating weight limit of a given airplane's galley is above a certain threshold value, the proposed modification would be required. The commenter suggests that the proposed AD specify that if a galley has a weight limit above the threshold value, the operator be given the option of reducing the weight limit to the threshold value and re-placarding the galley with the new limit, instead of modifying the airplane.

Another commenter proposes an option be included for operators to reduce the total weight limit of the galley, as opposed to doing the structural modification. The commenter adds that, for all airplanes other than Group 1, the proposed AD forces the operator to use Table A in the referenced service bulletin to determine the structural configuration of the airplane. Based on that configuration, and the allowable galley weight limit, the operator will do the applicable corrective action. The commenter proposes that the FAA specify a weight limit for all airplane groups which is similar to the Group 1 airplanes listed in the proposed AD. The commenter notes that, by doing this, the operator will have the option of either doing the modification and maintaining the current galley weight limit, or reducing the galley weight limit and avoiding the expensive modification.

We agree. We have added a new paragraph (d) to this AD that allows reducing the galley weight limit to 995 pounds or less as an alternative to doing the required modification. The reduction in the galley weight limit will require re-placarding to specify the maximum capacity limit of 995 pounds for the galley. If necessary, re-placarding is required to specify the load limit for individual compartments, to ensure that the total of the individual compartment weights does not exceed the maximum capacity for the galley.

Request To Change Applicability

One commenter states that the applicability section in the proposed AD specifies ''as listed in Boeing Special Attention Service Bulletin 737–53–1154, Revision 1, dated October 3, 2002,'' and paragraph (b) of the proposed AD requires doing the proposed modification within 18 months, per the referenced service bulletin. The commenter adds that the first step specified in the service bulletin is to determine the maximum operating weight of the number 2 galley; the proposed modification is only necessary on airplanes with that galley, and that have an allowable operating weight of more than 995 pounds. The commenter suggests adding further description to the applicability section of the proposed AD to avoid unnecessary research and inspection. The commenter also adds that the applicability specified in AD 95–02–08 includes a description of the galley

weight requirements which is similar to the requirements in this proposed AD.

We agree that the applicability section in this AD could be further clarified. We have changed that section to specify that the proposed AD is applicable to airplanes equipped with intercostal support structures at stringer 5R and having a number 2 galley weight that exceeds 995 pounds (including any attached equipment that imposes loads on the galley).

Request for Changes to Paragraph (c)

One commenter states that it would be helpful if the airplanes referenced in paragraph (c) of the proposed AD are identified. The commenter adds that there will be airplanes that are different from the specified configuration and those airplanes can be addressed in the alternative methods of compliance process.

We do not agree. We have determined that the service bulletin clearly identifies the specific group associated with each airplane in this AD. Identifying each airplane that has been modified, as noted in paragraph (c)(2) of this AD, would not relieve any burden on operators because we would still rely on operators to determine if the airplane was modified per the original issue of the referenced service bulletin. No change to the AD is made in this regard.

The same commenter asks that paragraph (c) be changed from ''* * * do the modification in paragraph (b) of this AD * * *'' to ''* * * modify the upper attachment support structure of galley 2 from body station 344 to 360 (inclusive) between right stringers 3 and 7.'' The commenter states that this change would prevent confusion.

We agree; we have changed paragraph (c) of this AD, as specified above, for clarification.

Conclusion

After careful review of the available data, including the comments noted above, we have determined that air safety and the public interest require the adoption of the rule with the changes previously described. These changes will neither increase the economic burden on any operator nor increase the scope of the AD.

Cost Impact

There are approximately 583 airplanes of the affected design in the worldwide fleet. We estimate that 170 airplanes of U.S. registry will be affected by this AD.

The new actions that are required by this AD will take between 8 and 22 work hours per airplane to accomplish, depending on the airplane's configuration. The average labor rate is $65 per work hour. Required parts will cost between $5,200 and $23,790 per airplane, depending on the airplane's configuration. Based on these figures, the cost impact of the requirements of this AD on U.S. operators is estimated to be between $5,720 and $25,220 per airplane.

The cost impact figures discussed above are based on assumptions that no operator has yet accomplished any of the requirements of this AD action, and that no operator would accomplish those actions in the future if this AD were not adopted. The cost impact figures discussed in AD rulemaking actions represent only the time necessary to perform the specific actions actually required by the AD. These figures typically do not include incidental costs, such as the time required to gain access and close up, planning time, or time necessitated by other administrative actions.

Regulatory Impact

The regulations adopted herein will not have a substantial direct effect on the States, on the relationship between the national Government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, it is determined that this final rule does not have federalism implications under Executive Order 13132.

For the reasons discussed above, I certify that this action (1) is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and (3) will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act. A final evaluation has been prepared for this action and it is contained in the Rules Docket. A copy of it may be obtained from the Rules Docket at the location provided under the caption **ADDRESSES.**

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

■ Accordingly, pursuant to the authority delegated to me by the Administrator, the Federal Aviation Administration amends part 39 of the Federal Aviation Regulations (14 CFR part 39) as follows:

PART 39—AIRWORTHINESS DIRECTIVES

■ 1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

■ 2. Section 39.13 is amended by removing amendment 39–9127 (60 FR 8295, February 14, 1995), and by adding a new airworthiness directive (AD), amendment 39–13862, to read as follows:

2004–23–07 Boeing: Amendment 39–13862. Docket 2002-NM–324-AD. Supersedes AD 95–02–08, Amendment 39–9127.

Applicability: Model 737–100, –200, –300, –400, and –500 series airplanes; certificated in any category; equipped with intercostal support structures at stringer 5R and having a number 2 galley weight of 996 pounds or more (including any attached equipment that imposes loads on the galley).

Compliance: Required as indicated, unless accomplished previously.

To prevent the galley from shifting, which could limit access to the galley door during emergencies, and result in injury to passengers and flightcrew, accomplish the following:

Service Bulletin Reference

(a) The term ''service bulletin,'' as used in this AD, means the Accomplishment Instructions of Boeing Special Attention Service Bulletin 737–53–1154, Revision 1, dated October 3, 2002.

Modification

(b) Except as provided by paragraph (c) or (d) of this AD, as applicable: Within 18 months after the effective date of this AD, modify the upper attachment support structure of galley 2 from body station 344 to 360 inclusive, between right stringers 3 and 7, in accordance with the service bulletin.

(c) For airplanes listed in paragraphs (c)(1) through (c)(3) of this AD: Within 18 months after the effective date of this AD, modify the upper attachment support structure of galley 2 from body station 344 to 360 inclusive, between right stringers 3 and 7. Do the modification in accordance with a method approved by the Manager, Seattle Aircraft Certification Office (ACO), FAA; or in accordance with data meeting the type certification basis of the airplane approved by a Boeing Company Designated Engineering Representative (DER) who has been authorized by the Manager, Seattle ACO, to make such findings. For a modification method to be approved, the approval must specifically reference this AD.

(1) Airplanes listed as Group 1 in the service bulletin, on which the galley has an allowable operating weight of 996 pounds or more.

(2) Airplanes listed as Group 2 in the service bulletin, on which the modifications specified in the initial release of the service bulletin have been incorporated.

(3) Airplanes listed as Groups 3 through 9 in the service bulletin for which the service bulletin specifies to contact Boeing.

Alternative to Accomplishing Modification

(d) Instead of accomplishing the modification required by paragraph (b) or (c) of this AD, as applicable: Within 18 months after the effective date of this AD, do the actions specified in paragraphs (d)(1), (d)(2), and (d)(3) of this AD, in accordance with a method approved by the Manager, Seattle ACO; or in accordance with data meeting the type certification basis of the airplane approved by a Boeing Company DER who has been authorized by the Manager, Seattle ACO, to make such findings.

(1) Reduce the total weight limit of the galley to a maximum capacity of 995 pounds or less.

(2) Re-placard to specify the maximum capacity limit for the galley.

(3) Re-placard to specify the load limit for individual compartments, as necessary, to ensure that the total of the individual compartment weights does not exceed the maximum capacity for the galley.

Alternative Methods of Compliance

(e) In accordance with 14 CFR 39.19, the Manager, Seattle ACO, is authorized to approve alternative methods of compliance (AMOCs) for this AD.

Incorporation by Reference

(f) Unless otherwise specified in this AD, the actions shall be done in accordance with Boeing Special Attention Service Bulletin 737–53–1154, Revision 1, dated October 3, 2002. This incorporation by reference was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. Copies may be obtained from Boeing Commercial Airplanes, P.O. Box 3707, Seattle, Washington 98124–2207. Copies may be inspected at the FAA, Transport Airplane Directorate, 1601 Lind Avenue, SW., Renton, Washington; or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call (202) 741–6030, or go to: *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.*

Effective Date

(g) This amendment becomes effective on December 20, 2004.

Issued in Renton, Washington, on November 1, 2004.

Ali Bahrami,

Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 04–24931 Filed 11–12–04; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 2002–NM–346–AD; Amendment 39–13864; AD 2004–23–09]

RIN 2120–AA64

Airworthiness Directives; Empresa Brasileira de Aeronautica S.A. (EMBRAER) Model EMB–135 and –145 Series Airplanes

AGENCY: Federal Aviation Administration, DOT.

ACTION: Final rule.

SUMMARY: This amendment supersedes an existing airworthiness directive (AD), applicable to certain EMBRAER Model EMB–135 and –145 series airplanes, that currently requires determining whether a defective auxiliary power unit (APU) exhaust silencer is installed on the airplane; and corrective actions if necessary. For certain airplanes, this amendment requires modification of the APU exhaust silencer, and reidentification of the part number for the APU exhaust silencer once the modification is accomplished. For certain other airplanes, this amendment requires repetitive inspections to determine the structural integrity of the APU exhaust silencer; corrective actions, if necessary; eventual modification of the APU exhaust silencer, which terminates the repetitive inspections; and reidentification of the part number for the APU exhaust silencer once the modification is accomplished. This amendment also adds airplanes to the applicability of the existing AD. The actions specified by this AD are intended to prevent separation of the aft baffle assembly from the APU exhaust silencer and consequent separation of the assembly from the airplane, which could cause damage to other airplanes during takeoff and landing operations, or injury to people on the ground. This action is intended to address the identified unsafe condition.

DATES: Effective December 20, 2004.

The incorporation by reference of certain publications listed in the regulations is approved by the Director of the Federal Register as of December 20, 2004.

ADDRESSES: The service information referenced in this AD may be obtained from Empresa Brasileira de Aeronautica S.A. (EMBRAER), P.O. Box 343—CEP 12.225, Sao Jose dos Campos—SP, Brazil. This information may be examined at the Federal Aviation Administration (FAA), Transport Airplane Directorate, Rules Docket, 1601 Lind Avenue, SW., Renton, Washington; or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call (202) 741–6030, or go to: *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.*

FOR FURTHER INFORMATION CONTACT: Todd Thompson, Aerospace Engineer, International Branch, ANM–116, FAA, Transport Airplane Directorate, 1601 Lind Avenue, SW., Renton, Washington 98055–4056; telephone (425) 227–1175; fax (425) 227–1149.

SUPPLEMENTARY INFORMATION: A proposal to amend part 39 of the Federal Aviation Regulations (14 CFR part 39) by superseding AD 2002–16–06, amendment 39–12845 (67 FR 52398, August 12, 2002), which is applicable to certain EMBRAER Model EMB–135 and –145 series airplanes, was published in the **Federal Register** on April 6, 2004 (69 FR 17993). For certain airplanes, the action proposed to require modification of the APU exhaust silencer, and reidentification of the part number for the APU exhaust silencer once the modification is accomplished. For certain other airplanes, the action proposed to require repetitive inspections to determine the structural integrity of the APU exhaust silencer; corrective actions, if necessary; eventual modification of the APU exhaust silencer, which terminates the repetitive inspections; and reidentification of the part number for the APU exhaust silencer once the modification is accomplished. That action also proposed to add airplanes to the applicability of the existing AD.

Comments

Interested persons have been afforded an opportunity to participate in the making of this amendment. Due consideration has been given to the comments received.

Request To Accomplish Terminating Action Without First Doing the Inspections

The commenter, an operator, requests that the proposed AD be revised to allow operators to ''bypass'' the inspections in Part I of the Accomplishment Instructions of EMBRAER Service Bulletin 145–49–0021, Change 03, dated September 12, 2003, and do just the modification in Part II of the Accomplishment Instructions of that service bulletin. The modification is the terminating action

for the repetitive inspections in the proposed AD.

We agree with the commenter's request to allow operators to do just the modification in Part II of the Accomplishment Instructions of EMBRAER Service Bulletin 145–49–0021, Change 03, instead of first doing the inspections in Part I of the Accomplishment Instructions. The purpose of this AD is to require operators to modify the auxiliary power unit (APU) exhaust silencer. The inspections specified in paragraphs (c) and (d) of the proposed AD are relieving actions that allow airplanes that do not have defective APU exhaust silencers to continue operating for a specified period of time before operators perform the terminating modification. The inspections are the means of determining whether an APU exhaust silencer is defective. We have revised paragraphs (c) and (d) of this AD to specify that operators that have done the terminating modification required by paragraph (e) of this AD do not have to do the inspections required by paragraphs (c) and (d).

Request for Credit for Accomplishment of Previous Revisions of Service Information

The commenter requests that the proposed AD be revised to give credit for actions accomplished previously per the original issue of EMBRAER Service Bulletin 145–49–0021, dated July 11, 2002; or per Change 01 of that service bulletin, dated July 31, 2002.

We agree with the commenter's request. We have determined that the Accomplishment Instructions are essentially the same in the original issue, Change 01, Change 02, and Change 03, of Service Bulletin 145–49–0021. The primary difference between the change levels is the effectivity of the airplanes. We have revised paragraph (g) of this final rule to include the original issue and Change 01 of Service Bulletin 145–49–0021 as additional appropriate sources of service information.

Conclusion

After careful review of the available data, including the comments noted above, we have determined that air safety and the public interest require the adoption of the rule with the changes previously described. We have determined that these changes will neither increase the economic burden on any operator nor increase the scope of the AD.

Cost Impact

There are approximately 394 airplanes of U.S. registry that will be affected by this AD.

The repetitive inspections specified in Part I of EMBRAER Service Bulletin 145–49–0021, Change 03, dated September 12, 2003; and EMBRAER Service Bulletin 145LEG–49–0001, Change 01, dated August 29, 2002; that are required by this AD will take approximately 1 work hour per airplane to accomplish, at an average labor rate of $65 per work hour. Based on these figures, the cost impact of the repetitive inspections on U.S. operators is estimated to be $65 per airplane, per inspection cycle.

The modification, including the part number reidentification, specified in Part I of EMBRAER Service Bulletin 145–49–0021, Change 03; and EMBRAER Service Bulletin 145LEG–49–0001, Change 01; will take approximately 4 work hours per airplane to accomplish, at an average labor rate of $65 per work hour. Required parts will be supplied by the part manufacturer at no cost to operators. Based on these figures, the cost impact of the modification is estimated to be $102,440, or $260 per airplane.

The modification, including the part number reidentification, specified in Part II of EMBRAER Service Bulletin 145–49–0021, Change 03, will take approximately 1 work hour per airplane to accomplish, at an average labor rate of $65 per work hour. Based on these figures, the cost impact of the modification is estimated to be $65 per airplane.

The cost impact figures discussed above are based on assumptions that no operator has yet accomplished any of the requirements of this AD action, and that no operator would accomplish those actions in the future if this AD were not adopted. The cost impact figures discussed in AD rulemaking actions represent only the time necessary to perform the specific actions actually required by the AD. These figures typically do not include incidental costs, such as the time required to gain access and close up, planning time, or time necessitated by other administrative actions.

Regulatory Impact

The regulations adopted herein will not have a substantial direct effect on the States, on the relationship between the national Government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, it is determined that this final rule does not have federalism implications under Executive Order 13132.

For the reasons discussed above, I certify that this action (1) is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and (3) will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act. A final evaluation has been prepared for this action and it is contained in the Rules Docket. A copy of it may be obtained from the Rules Docket at the location provided under the caption **ADDRESSES.**

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

■ Accordingly, pursuant to the authority delegated to me by the Administrator, the Federal Aviation Administration amends part 39 of the Federal Aviation Regulations (14 CFR part 39) as follows:

PART 39—AIRWORTHINESS DIRECTIVES

■ 1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

■ 2. Section 39.13 is amended by removing amendment 39–12845 (67 FR 52398, August 12, 2002), and by adding a new airworthiness directive (AD), amendment 39–13864, to read as follows:

2004–23–09 Empresa Brasileira De Aeronautica S.A. (EMBRAER): Amendment 39–13864. Docket 2002–NM–346–AD. Supersedes AD 2002–16–06, amendment 39–12845.

Applicability: Model EMB–135BJ series airplanes, as listed in EMBRAER Service Bulletin 145LEG–49–0001, Change 01, dated August 29, 2002; and Model EMB–135 and –145 series airplanes, as listed in EMBRAER Service Bulletin 145–49–0021, Change 03, dated September 12, 2003; certificated in any category.

Compliance: Required as indicated, unless accomplished previously.

To prevent separation of the aft baffle assembly from the APU exhaust silencer and consequent separation of the assembly from the airplane, which could cause damage to other airplanes during takeoff and landing operations, or injury to people on the ground, accomplish the following:

Modification

(a) For airplanes that have incorporated EMBRAER Alert Service Bulletin 145–49–A021, Change 01, dated May 13, 2002: Within 1,500 flight hours after the effective date of this AD, install a spacer and bolts (including torquing the bolts) in the APU exhaust silencer assembly per the Accomplishment Instructions of EMBRAER Service Bulletin 145LEG–49–0001, Change 01, dated August 29, 2002, (for Model EMB–135BJ series airplanes); or Part II of the Accomplishment Instructions of EMBRAER Service Bulletin 145–49–0021, Change 03, dated September 12, 2003, (for Model EMB–135 and –145 series airplanes); as applicable.

Reidentification of Modified Part

(b) For airplanes that have incorporated EMBRAER Alert Service Bulletin 145–49–A021, Change 01, dated May 13, 2002: After accomplishment of the modification required by paragraph (a) of this AD, before further flight, change the part number of the modified APU exhaust silencer assembly from 4503801B to 4503801C per the Accomplishment Instructions of EMBRAER Service Bulletin 145LEG–49–0001, Change 01, dated August 29, 2002; or Part II of the Accomplishment Instructions of EMBRAER Service Bulletin 145–49–0021, Change 03, dated September 12, 2003; as applicable.

Inspections

(c) For airplanes that have not incorporated EMBRAER Alert Service Bulletin 145–49–A021, Change 01, dated May 13, 2002; or that have not accomplished the modification required by paragraph (e) of this AD: Within 500 flight hours or 3 months after the effective date of this AD, whichever is first, do a one-time general visual inspection of the APU exhaust silencer to determine if the aft baffle is flush with the end of the cylindrical portion, and an inspection of the movement of the cylindrical portion of the APU exhaust silencer shell assembly, per the Accomplishment Instructions of EMBRAER Service Bulletin 145LEG–49–0001, Change 01, dated August 29, 2002; or Part I of the Accomplishment Instructions of EMBRAER Service Bulletin 145–49–0021, Change 03, dated September 12, 2003; as applicable.

(1) If the APU exhaust silencer assembly passes the inspections: Do the actions in paragraph (d) of this AD.

(2) If the APU exhaust silencer assembly does not pass one or both inspections: Before further flight, secure or remove the affected parts from the silencer, and placard the APU as ''Inoperative'' per the Accomplishment Instructions of the applicable service bulletin. No further action is required unless the APU is reactivated. To reactivate the APU: Before further flight, do the actions required by paragraph (e) of this AD.

Note 1: For the purposes of this AD, a general visual inspection is defined as: ''A visual examination of an interior or exterior area, installation, or assembly to detect obvious damage, failure, or irregularity. This level of inspection is made from within touching distance unless otherwise specified. A mirror may be necessary to enhance visual access to all exposed surfaces in the inspection area. This level of inspection is made under normally available lighting conditions such as daylight, hangar lighting, flashlight, or droplight and may require removal or opening of access panels or doors. Stands, ladders, or platforms may be required to gain proximity to the area being checked.''

Repetitive Inspections

(d) For airplanes that have not incorporated EMBRAER Alert Service Bulletin 145–49–A021, Change 01, dated May 13, 2002; or that have not accomplished the modification required by paragraph (e) of this AD: After doing the inspections required by paragraph (c) of this AD, before further flight, do a mechanical integrity inspection of the APU exhaust silencer assembly per the Accomplishment Instructions of EMBRAER Service Bulletin 145LEG–49–0001, Change 01, dated August 29, 2002; or Part I of the Accomplishment Instructions of EMBRAER Service Bulletin 145–49–0021, Change 03, dated September 12, 2003; as applicable.

(1) If the APU exhaust silencer assembly passes the inspection required by paragraph (d) of this AD: Do the same steps for the mechanical integrity inspection required by paragraph (d) of this AD in a counter-clockwise direction, per the Accomplishment Instructions of the applicable service bulletin. Repeat the inspections required by paragraphs (d) and (d)(1) of this AD thereafter at intervals not to exceed 500 flight hours or 3 months, whichever is first. The inspections may be repeated up to two times before accomplishment of the requirements of paragraph (e) of this AD.

(2) If the APU exhaust silencer assembly does not pass the inspection required by paragraph (d) of this AD: Before further flight, disassemble the APU exhaust silencer assembly or placard the APU as ''Inoperative'' per the Accomplishment Instructions of the applicable service bulletin. No further action is required unless the APU is reactivated. To reactivate the APU: Before further flight, do the actions required by paragraph (e) of this AD.

Modification/Terminating Action

(e) For airplanes that have not incorporated EMBRAER Alert Service Bulletin 145–49–A021, Change 01, dated May 13, 2002: Within 1,500 flight hours or 12 months after the effective date of this AD, whichever is first, except as provided by paragraphs (c)(2) and (d)(2) of this AD, do all of the applicable actions per the Accomplishment Instructions of EMBRAER Service Bulletin 145LEG–49–0001, Change 01, dated August 29, 2002; or Part I of the Accomplishment Instructions of EMBRAER Service Bulletin 145–49–0021, Change 03, dated September 12, 2003; as applicable. This constitutes terminating action for the repetitive inspections required by paragraph (d) of this AD.

Reidentification of Modified Part

(f) For airplanes that have not incorporated EMBRAER Alert Service Bulletin 145–49–A021, Change 01, dated May 13, 2002: After accomplishment of the modification required by paragraph (e) of this AD, before further flight, change the part number of the modified APU exhaust silencer assembly from 4503801B to 4503801C per the Accomplishment Instructions of EMBRAER Service Bulletin 145LEG–49–0001, Change 01, dated August 29, 2002; or Part I of the Accomplishment Instructions of EMBRAER Service Bulletin 145–49–0021, Change 03, dated September 12, 2003; as applicable.

Actions Previously Accomplished

(g) Accomplishment of the specified actions before the effective date of this AD per EMBRAER Service Bulletin 145–49–0021, dated July 11, 2002; Change 01, dated July 31, 2002; or Change 02, dated November 12, 2002; is considered acceptable for compliance with the applicable requirements of paragraphs (a), (b), (c), (d), (e), and (f) of this AD.

Parts Installation

(h) As of the effective date of this AD, no person may install on any airplane an APU exhaust silencer having P/N 4503801B.

Alternative Methods of Compliance

(i) In accordance with 14 CFR 39.19, the Manager, International Branch, ANM–116, FAA, Transport Airplane Directorate, is authorized to approve alternative methods of compliance for this AD.

Incorporation by Reference

(j) Unless otherwise specified in this AD, the actions must be done in accordance with EMBRAER Service Bulletin 145LEG–49–0001, Change 01, dated August 29, 2002; or EMBRAER Service Bulletin 145–49–0021, Change 03, dated September 12, 2003; as applicable. This incorporation by reference was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. Copies may be obtained from Empresa Brasileira de Aeronautica S.A. (EMBRAER), P.O. Box 343—CEP 12.225, Sao Jose dos Campos—SP, Brazil. Copies may be inspected at the FAA, Transport Airplane Directorate, 1601 Lind Avenue, SW., Renton, Washington; or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call (202) 741–6030, or go to: *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.*

Note 2: The subject of this AD is addressed in Brazilian airworthiness directive 2002–05–01R2, dated January 6, 2003.

Effective Date

(k) This amendment becomes effective on December 20, 2004.

Issued in Renton, Washington, on November 1, 2004.

Kalene C. Yanamura,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 04–24935 Filed 11–12–04; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 97

[Docket No. 30429 ; Amdt. No. 3109]

Standard Instrument Approach Procedures; Miscellaneous Amendments

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: This amendment establishes, amends, suspends, or revokes Standard Instrument Approach Procedures (SIAPs) for operations at certain airports. These regulatory actions are needed because of the adoption of new or revised criteria, or because of changes occurring in the National Airspace System, such as the commissioning of new navigational facilities, addition of new obstacles, or changes in air traffic requirements. These changes are designed to provide safe and efficient use of the navigable airspace and to promote safe flight operations under instrument flight rules at the affected airports.

DATES: This rule is effective November 15, 2004. The compliance date for each SIAP is specified in the amendatory provisions.

The incorporation by reference of certain publications listed in the regulations is approved by the Director of the Federal Register as of November 15, 2004.

ADDRESSES: Availability of matters incorporated by reference in the amendment is as follows:

For Examination—

1. FAA Rules Docket, FAA Headquarters Building, 800 Independence Avenue, SW., Washington, DC 20591;

2. The FAA Regional Office of the region in which the affected airport is located;

3. The Flight Inspection Area Office which originated the SIAP; or,

4. The National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call (202) 741–6030, or go to: *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.*

For Purchase—Individual SIAP copies may be obtained from:

1. FAA Public Inquiry Center (APA–200), FAA Headquarters Building, 800 Independence Avenue, SW., Washington, DC 20591; or

2. The FAA Regional Office of the region in which the affected airport is located.

By Subscription—Copies of all SIAPs, mailed once every 2 weeks, are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.

FOR FURTHER INFORMATION CONTACT: Donald P. Pate, Flight Procedure Standards Branch (AMCAFS–420), Flight Technologies and Programs Division, Flight Standards Service, Federal Aviation Administration, Mike Monroney Aeronautical Center, 6500 South MacArthur Boulevard, Oklahoma City, OK 73169 (Mail Address: P.O. Box 25082 Oklahoma City, OK 73125) telephone: (405) 954–4164.

SUPPLEMENTARY INFORMATION: This amendment to part 97 of the Federal Aviation Regulations (14 CFR part 97) establishes, amends, suspends, or revokes Standard Instrument Approach Procedures (SIAPs). The complete regulatory description of each SIAP is contained in official FAA form documents which are incorporated by reference in this amendment under 5 U.S.C. 552(a), 1 CFR part 51, and § 97.20 of the Federal Aviation Regulations (FAR). The applicable FAA Forms are identified as FAA Forms 8260–3, 8260–4, and 8260–5. Materials incorporated by reference are available for examination or purchase as stated above.

The large number of SIAPs, their complex nature, and the need for a special format make their verbatim publication in the **Federal Register** expensive and impractical. Further, airmen do not use the regulatory text of the SIAPs, but refer to their graphic depiction on charts printed by publishers of aeronautical materials. Thus, the advantages of incorporation by reference are realized and publication of the complete description of each SIAP contained in FAA form documents is unnecessary. The provisions of this amendment state the affected CFR (and FAR) sections, with the types and effective dates of the SIAPs. This amendment also identifies the airport, its location, the procedure identification and the amendment number.

The Rule

This amendment to part 97 is effective upon publication of each separate SIAP as contained in the transmittal. Some SIAP amendments may have been previously issued by the FAA in a National Flight Data Center (NFDC) Notice to Airmen (NOTAM) as an emergency action of immediate flight safety relating directly to published aeronautical charts. The circumstances which created the need for some SIAP amendments may require making them effective in less than 30 days. For the remaining SIAPs, an effective date at least 30 days after publication is provided.

Further, the SIAPs contained in this amendment are based on the criteria contained in the U.S. Standard for Terminal Instrument Procedures (TERPS). In developing these SIAPs, the TERPS criteria were applied to the conditions existing or anticipated at the affected airports. Because of the close and immediate relationship between these SIAPs and safety in air commerce, I find that notice and public procedure before adopting these SIAPs are impracticable and contrary to the public interest and, where applicable, that good cause exists for making some SIAPs effective in less than 30 days.

Conclusion

The FAA has determined that this regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. It, therefore—(1) is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a regulatory evaluation as the anticipated impact is so minimal. For the same reason, the FAA certifies that this amendment will not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

List of Subjects in 14 CFR Part 97

Air traffic control, Airports, Incorporation by reference, and Navigation (air).

Issued in Washington, DC on November 5, 2004.

James J. Ballough,

Director, Flight Standards Service.

Adoption of the Amendment

■ Accordingly, pursuant to the authority delegated to me, part 97 of the Federal Aviation Regulations (14 CFR part 97) is amended by establishing, amending, suspending, or revoking Standard Instrument Approach Procedures, effective at 0901 UTC on the dates specified, as follows:

PART 97—STANDARD INSTRUMENT APPROACH PROCEDURES

■ 1. The authority citation for part 97 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40103, 40106, 40113, 40114, 40120, 44502, 44514, 44701, 44719, 44721–44722.

■ 2. Part 97 is amended to read as follows:

Effective December 23, 2004

Fargo, ND, Hector Intl, RADAR–1, Amdt 11

Effective January 20, 2005

Mobile, AL, Mobile Downtown, ILS OR LOC RWY 32, Amdt 1
Mobile, AL, Mobile Downtown, VOR RWY 14, Amdt 7
Mobile, AL, Mobile Downtown, VOR RWY 18, Amdt 1
Mobile, AL, Mobile Downtown, VOR RWY 32, Amdt 11
Mobile, AL, Mobile Downtown, VOR/DME RNAV OR GPS RWY 36, Orig, CANCELLED
Mobile, AL, Mobile Downtown, RNAV (GPS) RWY 14, Orig
Mobile, AL, Mobile Downtown, RNAV (GPS) RWY 18, Orig
Mobile, AL, Mobile Downtown, RNAV (GPS) RWY 32, Orig
Mobile, AL, Mobile Downtown, RNAV (GPS) RWY 36, Orig
Wasilla, AK, Wasilla, RNAV (GPS) RWY 3, Orig
Crossett, AR, Z M Jack Stell Field, VOR/DME–A, Orig-C
Napa, CA, Napa County, VOR RWY 6, Amdt 12A
Monte Vista, CO, Monte Vista Muni, NDB RWY 20, Orig-A, CANCELLED
Fort Wayne, IN, Fort Wayne Intl, RNAV (GPS) RWY 5, Orig
Fort Wayne, IN, Fort Wayne Intl, RNAV (GPS) RWY 14, Orig
Fort Wayne, IN, Fort Wayne Intl, RNAV (GPS) RWY 23, Orig
Fort Wayne, IN, Fort Wayne Intl, RNAV (GPS) RWY 32, Orig
Fort Wayne, IN, Fort Wayne Intl, RADAR–1, Amdt 24
Fort Wayne, IN, Fort Wayne Intl, NDB RWY 32, Amdt 26
Fort Wayne, IN, Fort Wayne Intl, VOR OR TACAN RWY 5, Amdt 19
Fort Wayne, IN, Fort Wayne Intl, VOR OR TACAN RWY 14, Amdt 16
Fort Wayne, IN, Fort Wayne Intl, LOC BC RWY 23, Amdt 8, CANCELLED
De Quincy, LA, De Quincy Industrial Airpark, RNAV (GPS) RWY 15, Orig
De Quincy, LA, De Quincy Industrial Airpark, NDB RWY 15, Amdt 1A
De Quincy, LA, De Quincy Industrial Airpark, GPS RWY 15, Orig-A, CANCELLED
De Quincy, LA, De Quincy Industrial Airpark, RNAV (GPS) RWY 33, Orig
De Quincy, LA, De Quincy Industrial Airpark, VOR/DME RWY 33, Amdt 1
De Quincy, LA, De Quincy Industrial Airpark, GPS RWY 33, Orig-A, CANCELLED
Charlevoix, MI, Charlevoix Muni, RNAV (GPS) RWY 9, Orig
Charlevoix, MI, Charlevoix Muni, RNAV (GPS) RWY 27, Orig
Charlevoix, MI, Charlevoix Muni, NDB RWY 9, Amdt 10
Charlevoix, MI, Charlevoix Muni, NDB RWY 27, Amdt 11
Holland, MI, Tulip City, RNAV (GPS) RWY 8, Orig-A
Menominee , MI, Menominee-Marinette Twin County, RNAV (GPS) RWY 32, Orig-A
Owosso, MI, Owosso Community, RNAV (GPS) RWY 10, Orig-A
Alamogordo, NM, Alamogordo-White Sands Regional, NDB RWY 3, Amdt 5A, CANCELLED
Harrisburg, PA, Harrisburg Intl, ILS OR LOC RWY 13, Amdt 2; ILS RWY 13 (CAT II), Amdt 2; ILS RWY 13 (CAT III), Amdt 2
Honesdale, PA, Cherry Ridge, RNAV (GPS) RWY 36, Orig
Honesdale, PA, Cherry Ridge, VOR-A, Amdt 5
Pawtucket, RI, North Central State, NDB RWY 5, Amdt 2A, CANCELLED
Fredericksburg, TX, Gillespie County, RNAV (GPS) RWY 14, Orig
Fredericksburg, TX, Gillespie County, RNAV (GPS) RWY 32, Orig
Fredericksburg, TX, Gillespie County, VOR/DME-A, Amdt 3
Chetek, WI, Chetek Muni-Southworth, RNAV (GPS) RWY 17, Orig-A
Chetek, WI, Chetek Muni-Southworth, RNAV (GPS) RWY 35, Orig-A
Delavan, WI, Lake Lawn, RNAV (GPS) RWY 18, Orig-A
Manitowoc, WI, Manitowoc County, RNAV (GPS) RWY 35, Orig-A
Milwaukee, WI, General Mitchell Intl, RNAV (GPS) RWY 25R, Orig-A
Milwaukee, WI, General Mitchell Intl, RNAV (GPS) RWY 25L, Orig-A
Necedah, WI, Necedah, RNAV (GPS) RWY 36, Orig-A
New Richmond, WI, New Richmond Regional, RNAV (GPS) RWY 14, Orig-A
Park Falls, WI, Park Falls Muni, RNAV (GPS) RWY 18, Orig-A
Park Falls, WI, Park Falls Muni, RNAV (GPS) RWY 36, Orig-A
Rhinelander, WI, Rhinelander-Oneida County, RNAV (GPS) Y RWY 27, Orig-A
Rhinelander, WI, Rhinelander-Oneida County, RNAV (GPS) RWY 33, Orig-A
Viroqua, WI, Viroqua Muni, RNAV (GPS) RWY 11, Orig-A
Viroqua, WI, Viroqua Muni, RNAV (GPS) RWY 29, Orig-A

The FAA published an Amendment in Docket No. *30428,* Amdt No. *3108* to Part 97 of the Federal Aviation Regulations (Vol. *69* FR No. *210,* Page 63318; dated *Monday, November 1, 2004*) under section 97.*31* effective *20 Jan, 2005,* which is hereby rescinded as follows:

Columbus, GA., Columbus Metropolitan, Radar-1, Amdt 9

[FR Doc. 04–25213 Filed 11–12–04; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF COMMERCE

Bureau of Industry and Security

15 CFR Part 744

[Docket No.041103304–4304–01]

RIN 0694–AD12

Entity List: Removal of Four Russian Entities

AGENCY: Bureau of Industry and Security, Commerce.

ACTION: Final rule.

SUMMARY: This final rule amends the Export Administration Regulations by removing four Russian entities from the Entity List, and by removing certain license requirements for exports and reexports to these entities, in conformance with a determination of the Department of State to remove nonproliferation measures imposed on these entities in 1998 and 1999.

DATES: This rule is effective November 15, 2004.

ADDRESSES: You may submit comments, identified by RIN 0694–AD12, by any of the following methods:

- *E-mail: scook@bis.doc.gov.* Include ''RIN 0694–AD12'' in the subject line of the message.
- *Fax:* (202)482–3355
- *Mail or Hand Delivery/Courier:* Sharron Cook, U.S. Department of Commerce, Bureau of Industry and Security, Regulatory Policy Division, 14th & Pennsylvania Avenue, NW., Room 2705, Washington, DC 20230, ATTN: RIN 0694–AD12.

FOR FURTHER INFORMATION CONTACT: Eileen M. Albanese, Office of Exporter Services, Bureau of Industry and Security, Telephone: (202) 482–0436.

SUPPLEMENTARY INFORMATION:

Background

In 1998 and 1999, the Department of Commerce imposed license requirements on four Russian entities, under section 744.10 of the Export Administration Regulations (EAR), in conformance with determinations by the Department of State that these entities had engaged in nuclear or missile technology proliferation activities that required the imposition of measures pursuant to Executive Order 12938, as amended (''Proliferation of Weapons of Mass Destruction''). These entities were added to the Entity List, set forth in Supplement No. 4 to part 744 of the EAR, as follows:

1. Europalace 2000
2. Grafit (aka State Scientific Research Institute of Graphite or NIIGRAFIT)

3. MOSO Company

4. The Scientific Research and Design Institute of Power Technology (aka NIKIET, Research and Development Institute of Power Engineering (RDIPE), and ENTEK).

The Department of State made its determination with regard to, and imposed nonproliferation measures against, Europalace 2000, Grafit, and MOSO Company on July 30, 1998 (63 FR 42089). BIS imposed conforming license requirements on these three entities under the EAR on July 29, 1998 (63 FR 40363). The Department of State made its determination with regard to, and imposed nonproliferation measures against, the Scientific Research and Design Institute of Power Technology on January 8, 1999 (64 FR 2935), and BIS imposed license requirements on this entity under the EAR on March 26, 1999 (64 FR 14605).

On March 23, 2004, the Department of State determined that it is in the foreign policy and national security interests of the United States to remove nonproliferation measures imposed on these four Russian entities (69 FR 17262). In conformance with this determination, this final rule removes the license requirements under section 744.10 for exports and reexports to these entities, and removes these entities from the Entity List.

The removal of these entities from the Entity List eliminates the license requirements under section 744.10 of the EAR for exports and reexports to these entities. However, license requirements for exports and reexports set forth in part 744 still apply to these entities when the exporter or reexporter knows that the item will be used in a prohibited activity. BIS strongly urges the use of Supplement No. 3 to part 732 of the EAR, ''BIS's 'Know Your Customer' Guidance and Red Flags'' when exporting or reexporting.

Although the Export Administration Act expired on August 20, 2001, Executive Order 13222 of August 17, 2001 (66 FR 44025, August 22, 2001), extended by the Notice of August 6, 2004, 69 FR 48763 (August 10, 2004), continues the EAR in effect under the International Emergency Economic Powers Act.

Rulemaking Requirements

1. This final rule has been determined to be not significant for purposes of E.O. 12866.

2. Notwithstanding any other provision of law, no person is required to respond to, nor shall any person be subject to a penalty for failure to comply with a collection of information, subject to the requirements of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*) (PRA), unless that collection of information displays a currently valid Office of Management and Budget (OMB) Control Number. This rule involves a collection of information subject to the PRA. This collection has been approved by OMB under control number 0694–0088, ''Multi-Purpose Application,'' which carries a burden hour estimate of 58 minutes for a manual or electronic submission. Send comments regarding these burden estimates or any other aspect of these collections of information, including suggestions for reducing the burden, to David Rostker, Office of Management and Budget (OMB), by e-mail to *David_Rostker@omb.eop.gov,* or by fax to (202)395–7285; and to the Office of Administration, Bureau of Industry and Security, Department of Commerce, 14th and Pennsylvania Avenue, NW., Room 6883, Washington, DC 20230.

3. This rule does not contain policies with Federalism implications as that term is defined under E.O. 13132.

4. The provisions of the Administrative Procedure Act (5 U.S.C. 553) requiring notice of proposed rulemaking, the opportunity for public participation, and a delay in effective date, are inapplicable because this regulation involves a military and foreign affairs function of the United States (5 U.S.C. 553(a)(1)). Further, no other law requires that a notice of proposed rulemaking and an opportunity for public comment be given for this final rule. Because a notice of proposed rulemaking and an opportunity for public comment are not required to be given for this rule under the Administrative Procedure Act or by any other law, the analytical requirements of the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) are not applicable.

Therefore, this regulation is issued in final form. Although there is no formal comment period, public comments on this regulation are welcome on a continuing basis. Please refer to the **ADDRESSES** section cited above for comment submission.

List of Subjects in 15 CFR Part 744

Exports, Foreign trade, Reporting and recordkeeping requirements.

■ Accordingly, part 744 of the Export Administration Regulations (15 CFR parts 730–799) is amended as follows:

PART 744—[AMENDED]

■ 1. The authority citation for 15 CFR part 744 continues to read as follows:

Authority: 50 U.S.C. app. 2401 *et seq.*; 50 U.S.C. 1701 *et seq.*; 22 U.S.C. 3201 *et seq.*; 42 U.S.C. 2139a; Sec. 901–911, Pub. L. 106–387; Sec. 221, Pub. L. 107–56; E.O. 12058, 43 FR 20947, 3 CFR, 1978 Comp., p. 179; E.O. 12851, 58 FR 33181, 3 CFR, 1993 Comp., p. 608; E.O. 12938, 59 FR 59099, 3 CFR, 1994 Comp., p. 950; E.O. 12947, 60 FR 5079, 3 CFR, 1995 Comp., p. 356; E.O. 13026, 61 FR 58767, 3 CFR, 1996 Comp., p. 228; E.O. 13099, 63 FR 45167, 3 CFR, 1998 Comp., p. 208; E.O. 13222, 66 FR 44025, 3 CFR, 2001 Comp., p. 783; E.O. 13224, 66 FR 49079, 3 CFR, 2001 Comp., p. 786; Notice of November 9, 2001, 66 FR 56965, 3 CFR, 2001 Comp., p. 917; Notice of August 6, 2004, 69 FR 48763 (August 10, 2004).

■ 2. Supplement No. 4 to part 744 is amended by removing entries for the entities ''Europalace 2000, Moscow,'' ''Grafit (a.k.a. State Scientific Research Institute of Graphite or NIIGRAFIT), 2 Ulitsa Elektrodnaya, 111524, Moscow,'' ''MOSO Company, Moscow,'' and ''The Scientific Research and Design Institute of Power Technology (a.k.a. NIKIET, Research and Development Institute of Power Engineering (RDIPE), and ENTEK) (including at 101000, P.O. Box 788, Moscow, Russia)'' under the country of ''Russia''.

Dated: November 8, 2004.

Peter Lichtenbaum,

Assistant Secretary for Export Administration.

[FR Doc. 04–25308 Filed 11–12–04; 8:45 am]

BILLING CODE 3510–33–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

21 CFR Part 180

[Docket No. 2004F–0066]

Food Additives Permitted in Food on an Interim Basis or in Contact With Food Pending Additional Study; Mannitol

AGENCY: Food and Drug Administration, HHS.

ACTION: Final rule.

SUMMARY: The Food and Drug Administration (FDA) is amending the food additive regulations to permit the manufacture of mannitol by fermentation of sugars such as fructose, glucose, or maltose by the action of the microorganism *Lactobacillus intermedius* (*fermentum*). This action is in response to a petition filed by zuChem, Inc.

DATES: This rule is effective November 15, 2004. Submit written or electronic objections and requests for a hearing by December 15, 2004.

ADDRESSES: You may submit written objections and requests for a hearing,

identified by Docket No. 2004F–0066, by any of the following methods:

- Federal eRulemaking Portal: *http://www.regulations.gov*. Follow the instructions for submitting comments.
- Agency Web site: *http://www.fda.gov/dockets/ecomments*. Follow the instructions for submitting comments on the agency Web site.
- E-mail: *fdadockets@oc.fda.gov*. Include Docket No. 2004F–0066 in the subject line of your e-mail message.
- FAX: 301–827–6870.
- Mail/Hand delivery/Courier [For paper, disk, or CD-ROM submissions]: Division of Dockets Management (HFA–305), Food and Drug Administration, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852.

Instructions: All submissions received must include the agency name and docket number for this rulemaking. All objections received will be posted without change to *http://www.fda.gov/ohrms/dockets/default.htm*, including any personal information provided. For detailed instructions on submitting objections, see the ''Objections'' heading of the **SUPPLEMENTARY INFORMATION** section of this document.

Docket: For access to the docket to read background documents or comments received, go to *http://www.fda.gov/ohrms/dockets/default.htm* and insert the docket number, found in brackets in the heading of this document, into the ''Search'' box and follow the prompts and/or go to the Division of Dockets Management, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852.

FOR FURTHER INFORMATION CONTACT: Celeste Johnston, Center for Food Safety and Applied Nutrition (HFS–265), Food and Drug Administration, 5100 Paint Branch Pkwy., College Park, MD 20740–3835, 301–436–1282.

SUPPLEMENTARY INFORMATION:

I. Background

In a notice published in the **Federal Register** of February 19, 2004 (69 FR 7759), FDA announced that a food additive petition (FAP 4A4754) had been filed by zuChem, Inc., c/o Hyman, Phelps and McNamara, P.C., 700 13th Street NW., Washington, DC 20005. The petition proposed to amend the food additive regulations in § 180.25 *Mannitol* (21 CFR 180.25) to permit the manufacture of mannitol by fermentation of sugars such as fructose, glucose, and maltose by the action of the microorganism *L. intermedius* (*fermentum*).

In 1973, the agency proposed to affirm mannitol as generally recognized as safe (GRAS) based on the findings by the Select Committee on GRAS Substances from the Life Sciences Research Office of the Federation of American Societies for Experimental Biology (38 FR 20046, July 26, 1973). In response to the proposal, the agency received comments, including information raising questions about the safety of mannitol. Rather than affirm the GRAS status of mannitol, the agency instead decided to establish an interim food additive regulation for mannitol, pending additional study of the ingredient (39 FR 34178, September 23, 1974) and based on the conclusion that there would be no increased risk to the public health to continue existing uses and levels of use of mannitol while additional studies were carried out. The regulation was subsequently amended (61 FR 7990, March 1, 1996) to permit the manufacture of mannitol by fermentation of sugars or sugar alcohols by the action of the yeast *Zygosaccharomyces rouxii*.

The proposed fermentation organism, *L. fermentum*, is currently used in various food applications. For example, strains of *L. fermentum* are used in sourdough bread and pressed curd cheeses, and FDA has affirmed as GRAS a urease preparation from *L. fermentum* for use in the manufacture of wine. The petitioner has submitted data in support of the microbiological safety of mannitol produced by this bacterium. In addition, the petitioner has provided detailed information on the process used to produce mannitol by this fermentation method, including information on the purification steps that are used. FDA concludes, having considered the evidence concerning the production organism and the purification procedures, that *L. intermedius* (*fermentum*) will not be present in the final product and can be safely used in the fermentation of fructose and other sugars to produce mannitol provided that the purity of the culture is maintained, and that a nonpathogenic, nontoxicogenic strain of *L. intermedius* (*fermentum*) is used (Ref. 1).

II. Conclusion

The current interim regulation for mannitol specifies manufacturing procedures that do not include the proposed fermentation process. FDA has reviewed data and information in the petition on the chemical equivalence of mannitol produced using *L. intermedius* (*fermentum*) and mannitol produced by the currently-regulated methods. Based on its review, the agency concludes that mannitol manufactured by fermentation of sugars by the action of *L. intermedius* (*fermentum*) is equivalent to mannitol produced by the currently-regulated methods as described in § 180.25. In addition, mannitol manufactured by the proposed fermentation process will have the same intended technical effect and uses as mannitol produced by the currently-regulated methods. Consequently, there will be no change in exposure to mannitol (Refs. 2 and 3). Therefore, FDA concludes that § 180.25 should be amended as set forth in this document.

III. Public Disclosure

In accordance with § 171.1(h) (21 CFR 171.1(h)), the petition and the documents that FDA considered and relied upon in reaching its decision to approve the petition are available for inspection at the Center for Food Safety and Applied Nutrition by appointment with the information contact person listed (see **FOR FURTHER INFORMATION CONTACT**). As provided in § 171.1(h), the agency will delete from the documents any materials that are not available for public disclosure before making the documents available for inspection.

IV. Environmental Impact

The agency has previously considered the environmental effects of this rule as announced in the notice of filing for FAP 4A4754. No new information or comments have been received that would affect the agency's previous determination that there is no significant impact on the human environment and that an environmental impact statement is not required.

V. Paperwork Reduction Act of 1995

This final rule contains no collection of information. Therefore, clearance by the Office of Management and Budget under the Paperwork Reduction Act of 1995 is not required.

VI. Objections

Any person who will be adversely affected by this regulation may file with the Division of Dockets Management (see **ADDRESSES**) written or electronic objections (see **DATES**). Each objection shall be separately numbered, and each numbered objection shall specify with particularity the provisions of the regulation to which objection is made and the grounds for the objection. Each numbered objection on which a hearing is requested shall specifically so state. Failure to request a hearing for any particular objection shall constitute a waiver of the right to a hearing on that objection. Each numbered objection for which a hearing is requested shall include a detailed description and analysis of the specific factual information intended to be presented in support of the objection in the event

that a hearing is held. Failure to include such a description and analysis for any particular objection shall constitute a waiver of the right to a hearing on the objection. Three copies of all documents are to be submitted and are to be identified with the docket number found in brackets in the heading of this document. Any objections received in response to the regulation may be seen in the Division of Dockets Management (see **ADDRESSES**) between 9 a.m. and 4 p.m., Monday through Friday.

VII. References

The following references have been placed on display in the Division of Dockets Management (see **ADDRESSES**) and may be seen by interested persons between 9 a.m. and 4 p.m., Monday through Friday.

1. FDA memorandum from P. C. DeLeo, Division of Petition Review, to C. Johnston, Division of Petition Review, April 21, 2004.

2. FDA memorandum from D. E. Folmer, Division of Petition Review, to C. Johnston, Division of Petition Review, April 20, 2004.

3. FDA memorandum from D. E. Folmer, Division of Petition Review, to C. Johnston, Division of Petition Review, July 29, 2004.

List of Subjects in 21 CFR Part 180

Food additives.

■ Therefore, under the Federal Food, Drug, and Cosmetic Act and under authority delegated to the Commissioner of Food and Drugs and redelegated to the Director, Center for Food Safety and Applied Nutrition, 21 CFR part 180 is amended as follows:

PART 180—FOOD ADDITIVES PERMITTED IN FOOD ON AN INTERIM BASIS OR IN CONTACT WITH FOOD PENDING ADDITIONAL STUDY

■ 1. The authority citation for 21 CFR part 180 continues to read as follows:

Authority: 21 U.S.C. 321, 342, 343, 348, 371; 42 U.S.C. 241.

■ 2. Section 180.25 is amended by adding paragraph (a)(3) to read as follows:

§ 180.25 Mannitol.

(a) * * *

(3) A pure culture fermentation of sugars such as fructose, glucose, or maltose using the nonpathogenic, nontoxicogenic bacterium *Lactobacillus intermedius* (*fermentum*).

* * * * *

Dated: October 27, 2004.

Leslye M. Fraser,

Director, Office of Regulations and Policy, Center for Food Safety and Applied Nutrition.

[FR Doc. 04–25243 Filed 11–12–04; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF JUSTICE

28 CFR Part 0

[AG Order No. 2738–2004]

Delegations of Authority; Federal Bureau of Investigation

AGENCY: Department of Justice.

ACTION: Final rule.

SUMMARY: Recent consultations between criminal law enforcement investigative agencies and the Department of Justice have suggested the need to simplify and clarify the delegations of authority to the Federal Bureau of Investigation to investigate any criminal violations of law in certain foreign counterintelligence areas. This final rule changes the language of the delegations of authority to eliminate confusion about the scope of the delegation.

EFFECTIVE DATE: November 15, 2004.

FOR FURTHER INFORMATION CONTACT: Bruce C. Swartz, Deputy Assistant Attorney General, Criminal Division, United States Department of Justice, Washington, DC 20530 (202) 514–2333 (this is not a toll-free number).

SUPPLEMENTARY INFORMATION: The Attorney General has authority to investigate any violation of the criminal laws of the United States. 28 U.S.C. 533. As a general proposition, the Attorney General has delegated general investigative authority to the Federal Bureau of Investigation. 28 CFR 0.85(a). Recent consultations among investigative agencies have indicated that confusion has been created by the use of limiting language in the formal delegations of authority within the Department. The limitation of the Federal Bureau of Investigation's authority to the extent that investigative authority is assigned elsewhere was not intended as other than an internal management tool. The Department has determined that the limitation should be stated more clearly and applicable only when statute or other authority, such as an Executive Order or Attorney General delegation, assigns investigative authority exclusively to another agency or component. Accordingly, this final rule amends the language in 28 CFR part 0.

Administrative Procedure Act

This rule relates to matters of agency management and personnel and, therefore, is exempt from the usual requirements of prior notice and comment and a 30-day delay in effective date. *See* 5 U.S.C. 553(a)(2) and (d). The rule only alters an internal delegation to the Federal Bureau of Investigation.

Regulatory Flexibility Act

The Attorney General, in accordance with the Regulatory Flexibility Act, 5 U.S.C. 605(b), has reviewed this rule and, by approving it, certifies that it will not have a significant economic impact on a substantial number of small entities because it pertains to personnel and administrative matters affecting the Department. Further, a Regulatory Flexibility Analysis is not required for this final rule because the Department was not required to publish a general notice of proposed rulemaking for this matter.

Executive Order 12866

This rule has been drafted and reviewed in accordance with Executive Order 12866, Regulatory Planning and Review, section 1(b), Principles of Regulation. This rule is limited to agency organization, management and personnel matters as described by Executive Order 12866, § 3(d)(3) and, therefore, is not a ''regulation'' or ''rule'' as defined by that Executive Order.

Executive Order 12988

This regulation meets the applicable standards set forth in sections 3(a) and 3(b)(2) of Executive Order 12988, Civil Justice Reform.

Executive Order 13132

This rule will not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, in accordance with Executive Order 13132, Federalism, the Department has determined that this rule does not have sufficient federalism implications to warrant the preparation of a federalism summary impact statement.

Unfunded Mandates Reform Act of 1995

This rule will not result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million or more in any one year, and it will not significantly or uniquely affect small governments. Therefore, no actions are necessary under the provisions of the Unfunded Mandates Reform Act of 1995, 2 U.S.C. 1501 *et seq.*

Small Business Regulatory Enforcement Fairness Act of 1996

This rule is not a major rule as defined by section 251 of the Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA), 5 U.S.C. 804. This rule will not result in an

annual effect on the economy of $100 million or more, a major increase in costs or prices, or significant adverse effects on competition, employment, investment, productivity, innovation, or the ability of United States-based enterprises to compete with foreign-based enterprises in domestic and export markets.

This action pertains to agency management, personnel, and organization and does not substantially affect the rights or obligations of non-agency parties. Accordingly, it is not a rule for purposes of the reporting requirement of 5 U.S.C. 801.

Congressional Review Act

This action pertains to agency management, personnel and organization and does not substantially affect the rights or obligations of non-agency parties and, accordingly, is not a ''rule'' as that term is used by the Congressional Review Act (Subtitle E of the Small Business Regulatory Enforcment Fairness Act of 1996 (SBREFA)). Therefore, the reporting requirement of 5 U.S.C. 801 does not apply.

List of Subjects in 28 CFR Part 0

Authority delegations (Government agencies), Government employees, Organization and functions (Government agencies), Whistleblowing.

■ Accordingly, chapter 1 of title 28 of the Code of Federal Regulations is amended as follows:

PART 0—ORGANIZATION OF THE DEPARTMENT OF JUSTICE

■ 1. The authority citation for part 0 continues to read as follows:

Authority: 5 U.S.C. 301; 28 U.S.C. 509, 510, 515–519.

■ 2. In § 0.85, paragraph (a) is amended by removing ''specifically'' and adding in its place ''exclusively,'' and paragraph (d) is revised to read as follows:

§ 0.85 General functions.

* * * * *

(d) Carry out the Presidential directive of September 6, 1939, as reaffirmed by Presidential directives of January 8, 1943, July 24, 1950, and December 15, 1953, designating the Federal Bureau of Investigation to take charge of investigative work in matters relating to espionage, sabotage, subversive activities, and related matters, including investigating any potential violations of the Arms Export Control Act, the Export Administration Act, the Trading with the Enemy Act, or the International Emergency Economic Powers Act, relating to any foreign counterintelligence matter.

* * * * *

Dated: November 5, 2004.

John Ashcroft,

Attorney General.

[FR Doc. 04–25252 Filed 11–12–04; 8:45 am]

BILLING CODE 4410–02–M

PENSION BENEFIT GUARANTY CORPORATION

29 CFR Parts 4022 and 4044

Benefits Payable in Terminated Single-Employer Plans; Allocation of Assets in Single-Employer Plans; Interest Assumptions for Valuing and Paying Benefits

AGENCY: Pension Benefit Guaranty Corporation.

ACTION: Final rule.

SUMMARY: The Pension Benefit Guaranty Corporation's regulations on Benefits Payable in Terminated Single-Employer Plans and Allocation of Assets in Single-Employer Plans prescribe interest assumptions for valuing and paying benefits under terminating single-employer plans. This final rule amends the regulations to adopt interest assumptions for plans with valuation dates in December 2004. Interest assumptions are also published on the PBGC's Web site (*http://www.pbgc.gov*).

EFFECTIVE DATES: December 1, 2004.

FOR FURTHER INFORMATION CONTACT: Harold J. Ashner, Assistant General Counsel, Office of the General Counsel, Pension Benefit Guaranty Corporation, 1200 K Street, NW., Washington, DC 20005, 202–326–4024. (TTY/TDD users may call the Federal relay service toll-free at 1–800–877–8339 and ask to be connected to 202–326–4024.)

SUPPLEMENTARY INFORMATION: The PBGC's regulations prescribe actuarial assumptions—including interest assumptions—for valuing and paying plan benefits of terminating single-employer plans covered by title IV of the Employee Retirement Income Security Act of 1974. The interest assumptions are intended to reflect current conditions in the financial and annuity markets.

Three sets of interest assumptions are prescribed: (1) a set for the valuation of benefits for allocation purposes under section 4044 (found in Appendix B to Part 4044), (2) a set for the PBGC to use to determine whether a benefit is payable as a lump sum and to determine lump-sum amounts to be paid by the PBGC (found in Appendix B to Part 4022), and (3) a set for private-sector pension practitioners to refer to if they wish to use lump-sum interest rates determined using the PBGC's historical methodology (found in Appendix C to Part 4022).

Accordingly, this amendment (1) adds to Appendix B to Part 4044 the interest assumptions for valuing benefits for allocation purposes in plans with valuation dates during December 2004, (2) adds to Appendix B to Part 4022 the interest assumptions for the PBGC to use for its own lump-sum payments in plans with valuation dates during December 2004, and (3) adds to Appendix C to Part 4022 the interest assumptions for private-sector pension practitioners to refer to if they wish to use lump-sum interest rates determined using the PBGC's historical methodology for valuation dates during December 2004.

For valuation of benefits for allocation purposes, the interest assumptions that the PBGC will use (set forth in Appendix B to part 4044) will be 3.80 percent for the first 20 years following the valuation date and 5.00 percent thereafter. These interest assumptions are unchanged from those in effect for November 2004.

The interest assumptions that the PBGC will use for its own lump-sum payments (set forth in Appendix B to part 4022) will be 2.75 percent for the period during which a benefit is in pay status and 4.00 percent during any years preceding the benefit's placement in pay status. These interest assumptions are unchanged from those in effect for November 2004.

For private-sector payments, the interest assumptions (set forth in Appendix C to part 4022) will be the same as those used by the PBGC for determining and paying lump sums (set forth in Appendix B to part 4022).

The PBGC has determined that notice and public comment on this amendment are impracticable and contrary to the public interest. This finding is based on the need to determine and issue new interest assumptions promptly so that the assumptions can reflect, as accurately as possible, current market conditions.

Because of the need to provide immediate guidance for the valuation and payment of benefits in plans with valuation dates during December 2004, the PBGC finds that good cause exists for making the assumptions set forth in this amendment effective less than 30 days after publication.

The PBGC has determined that this action is not a ''significant regulatory action'' under the criteria set forth in Executive Order 12866.

Because no general notice of proposed rulemaking is required for this amendment, the Regulatory Flexibility Act of 1980 does not apply. See 5 U.S.C. 601(2).

List of Subjects

29 CFR Part 4022

Employee benefit plans, Pension insurance, Pensions, Reporting and recordkeeping requirements.

29 CFR Part 4044

Employee benefit plans, Pension insurance, Pensions.

■ In consideration of the foregoing, 29 CFR parts 4022 and 4044 are amended as follows:

PART 4022—BENEFITS PAYABLE IN TERMINATED SINGLE-EMPLOYER PLANS

■ 1. The authority citation for part 4022 continues to read as follows:

Authority: 29 U.S.C. 1302, 1322, 1322b, 1341(c)(3)(D), and 1344.

■ 2. In appendix B to part 4022, Rate Set 134, as set forth below, is added to the table. (The introductory text of the table is omitted.)

Appendix B to Part 4022—Lump Sum Interest Rates for PBGC Payments

* * * * *

Rate set	For plans with a valuation date		Immediate annuity rate (percent)	Deferred annuities (percent)				
	On or after	Before		i_1	i_2	i_3	n_1	n_2
*	*	*	*	*	*	*	*	
134	12–1–04	1–1–05	2.75	4.00	4.00	4.00	7	8

3. In appendix C to part 4022, Rate Set 134, as set forth below, is added to the table. (The introductory text of the table is omitted.)

Appendix C to Part 4022—Lump Sum Interest Rates for Private-Sector Payments

* * * * *

Rate set	For plans with a valuation date		Immediate annuity rate (percent)	Deferred annuities (percent)				
	On or after	Before		i_1	i_2	i_3	n_1	n_2
*	*	*	*	*	*	*	*	
134	12–1–04	1–1–05	2.75	4.00	4.00	4.00	7	8

PART 4044—ALLOCATION OF ASSETS IN SINGLE-EMPLOYER PLANS

■ 4. The authority citation for part 4044 continues to read as follows:

Authority: 29 U.S.C. 1301(a), 1302(b)(3), 1341, 1344, 1362.

■ 5. In appendix B to part 4044, a new entry, as set forth below, is added to the table. (The introductory text of the table is omitted.)

Appendix B to Part 4044—Interest Rates Used To Value Benefits

* * * * *

For valuation dates occurring in the month—	The values of i_t are:					
	i_t	for t =	i_t	for t =	i_t	for t =
*	*	*	*	*	*	*
December 2004	.0380	1–20	.0500	>20	N/A	N/A

Issued in Washington, DC, on this 9th day of December 2004.

Joseph H. Grant,

Deputy Executive Director and Chief Operating Officer, Pension Benefit Guaranty Corporation.

[FR Doc. 04–25320 Filed 11–12–04; 8:45 am]

BILLING CODE 7708–01–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 1

[WT Docket No. 00–230; FCC 03–113; DA 04–239; DA 04–252]

Promoting Efficient Use of Spectrum Through Elimination of Barriers to the Development of Secondary Markets

AGENCY: Federal Communications Commission.

ACTION: Final rule, announcement of effective date.

SUMMARY: The Wireless Telecommunications Bureau (Bureau) of the Federal Communications Commission (Commission) announces that certain Commission rules adopted in the Secondary Markets proceeding (WT Docket No. 00–230) in 2003, to the extent they contained information collection requirements relating to spectrum leasing notifications and applications that required approval by the Office of Management and Budget (OMB), are now in effect with the issuance of FCC Form 603–T.

DATES: Sections 1.913(a), 1.913(a)(3), 1.2002(d), 1.2003, 1.9003, 1.9020(e), 1.9030(e), and 1.9035(e), published at 68 FR 66252 (Nov. 25, 2003), contained information collection requirements that

became effective on February 2, 2004, following approval by the Office of Management and Budget (OMB).

FOR FURTHER INFORMATION CONTACT: Paul Murray, Wireless Telecommunications Bureau, at (202) 418–7240, or via the Internet at *Paul.Murray@fcc.gov;* for additional information concerning the information collections contained in this document, contact Judith-B.Herman at (202) 418–0214, or via the Internet at *Judith.B-Herman@fcc.gov.*

Announcement of Effective Date of Certain Commission Rules

1. In the February 2, 2004 *Public Notice,* DA 04–252, 19 FCC Rcd 1911, the Wireless Telecommunications Bureau announced the availability of FCC Form 603–T for use by spectrum leasing parties filing spectrum leasing notifications and applications with the Commission, and the rules requiring use of FCC Form 603–T became effective as of that date. FCC Form 603–T contain information collection necessary for the implementation of certain spectrum leasing rules adopted by the Commission in 2003 in the *Secondary Markets First Report and Order,* published at 68 Fed. Reg. 66252 (Nov. 25, 2003). As noted therein, the effective date of certain of the Commission's spectrum leasing rules adopted in the *Secondary Markets First Report and Order*—specifically sections 1.913(a), 1.913(a)(3), 1.2002(d), 1.2003, 1.9003, 1.9020(e), 1.9030(e), and 1.9035(e)—would not become effective until the information collection requirements contained in those rules were approved by the Office of Management and Budget (OMB). The Bureau reiterated this discussion regarding the effective date of certain spectrum leasing rules in its *Memorandum Opinion and Order,* DA 04–239, 19 FCC Rcd 1542, January 30, 2004.

2. On January 29, 2004, OMB approved of the use of Form 603–T on an interim basis. Accordingly, the revisions to sections 1.913(a), 1.913(a)(3), 1.2002(d), 1.2003, and the new rules involving use of certain forms of information collection as set forth of 1.9003, 1.9020(e), 1.9030(e), and 1.9035(e) of the Commission's spectrum leasing rules, 47 CFR 1.913(a), 1.913(a)(3), 1.2002(d), 1.2003, 1.9003, 1.9020(e), 1.9030(e), and 1.9035(e), became effective with the issuance of FCC Form 603–T on February 2, 2004.

Federal Communications Commission.

Marlene H. Dortch,

Secretary.

[FR Doc. 04–25288 Filed 11–12–04; 8:45 am]

BILLING CODE 6712–01–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 73

[DA 04–3482, MB Docket No. 04–236, RM–11001]

Digital Television Broadcast Service; Fresno, CA.

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: The Commission, at the request of KSEE License, Inc., substitutes DTV channel 38 for DTV channel 16 at Fresno, California. *See* 69 FR 41444, July 9, 2004. DTV channel 38 can be allotted to Fresno, California, in compliance with the principle community coverage requirements of Section 73.625(a) at reference coordinates 37–04–19 N. and 119–25–48 W. with a power of 326, HAAT of 601 meters and with a DTV service population of 1224 thousand. With this action, this proceeding is terminated.

DATES: Effective December 20, 2004.

FOR FURTHER INFORMATION CONTACT: Pam Blumenthal, Media Bureau, (202) 418–1600.

SUPPLEMENTARY INFORMATION: This is a synopsis of the Commission's Report and Order, MB Docket No. 04–236, adopted October 29, 2004, and released November 5, 2004. The full text of this document is available for public inspection and copying during regular business hours in the FCC Reference Information Center, Portals II, 445 12th Street, SW., Room CY–A257, Washington, DC. This document may also be purchased from the Commission's duplicating contractor, Best Copy and Printing, Inc., 445 12th Street, SW., Room CY–B402, Washington, DC, 20554, telephone 301–816–2820, facsimile 301–816–0169, or via-e-mail *joshir@erols.com.*

This document does not contain [new or modified] information collection requirements subject to the Paperwork Reduction Act of 1995 (PRA), Public Law 104–13. In addition, therefore, it does not contain any new or modified ''information collection burden for small business concerns with fewer than 25 employees,'' pursuant to the Small Business Paperwork Relief Act of 2002, Public Law 107–198, *see* 44 U.S.C. 3506(c)(4).

The Commission will send a copy of this [Report & Order *etc.*] in a report to be sent to Congress and the General Accounting Office pursuant to the Congressional Review Act, *see* 5 U.S.C. 801(a)(1)(A).

List of Subjects in 47 CFR Part 73

Digital television broadcasting, Television.

■ Part 73 of title 47 of the Code of Federal Regulations is amended as follows:

PART 73—[AMENDED]

■ 1. The authority citation for part 73 continues to read as follows:

Authority: 47 U.S.C. 154, 303, 334 and 336.

§ 73.622 [Amended]

■ 2. Section 73.622(b), the Table of Digital Television Allotments under California, is amended by removing DTV channel 16 and adding DTV channel 38 at Fresno.

Federal Communications Commission.

Barbara A. Kreisman,

Chief, Video Division, Media Bureau.

[FR Doc. 04–25263 Filed 11–12–04; 8:45 am]

BILLING CODE 6712–01–P

Proposed Rules

Federal Register
Vol. 69, No. 219
Monday, November 15, 2004

This section of the FEDERAL REGISTER contains notices to the public of the proposed issuance of rules and regulations. The purpose of these notices is to give interested persons an opportunity to participate in the rule making prior to the adoption of the final rules.

DEPARTMENT OF AGRICULTURE

Rural Housing Service

Rural Business-Cooperative Service

Rural Utilities Service

Farm Service Agency

7 CFR Parts 1782, 1951, 1955, and 1956

RIN 0572–AB59

Servicing of Water Programs Loans and Grants

AGENCY: Rural Utilities Service, USDA.

ACTION: Proposed rule.

SUMMARY: The Rural Utilities Service (RUS) proposes to consolidate and amend the regulations utilized to service water and waste loan and grant programs. The proposed rule will combine the water and waste loan and grant servicing regulations found in 7 CFR parts 1951, 1955 and 1956 into one regulation. Unnecessary and burdensome requirements for water and waste loan and grant servicing under the program will be eliminated. The streamlining of the water and waste loan and grant servicing regulation will allow RUS to provide better service to entities needing assistance in resolving financial and economic problems in their communities and in general improve the quality of life in rural areas. Additionally, this rule proposes to implement Section 6018 of the Farm Security and Rural Investment Act of 2002 (7 U.S.C. 1936a) for the Rural Business-Cooperative Service (RBS), Rural Housing Service (RHS) and RUS.

DATES: Comments on the proposed rule must be received on or before January 14, 2005.

ADDRESSES: You may submit comments by any of the following methods:

- Federal eRulemaking Portal: Go to *http://www.regulations.gov.* Follow the online instructions for submitting comments.
- Agency Web Site: *http://www.usda.gov/rus/index2/Comments.htm.* Follow the instructions for submitting comments.
- E-mail: *RUSComments@usda.gov.* Include in the subject line of the message ''7 CFR 1782.''
- Mail: Addressed to Richard Annan, Acting Director, Program Development and Regulatory Analysis, Rural Utilities Service, United States Department of Agriculture, 1400 Independence Avenue, SW., STOP 1522, Washington, DC 20250–1522.
- Hand Delivery/Courier: Addressed to Richard Annan, Acting Director, Program Development and Regulatory Analysis, Rural Utilities Service, United States Department of Agriculture, 1400 Independence Avenue, SW., Room 5168–S, Washington, DC 20250–1522.

Instructions: All submissions received must include the agency name and the subject heading ''7 CFR 1782''. All comments received must identify the name of the individual (and the name of the entity, if applicable) who is submitting the comment. All comments received will be posted without change to *http://www.usda.gov/rus/index2/Comments.htm*, including any personal information provided.

FOR FURTHER INFORMATION CONTACT: Anita O'Brien, Loan Specialist, Water and Environmental Programs, Rural Utilities Service, Room 2230 South Building, Stop 1570, 1400 Independence Ave., SW., Washington, DC 20250–1570. Telephone: (202) 690–3789, FAX: (202) 690–0649, e-mail: *anita.obrien@usda.gov.*

SUPPLEMENTARY INFORMATION:

Classification

Executive Order 12866

This proposed rule has been determined to be not significant for purposes of Executive Order 12866 and, therefore, has not been reviewed by the Office of Management and Budget (OMB).

Executive Order 12988

This proposed rule has been reviewed in accordance with Executive Order 12988, Civil Justice Reform. RUS has determined that this proposed rule meets the applicable standards provided in section 3 of the Executive Order. In addition, all State and local laws and regulations that are in conflict with this rule will be pre-empted; no retroactive effect will be given to the rule; and in accordance with sec. 212(e) of the Department of Agriculture Reorganization Act of 1994 (7 U.S.C. sec. 6912(e)), appeal procedures must be exhausted before an action against the Department or its agencies may be initiated.

Regulatory Flexibility Act Certification

It has been determined that the Regulatory Flexibility Act is not applicable to this rule since the Rural Utilities Service is not required by 5 U.S.C. 551 *et seq.* or any other provision of law to publish a notice of proposed rulemaking with respect to the subject matter of this rule.

Information Collection and Recordkeeping Requirements

In accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. chapter 35), RUS is requesting comments on the collection of information incorporated in this proposed rule. The reporting burden will be transferred from nine existing regulations into regulation 1782 and where possible, the reporting burden will be reduced.

Title: Servicing of Water and Waste Programs.

Type of Request: New collection.

Abstract: RUS' Water and Environmental Programs (WEP) provide financing and technical assistance for development and operation of safe and affordable water supply systems and sewage and other waste disposal facilities. WEP provides loans, guaranteed loans and grants for water, sewer, storm water, and solid waste disposal facilities in rural areas and towns of up to 10,000 people. The recipients of the assistance covered by 7 CFR part 1782 must be public entities. These can include municipalities, counties, special purpose districts; federally designated Indian tribes, land corporations not operated for profit, including cooperatives. The information, which is for the most part financial in nature, is needed by the Agency to determine if borrowers, based on their individual situations, qualify for the various servicing options.

Estimate of Burden: Public reporting burden for this collection of information is estimated to average 30 hours per response.

Respondents: Business or other for profit and non-profit institutions, and state and local governments.

Estimated Number of Respondents: 2,000.

Estimated Number of Responses per Respondents: 1.35.

Estimated Total Annual Burden on Respondents: 80,976 hours.

The subject regulation is published for public review and comment. Copies of this information collection can be obtained from Michele Brooks, Program Development and Regulatory Analysis, Rural Utilities Service. Telephone: (202) 690–1078.

Comments on this information collection must be received by January 14, 2005.

Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information including the validity of the methodology and assumptions used; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including the use of automated collection techniques or other forms of information technology.

Send comments regarding this information collection requirement to Michele Brooks, Program Development and Regulatory Analysis, USDA, Rural Utilities Service, 1400 Independence Ave., SW., Room 5166, Stop 1522, Washington, DC 20250–1522.

Comments are best assured of having full effect if OMB receives them within 30 days of publication in the **Federal Register**. All comments will be summarized, included in the request for OMB approval, and will become a matter of public record.

National Environmental Policy Act Certification

The Administrator of RUS has determined that this proposed rule will not significantly affect the quality of the human environment as defined by the National Environmental Policy Act of 1969 (42 U.S.C. 4321 *et seq.*). Therefore, this action does not require an environmental impact statement or assessment.

Catalog of Federal Domestic Assistance

The program described by this proposed rule is listed in the Catalog of Federal Domestic Assistance Programs under numbers (1) 10.760—Water and Waste Disposal System for Rural Communities, (2) 10.761—Technical Assistance and Training Grants, (3) 10.762—Solid Waste Management Grants (4) 10.763—Emergency Community Assistance Grants, and (5) 10.770—section 306C Water and Waste Loans and Grants. This catalog is available on a subscription basis from the Superintendent of Documents, the United States Government Printing Office, Washington, DC 20402–9325, telephone number (202) 512–1800.

Executive Order 12372

This program is listed in the Catalog of Federal Domestic Assistance under numbers (1) 10.760—Water and Waste Disposal (WWD) System for Rural Communities, (2) 10.763—Emergency Community Assistance Grants, and (3) 10.770—Water and Waste Loans and Grants (section 306C), and is subject to the provisions of Executive Order 12372 which requires intergovernmental consultation with State and local officials.

Unfunded Mandates

This rule contains no Federal mandates (under the regulatory provision of title II of the Unfunded Mandates Reform Act of 1995) for State, local, and tribal governments or the private sector. Therefore, this rule is not subject to the requirements of section 202 and 205 of the Unfunded Mandates Reform Act.

Executive Order 13132, Federalism

The policies contained in this proposed rule do not have any substantial direct effect on states, on the relationship between the national government and the states, or on the distribution of power and responsibilities among the various levels of government. Nor does this proposed rule impose substantial direct compliance costs on state and local governments. Therefore, consultation with states is not required.

Background

RUS' water and waste program is administered by Water and Environmental Programs (WEP). The water and waste loan and grant programs are authorized by various sections of the Consolidated Farm and Rural Development Act (7 U.S.C. 1921 *et seq.*), as amended. The regulations for these programs have not been completely reviewed for many years. The 1994 streamlining and reorganization of the Department of Agriculture provided an opportunity to review and rewrite the water and waste loan and grant servicing regulations. A task force was formed for that purpose. The aim of the task force was to make the regulations easier to understand, eliminate unnecessary requirements, and continue to protect the interest of the U. S. taxpayer. The program provides loan servicing options for communities facing financial problems. Servicing options should result in reasonable user costs for rural residents, rural businesses, and other rural users. Additionally, in order to provide uniformity, servicing provisions for grants are addressed in the Departmental Grant Regulations listed cited in 1782.7.

Major changes are:

1. Combines servicing regulations found in 7 CFR parts 1951, 1955 and 1956 into one regulation.

2. The field staff is provided with more authority to service water and waste loans and grants.

3. The application process for servicing actions has been streamlined to reduce unnecessary paperwork and improve service to the rural communities. There will be fewer regulations and the number of pages in the Code of Federal Regulations will be greatly reduced.

4. The functions of the former Farmers Home Administration (FmHA) and the Rural Development Administration (RDA) relating to the water and waste loan and grant programs authorized by various sections of the Consolidated Farm and Rural Development Act, (7 U.S.C. 1926(a)), have been transferred to RUS based on the Department of Agriculture Reorganization Act of 1994, 7 U.S.C. 6942. Therefore in order to enhance the delivery of borrower services and better assist the public, RUS is simplifying and rewriting regulations originally published by FmHA and RDA. All parts pertaining to the water and waste loan program will be moved into 7 CFR part 1782. This action will have no effect on the Rural Housing Services (RHS) community facilities loan program, as this action makes no policy changes in the regulation with the exception of implementing section 6018 of the Farm Security and Rural Investment Act of 2002 (7 U.S.C. 1936a). The following programs are affected by these amendments: (1) Water and Waste Disposal Loans and Grants, (2) Watershed loans and advances, (3) Resource Conservation and Development loans, (4) Technical Assistance and Training grants, (5) Emergency Community Assistance grants, (6) Solid Waste Management grants, and (7) Section 306C Water and Waste Facility Loans and Grants to Alleviate Health Risks.

5. Implement Sec. 6018 of the Farm Security and Rural Investment Act of 2002. This change will allow the borrower or grant recipient to use property (real and personal) purchased or improved with the loan or grant funds or proceeds from the sale of property (real and personal) purchased with such funds, for another project or activity. The RUS proposes to include language to implement this provision in 7 CFR 1782.23. These provisions will also be applicable to the RBS and RHS programs by adding § 1951.218 to 7 CFR part 1951, subpart E.

The Regulations

RUS has completed a consolidation of regulations affecting WEP loans and grants. Prior to this rule becoming effective, WEP borrowers were affected, in part, by the following regulations:

7 CFR part 1951, subpart A—Account Servicing Policies.

7 CFR part 1951, subpart D—Final Payment on Loans.

7 CFR part 1951, subpart E—Servicing of Community and Direct Business Programs Loans and Grants.

7 CFR part 1951, subpart F—Analyzing Credit Needs and Graduation of Borrowers.

7 CFR part 1951, subpart O—Servicing Cases Where Unauthorized Loan(s) or Other Financial Assistance Was Received—Community and Insured Business Programs.

7 CFR part 1955, subpart A—Liquidation of Loans Secured by Real Estate and Acquisition of Real and Chattel Property.

7 CFR part 1955, subpart B—Management of Property.

7 CFR part 1955, subpart C—Disposal of Inventory Property.

7 CFR part 1956, subpart C—Debt Settlement—Community and Business Programs.

All of the above mentioned regulations include regulatory provisions of other programs of the former FmHA such as farm loans, business and industrial loans, single family housing, and multi-family housing. RUS is consolidating all regulatory actions in the above mentioned regulations which affect WEP loan and grant servicing into one new regulation—7 CFR part 1782. This consolidated regulation will clarify for our borrowers and grantees, the available servicing tools and the requirements to utilize these tools.

Additionally, RUS proposes to remove all administrative processes from the regulations, leaving only regulatory actions that impact the public. This streamlining will make the regulation more concise and much easier to read and understand. The Agency will issue a Staff Instruction that will include the administrative portion, which outlines the Agency's internal processing procedures. The Staff Instruction will be available to the public upon request at no cost.

Conclusion

RUS believes the consolidation and streamlining of the regulations for this program will maximize the ability of the Borrowers to use and understand the available servicing tools under this program. This consolidation is consistent with the Administration's efforts to streamline Government functions, improve the efficiency and effectiveness of Government activities, and strive to be more borrower friendly. This effort will enable the Agency to reduce regulations, streamline Agency operations and provide servicing assistance with fewer staff resources.

List of Subjects

7 CFR Part 1782

Accounting, Appeal procedures, Auditing, Debts, Delinquency, Grant programs—Agriculture, Insurance, Loan programs—Agriculture.

7 CFR Part 1951

Accounting, Credit, Grant programs—Agriculture, Loan Programs—Agriculture, Low and moderate-income housing loans—Rent subsidies, reporting, and recordkeeping requirements, Rural areas.

7 CFR Part 1955

Government property, Government property management, Surplus government property.

7 CFR Part 1956

Accounting, Loan programs—Agriculture, Rural areas.

Therefore, chapters XVII and XVIII of title 7, Code of Federal Regulations are proposed to be amended as follows:

CHAPTER XVII—RURAL UTILITIES SERVICE, DEPARTMENT OF AGRICULTURE

1. Part 1782 is added to read as follows:

PART 1782—SERVICING OF WATER AND WASTE PROGRAMS

Sec.

Authority: 5 U.S.C. 301; 7 U.S.C. 1981; 16 U.S.C. 1005.

§ 1782.1 Purpose.

This part outlines the Rural Utilities Service's (RUS) policies and procedures for servicing direct and insured Water and Waste Disposal loans and grants; Watershed loans and advances; Resource Conservation and Development loans; Technical Assistance and Training grants; Emergency Community Water Assistance grants; Solid Waste Management grants; and section 306C WWD loans and grants.

§ 1782.2 Objectives.

Loan and grant servicing is provided by RUS in order to assist recipients in complying with the established objectives and requirements for loans and grants, repaying loans on schedule, acting in accordance with any necessary agreements, and protecting RUS' financial interest. Servicing by RUS includes, but is not limited to, the review of budgets, management reports, audits and financial statements; performing security inspections; providing, arranging or recommending technical assistance; evaluating environmental impacts of proposed actions by the Borrower; and performing civil rights compliance and graduation reviews.

§ 1782.3 Definitions.

Acceleration. A written notice informing the borrower that the total unpaid principal and interest is due and payable immediately.

Adjustment. Satisfaction of a debt, including release of liability, when acceptance by the agency is conditioned upon completion of payment of the adjusted amount at a specific time or times; with or without the payment of

any consideration when the adjustment offer is approved. An adjustment is not a final settlement until all payments under the adjustment agreement have been made.

Administrator. Administrator of RUS.

Agency. RUS or any employee acting on its behalf in accordance with appropriate delegations of authority.

Assumption of debt. Agreement by one party to legally bind itself to pay the debt incurred by another.

Borrower. Recipient of RUS or predecessor agency loan assistance.

Cancellation. Final discharge of debt with a release of liability.

Chargeoff. Write off of a debt and termination of servicing activity without release of liability. A Chargeoff is a decision upon the part of the Agency to remove debt from Agency receivables; however, future payments may be received.

Compromise. Satisfaction of a debt including a release of liability by accepting a lump-sum payment of less than the total amount owed.

Defeasance. Defeasance is the use of invested proceeds from a new bond issue to repay outstanding bonds in accordance with the repayment schedule of the outstanding bonds. The new issue supersedes the contractual agreements from the prior issue.

Disposition of facility. Relinquishing control of a facility to another entity.

False information. Information, known to be incorrect, provided with the intent to obtain benefits which would not have been obtainable based on correct information.

Government. The United States of America acting through the RUS, USDA. USDA and RUS may be used interchangeably throughout this part.

Grantee. Recipient of RUS or predecessor agency grant assistance, technical assistance, or services.

Letter of Conditions. A written document that describes the conditions which the borrower and/or grantee must meet for funds to be advanced and the loan and/or grant to be closed.

Liquidation. To satisfy a debt through the sale of a borrower's assets and discharge of liabilities.

Parity Lien. A lien having an equal lien position to another lender's lien on a borrower's asset.

Reasonable rates and terms. Commercial rates and terms borrowers are expected to pay when borrowing for similar purposes and periods of time.

Rural Development. The mission area of the Under Secretary for Rural Development. Rural Development State and local offices administer the water and waste programs on behalf of RUS.

Rural Utilities Service (RUS). An Agency of the USDA established pursuant to section 232 of the Department of Agriculture Reorganization Act of 1994 (Pub. L. 103–354).

Servicing office. The USDA office which maintains the official file of the borrower or grantee and is responsible for the routine servicing of the loan and grant account.

Servicing official. A USDA official who has been delegated loan and grant approval and servicing authorities subject to any dollar limitations within applicable programs.

Settlement. Compromise, adjustment, cancellation, or chargeoff of a debt owed USDA. The term ''settlement'' is used for convenience in referring to compromise, adjustment, cancellation, or chargeoff action, individually or collectively.

Subordination agreement. A formal agreement whereby RUS permits another lender to have a senior or prior lien position on a borrower's assets to facilitate the borrower's obtaining financing from another source of credit. A subordinate lien position is an inferior or junior lien position.

USDA. United States Department of Agriculture.

Unliquidated obligations. Obligated loan or grant funds that have not been advanced.

Voluntary conveyance. A method by which title to security is voluntarily transferred to the Government.

§ 1782.4 Availability of forms and regulations.

Information about the availability of forms, regulations, bulletins, and procedures referenced in this chapter are available in any office of the USDA/Rural Development or RUS, United States Department of Agriculture, Washington, DC 20250–1500 or at the Web site *http://www.usda.gov/rus/water.*

§ 1782.5 Nondiscrimination.

Each instrument of conveyance required for a transfer, assumption, sale of facility, or other servicing action under this subpart will comply with Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, section 504 of the Rehabilitation Act of 1973, and other similarly worded Federal statutes and regulations issued pursuant thereto that prohibits discrimination on the basis of race, color, national origin, handicap, religion, age, or sex in programs or activities receiving Federal financial assistance. Such provisions apply for as long as the property continues to be used for the same or similar purposes for which the Federal assistance was extended, or for so long as the purchaser owns it, whichever is later.

§ 1782.6 [Reserved]

§ 1782.7 Grants.

Servicing actions relating to RUS grants are governed by the provisions of 7 CFR parts 3015, 3016, 3017, 3018, 3019, 3021, and 3052 as applicable, and Executive Order (E.O.) 12803. Grantees remain responsible for property acquired with grant funds in accordance with terms of a grant agreement and applicable regulations.

§ 1782.8 Payments.

Payments will be applied in accordance with the terms of the debt instrument. Information on non-typical payments can be obtained from the Servicing official or office. All new borrowers will use pre-authorized debits as required in their Letter of Conditions.

§ 1782.9 Environmental requirements.

Servicing actions involving subordination and lease or sale of RUS owned property will be reviewed for compliance with 7 CFR part 1794 as required in § 1794.3. The appropriate environmental review will be completed prior to approval of the servicing action.

§ 1782.10 Audit requirements.

Audits for loans will be required in accordance with § 1780.47 of this title. If the borrower becomes delinquent or is experiencing problems, the servicing official will require an audit or other documentation deemed necessary to resolve the delinquency. The provisions of 7 CFR part 3052 address audit requirements for recipients of federal grants.

§ 1782.11 Refinancing requirements.

If at any time it appears to the Government that the borrower is able to refinance the amount of the indebtedness then outstanding, in whole or in part, by obtaining a loan for such purposes from responsible cooperative or private credit sources, at reasonable rates and terms, the borrower will, upon request of the Government, apply for and accept such loan in sufficient amount to repay the Government and will take all such actions as may be required in connection with such loan.

§ 1782.12 Sale or exchange of security property.

A cash sale of all or a portion of a borrower's assets or an exchange of security property may be approved subject to the conditions set forth in this section.

(a) *Approval conditions.* Approval may be given when the servicing official determines that:

(1) The consideration is for the full amount of the debt or the present fair market value as determined by an appraisal completed by a qualified Rural Development employee or an independent appraiser as determined appropriate by the approval official;

(2) The sale or exchange will not prevent carrying out the purpose of the loan;

(3) The remaining property is adequate security for the loan and the transaction will not adversely affect RUS' security position;

(4) If the property to be sold or exchanged will be used for similar purposes that the loan was made, the purchaser will:

(i) Execute Form RD 400–4, ''Assurance Agreement.'' The instrument of conveyance will contain the civil rights covenant referenced in 7 CFR 1901.202(e); and

(ii) Provide RUS with a written agreement assuming all rights and obligations of the original borrower, and

(5) Proceeds remaining after paying any reasonable and necessary selling expenses are to be used for one or more of the following purposes:

(i) To pay RUS debt, pay on debts secured by a prior lien, and pay on debts secured by a parity or subsequent lien if it is to RUS' advantage;

(ii) To purchase or acquire property more suited to the borrower's needs, providing RUS security position is maintained; and

(iii) To develop or enlarge the facility if necessary to improve the borrower's debt-paying ability, place the operation on a sounder financial basis, or further the loan objectives and purposes.

(b) *Sale of assets financed with RUS grants.* The requirements for the sale or disposition of assets financed with RUS grants are determined by the terms of the grant agreement, 7 CFR parts 3015, 3016, and 3019, and E.O. 12803, as applicable.

(c) *Release from liability.* If a borrower can no longer meet the objectives of the loan, the property may be sold. If the full amount of the borrower's debt is paid or assumed, the State Director may release the borrower from liability.

§ 1782.13 Transfer of Security and Assumption of Loans.

It is RUS policy to approve transfers and assumptions to transferees that will continue the original purpose of the loan. Assistant Administrator written concurrence is required when the transfer exceeds the State Director's loan approval authority. The transfer will be approved in accordance with the following requirements:

(a) *General requirements for transferees.* The fulfillment of the following requirements for transfers will be determined by the approval official, in his or her discretion:

(1) The transferees must meet the eligibility requirements of 7 CFR 1780.7 and provide the same information required in 7 CFR Part 1780, subpart B for application processing.

(2) The transfer will not be disadvantageous to the Government as determined by the approval official.

(3) If the RUS debt(s) exceeds the present market value of the security as determined by an appraisal, the transferee will assume an amount at least equal to the present market value.

(4) RUS must concur in plans for disposition of funds in any reserve account, including project construction bank accounts. A reserve account may be considered as a transferable asset.

(5) The transferee will assume all of the borrower's responsibilities regarding loans. The transferee will also agree to accept the original loan conditions plus any conditions set forth by RUS with regard to the transfer.

(6) A current appraisal will be completed to establish the present market value of the security when the full debt is not being assumed.

(7) There must be no lien, judgement, or similar claims of other parties against the RUS security being transferred unless the transferee is willing to accept such claims. RUS must also determine that the claims will not prevent the transferee from repaying the RUS debt, meeting all operating and maintenance costs, and maintaining required reserves. The written consent of any other lienholder will be obtained where required.

(8) A letter of conditions establishing requirements to be met in connection with the transfer will be issued, and the transferee will be required to execute Form RD 1942–46, ''Letter of Intent to Meet Conditions,'' prior to closing of the transfer.

(9) The transferee will obtain insurance according to RUS requirements.

(10) The effective date of the transfer is the date the transfer is closed, which is the same date Form RD 1951–15, ''Community Programs Assumption Agreement,'' or other appropriate assumption agreement, which is executed and delivered by all necessary parties.

(11) Title to all assets will be conveyed from the transferor to the transferee unless all parties concerned, including RUS, agree upon other arrangements. All instruments of conveyance will contain the necessary nondiscrimination covenant as referred to in *§ 1782.5.*

(12) If the transfer and assumption is to one or more members of the borrower's organization, there must not be a loss to the Government.

(13) The State Director is authorized to approve transfers to eligible transferees at the same interest rate as on the borrower's note(s) or bond(s). The maturity of the debt instrument for the assumed debt may not exceed the lesser of the repayment period authorized in 7 CFR 1780.13(e) for a ''new'' loan or the expected life of the facility.

(14) RUS National Office concurrence is required for transfers not in compliance with paragraphs (a)(1) through (14) of this section.

(b) *Loan requirements for eligible transferees.* If a loan is evidenced and secured by a note and lien on real or chattel property, Form RD 1951–15, or other appropriate assumption agreement will be executed by the transferee. If a bond secures a loan, transfer documents will be developed by bond counsel and approved by Office of the General Counsel, USDA (OGC).

(1) Loans being transferred and assumed may be combined when the security is the same, new terms are being provided, a new debt instrument will be issued, and the loans have the same interest rate and are for the same purpose. If applicable, 7 CFR 1780.94(l) will govern the preparation of any new debt instruments required.

(2) A loan may be made in connection with a transfer if the transferee meets all eligibility and other requirements for the kind of loan being made. Such a loan will be considered as a separate loan, and must be evidenced by a separate debt instrument. However, it is permissible to have one authorizing loan resolution or ordinance if permitted by State statutes.

(3) Any development funds remaining in a bank account that are not refunded to RUS will be transferred to a bank account for the transferee. This will occur simultaneously with the closing of the transfer and the funds will be used in completing planned development.

(c) *Release from liability.* Transferors may be released from liability when their debt is paid in full or when the debt is settled in accordance with § 1782.20 of this part.

(d) *Transfer of facility financed with RUS grants.* The requirements for the sale or disposition of assets financed with RUS grants are determined by the terms of the grant agreement, 7 CFR

parts 3015, 3016, and 3019, and E.O. 12803, as applicable.

§ 1782.14 Protection of Service Areas—7 U.S.C. 1926(b).

(a) 7 U.S.C. 1926(b) was enacted to protect the service area of RUS borrowers with outstanding loans, or those loans sold in the sale of assets authorized by the ''Joint Resolution Making Continuing Appropriations for the Fiscal Year 1987, Pub. L. 99–591, 100 Stat. 3341 (1986),'' from loss of users due to actions or activities of other entities in the service area of the RUS financed system. Without this protection, other entities could extend service to users within the service area and thereby undermine the purpose of the congressionally mandated water and waste loan and grant programs; and jeopardize the borrower's ability to repay its RUS debt.

(b) Responsibility for initiating action in response to those actions prohibited by 7 U.S.C. 1926(b) rests with the borrower.

§ 1782.15 Mergers and consolidations.

Mergers and consolidations will be processed the same as a transfer and assumption, although approvals by RUS will give consideration to the differences under the applicable law regarding the type of transaction under consideration. Mergers occur when two or more entities combine in such a manner that only one remains in existence. Consolidations occur when two or more entities combine to form a new consolidated entity, and the original entities cease to exist. In both mergers and consolidations, the surviving or emerging entity acquires the assets and assumes the liabilities of the entity or entities that ceased to exist.

§ 1782.16 Defeasance of RUS indebtedness.

Defeasance, or amending outstanding loan instruments and agreements to permit defeasance of RUS debt instruments, is not authorized.

§ 1782.17 Subordination of security or parity lien.

In order for RUS to agree to either a subordination or to a parity lien position, the borrower must submit a written request to the servicing office.

(a) The written request for parity or subordination must contain the following items:

(1) An explanation of the purpose of the request for parity or subordination; amount of loan for which parity or subordination is requested; description of security property; type of security instrument; name, and address of financial institution requesting the transaction; and other information determined necessary by the servicing official to evaluate the request.

(2) Current financial statements or an audit, if available or determined necessary by the servicing official.

(3) An annual operating budget which projects income and expenses for a typical year's operation. If construction is involved, the budget must be projected through the first full year of operation following completion of the planned improvements.

(4) A copy of the proposed security instrument.

(5) A certification from the borrower that the RUS debt cannot be refinanced at reasonable rates and terms.

(6) An appraisal, when the primary security is real estate or determined necessary by the servicing official in order to determine the adequacy of loan security or repayment ability.

(7) A certification that any development work will comply with subpart C of part 1780 of this chapter.

(8) Requests for a subordination of security are subject to the appropriate environmental review as required by § 1794.3 of this chapter.

(b) Requests for parity or subordination must comply with requirements of paragraph (a) of this section, requirements as specified in the bond or loan documents, the requirements as specified in § 1780.94(i) of this chapter, and as provided in applicable State law.

(c) Proposals for tax exempt issues will be considered for parity only.

(d) Once the borrower has met all of the requirements in paragraphs (a), (b) and (c) of this section and the proposal is determined to be in the Government's interest, RUS will then grant approval of the borrower's request for parity or subordination.

§ 1782.18 [Reserved]

§ 1782.19 Third party agreements.

The State Director may authorize third party operation, maintenance, and management of an RUS financed facility. The borrower's attorney must review the contract, management agreement, written lease or other third party agreement and issue an opinion to the agency as to their legal sufficiency. The borrower shall retain the legal authority necessary for owning, constructing, operating and maintaining the facility.

§ 1782.20 Debt settlement.

Pursuant to 7 U.S.C. 1981 this section prescribes policies for debt settlement of Water and Waste Disposal Loans; Watershed loans and advances; Resource Conservation and Development loans; and 306(c) Water and Waste Facility loans.

(a) *General requirements for debt settlement.* (1) The debt or any extension thereof on which settlement is requested must be due and payable. The debt will be due and payable either under the terms of the note or other instrument, or by acceleration, unless the debt is to be cancelled without application under paragraph (e)(2) of this section or charged off under paragraph (f) of this section.

(2) Normally, all security will be disposed of prior to the date of application for debt settlement unless it is necessary to abandon security through the debt settlement process. In such cases, debt settlement may proceed if the servicing official determines that further collection efforts would be ineffective, uneconomical, and not in the best interests of the Government.

(3) Debtors will not be permitted to sell security and use the proceeds as part or all of a compromise/adjustment debt settlement offer.

(4) Request for debt settlement will consist of Form RD 1956–1 ''Application For Settlement of Indebtedness,'' current financial information, description and estimated market value of collateral, and status of operation (*i.e.* number of users, compliance with environmental issues, etc.).

(5) OGC advice on compliance with State or Federal statutes that may affect the debt settlement action must be requested.

(b) *Debts ineligible for settlement.* Debts will not be settled if:

(1) Referral to OIG and/or to OGC is contemplated or pending because of suspected criminal violation, or

(2) Civil action to protect the interest of the Government is contemplated or pending, or

(3) An investigation for suspected fiscal irregularity is contemplated or pending, or

(4) The debtor requests settlement of a claim that has been referred to or a judgment obtained by the United States Attorney. The settlement offer and any related payment must be submitted directly to the United States Attorney for consideration.

(c) *Types of debt settlement.* Typically, debt settlement will be accomplished through compromise/adjustment, chargeoff, or cancellation. Any debt remaining after the security has been liquidated, by sale or transfer, will be cancelled if there are no other assets from which to collect the debt. The servicing official will proceed with

advice from OGC and the National Office, as required.

(d) *Compromise and adjustment.* Debts may be compromised or adjusted and security retained by the debtor, provided:

(1) The debtor is unable to pay the indebtedness in full, and

(2) The debtor has offered an amount equal to the present fair market value of all security or facility financed, and

(3) The debtor has offered any additional amount that the debtor is able to pay.

(e) *Cancellation.* Nonjudgment debts, regardless of the amount, may be cancelled with or without application by the debtor.

(1) *With application by the debtor.* Debts may be cancelled upon application of the debtor, subject to the following conditions:

(i) The servicing official furnishes a favorable recommendation concerning the cancellation;

(ii) There is no known security for the debt and the debtor has no other assets from which the debt could be collected;

(iii) The debtor is unable to pay any part of the debt and has no reasonable prospect of being able to do so; and

(iv) The debt or any extension thereof is due and payable under the terms of the note or other instrument, or due to acceleration by written notice prior to the date of application.

(2) *Without application by debtor.* Debts may be cancelled upon a favorable recommendation of the servicing official in the following instances:

(i) *Debtors discharged in bankruptcy.* If there is no security for the debt, debts discharged in bankruptcy shall be cancelled by the use of Form RD 1956–1. A copy of the Bankruptcy Court's Discharge Order must be attached.

(ii) *Impractical to obtain debtor's signature.* Debts may be cancelled if it is impractical to obtain a signed application and the requirements of paragraphs (e)(1) of this section are met. Form RD 1956–1 will document the specific reason(s) why it was impossible or impracticable to obtain the signature of the debtor. If the debtor refused to sign the application, the reason(s) should be documented.

(f) *Chargeoff.* (1) *Judgment debts.* Judgment debts, regardless of the amount, may be charged off without the debtor's signature upon a favorable recommendation of the servicing official provided:

(i) The United States Attorney's file is closed, and

(ii) The requirements of paragraph (e)(2)(ii) of this section, if applicable, have been met, or 2 years have elapsed since any collections were made on the judgment. The debtor must also have no equity in the property subject to the lien or upon which a lien can be obtained.

(2) *Nonjudgment debts.* Debts that cannot be settled under other sections of this part may be charged off without the debtor's signature upon a favorable recommendation of the servicing official in the following instances:

(i) When OGC advises in writing that the claim is legally without merit, or that evidence necessary to prove the claim in court cannot be provided; or

(ii) When there is no known security for the debt, the debtor has no other assets from which the debt could be collected, and the debtor:

(A) Is unable to pay any part of the debt and has no reasonable prospect of being able to do so; or

(B) Is able to pay part or all of the debt but refuses to do so, and OGC provides an opinion to the effect that the Government cannot enforce collection of a significant amount from assets or income.

§ 1782.21 [Reserved]

§ 1782.22 Exception authority.

The Administrator may, in individual cases, make an exception to any requirement or provision of this part which is not inconsistent with the authorizing statute or other applicable law and is determined to be in the Government's interest. Requests for exceptions must be made in writing by the State Director and supported with documentation to explain the adverse effect on the Government's interest, propose alternative course(s) of action, and show how the adverse affect will be eliminated or minimized if the exception is granted. The exception decision will be documented in writing, signed by the Administrator, and retained in the files.

§ 1782.23 Use of Rural Development Loans and Grants for other purposes.

(a) If, after making a loan or a grant, the Administrator determines that the circumstances under which the loan or grant was made have sufficiently changed to make the project or activity for which the loan or grant was made available no longer appropriate, the Administrator may allow the borrower or grantee to use property (real and personal) purchased or improved with the loan or grant funds, or proceeds from the sale of property (real and personal) purchased with such funds, for another project or activity that:

(1) Will be carried out in the same area as the original project or activity;

(2) Meets the criteria for a loan or grant described in section 381E(d) of the Consolidated Farm and Rural Development Act, as amended; and

(3) Satisfies such additional requirements as are established by the Administrator.

(b) If the new use of the property is under the authority of another USDA Agency Administrator, the other Administrator will be consulted on whether the new use will meet the criteria of the other program. Since the new project or activity must be carried out in the same area as the original project or activity, a new rural area determination will not be necessary.

(c) Borrowers and grantees that wish to use the proceeds for other purposes may make their request through the appropriate Rural Development State Office. Permission to use this option will be exercised on a case-by-case-basis on applications submitted through the State Office to the Administrator for consideration. If the proposal is approved, the Administrator will issue a memorandum to the State Director outlining the conditions necessary to complete the transaction.

§ 1782.24–1782.99 [Reserved]

§ 1782.100 OMB Control Number.

The information collection requirements in this part are approved by the Office of Management and Budget (OMB) and assigned OMB Control Number 0572–XXXX.

CHAPTER XVIII—RURAL HOUSING SERVICE, RURAL BUSINESS—COOPERATIVE SERVICE, RURAL UTILITIES SERVICE, AND FARM SERVICE AGENCY, DEPARTMENT OF AGRICULTURE.

PART 1951—SERVICING AND COLLECTIONS

2. The authority citation for part 1951 continues to read as follows:

Authority: 5 U.S.C. 301; 7 U.S.C. 1989; 42 U.S.C. 1480.

Subpart A—Account Servicing Policies

3. Amend § 1951.1 by adding the following sentence to the end of the section:

§ 1951.1 Purpose.

* * * This subpart does not apply to Water and Waste Programs of the Rural Utilities Service, Watershed loans, or Resource Conservation and Development loans, which are serviced under part 1782 of this title.

Subpart D—Final Payment on Loans

4. Revise § 1951.151 to read as follows:

§ 1951.151 Purpose.

This subpart prescribes authorizations, policies and procedures of the Farm Service Agency (FSA), Rural Housing Service (RHS), and Rural Business—Cooperative Service (RBS), herein referred to as ''Agency,'' for processing final payment of all loans. This subpart does not apply to direct Single Family Housing customers of the RHS. This subpart does not apply to Water and Waste Programs of the Rural Utilities Service, Watershed loans, Resource Conservation and Development loans, which are serviced under part 1782 of this title.

Subpart E—Servicing of Community and Direct Business Programs Loans and Grants

5. Revise § 1951.201 to read as follows:

§ 1951.201 Purposes.

This subpart prescribes the Rural Development mission area policies, authorizations, and procedures for servicing Community Facility loans and grants; Rural Business Enterprise/ Television Demonstration grants; Association Recreation loans; Direct Business loans; Economic Opportunity Cooperative loans; Rural Renewal loans; Energy Impacted Area Development Assistance Program grants; National Nonprofit Corporation grants; System for Delivery of Certain Rural Development Programs panel grants; and Rural Cooperative Development Grants in subpart F of part 4284 of this title. Rural Development State Offices act on behalf of the Rural Business-Cooperative Service, and the Farm Service Agency as to loan and grant programs formerly administered by the Farmers Home Administration and the Rural Development Administration. Loans sold without insurance to the private sector will be serviced in the private sector and will not be serviced under this subpart. The provisions of this subpart are not applicable to such loans. Future changes to this subpart will not be made applicable to such loans. This subpart does not apply to Water and Waste Programs of the Rural Utilities Service, Watershed loans, and Resource Conservation and Development Loans, which are serviced under part 1782 of this title.

6. Add § 1951.218 to read as follows:

§ 1951.218 Use of Rural Development Loans and Grants for other purposes.

(a) If, after making a loan or a grant, the Administrator determines that the circumstances under which the loan or grant was made have sufficiently changed to make the project or activity for which the loan or grant was made available no longer appropriate, the Administrator may allow the loan borrower or grant recipient to use property (real and personal) purchased or improved with the loan or grant funds, or proceeds from the sale of property (real and personal) purchased with such funds, for another project or activity that:

(1) Will be carried out in the same area as the original project or activity;

(2) Meets the criteria for a loan or grant described in section 381E(d) of the Consolidated Farm and Rural Development Act, as amended; and

(3) Satisfies such additional requirements as are established by the Administrator.

(b) For the purpose of this section, Administrator means the Administrator of the Rural Housing Service or Rural Business-Cooperative Service that has the delegated authority to administer the loan or grant program that covers the property or the proceeds from the sale property proposed to be used in another way.

(c) If the new use of the property is under the authority of another Administrator, the other Administrator will be consulted on whether the new use will meet the criteria of the other program. Since the new project or activity must be carried out in the same area as the original project or activity, a new rural area determination will not be necessary.

(d) Borrowers and grantees that wish to take advantage of this option may make their request through the appropriate Rural Development State Office. Permission to use this option will be exercised on a case-by-case-basis on applications submitted through the State Office to the Administrator for consideration. If the proposal is approved, the Administrator will issue a memorandum to the State Director outlining the conditions necessary to complete the transaction.

Subpart F—Analyzing Credit Needs and Graduation of Borrowers

6. Revise § 1951.251 to read as follows:

§ 1951.251 Purpose.

This subpart prescribes the policies to be followed when analyzing a direct borrower's need for continued Agency supervision, further credit, and graduation. All loan accounts will be reviewed for graduation in accordance with this subpart, with the exception of Guaranteed, Rural Development Loan Funds, and Rural Rental Housing loans made to build or acquire new units pursuant to contracts entered into on or after December 15, 1989, and Intermediary Relending Program loans. The term ''Agency'' used in this subpart refers to the Farm Service Agency (FSA) (including its county and State committees and their personnel), Rural Housing Service (RHS), or Rural Business-Cooperative Service (RBS), depending upon the loan program discussed herein. This subpart does not apply to RHS direct single family housing (SFH) customers. In addition, this subpart does not apply to Water and Waste Programs of the Rural Utilities Service, Watershed loans, Resource Conservation and Development loans, which are serviced under part 1782 of this title.

Subpart O—Servicing Cases Where Unauthorized Loan(s) or Other Financial Assistance Was Received—Community and Insured Business Programs

7. Revise § 1951.701 to read as follows:

§ 1951.701 Purpose.

This subpart prescribes the policies and procedures for servicing Community and Business Program loans and/or grants made by Rural Development when it is determined that the borrower or grantee was not eligible for all or part of the financial assistance received in the form of a loan, grant, or subsidy granted, or any other direct financial assistance. It does not apply to guaranteed loans. Loans sold without insurance by the Rural Development to the private sector will be serviced in the private sector and will not be serviced under this subpart. The provisions of this subpart are not applicable to such loans. Future changes to this subpart will not be made applicable to such loans. This subpart does not apply to Water and Waste Programs of the Rural Utilities Service, Watershed loans, and Resource Conservation and Development Loans, which are serviced under part 1782 of this title.

PART 1955—PROPERTY MANAGEMENT

8. The authority citation for part 1955 continues to read as follows:

Authority: 5 U.S.C. 301; 7 U.S.C. 1989; and 42 U.S.C. 1480.

Subpart A—Liquidation of Loans Secured by Real Estate and Acquisition of Real and Chattel Property

9. Revise § 1955.1 to read as follows:

§ 1955.1 Purpose.

This subpart delegates authority and prescribes procedures for the liquidation of loans to individuals and to organizations as identified in § 1955.3. It pertains to the Farm Credit programs of the Farm Service Agency (FSA), Multi-Family Housing (MFH) and Community Facilities (CF) programs of the Rural Housing Service (RHS), and direct programs of the Rural Business-Cooperative Service (RBS). Guaranteed RBS loans are liquidated upon direction from the Deputy Administrator, Business Programs, RBS. This subpart does not apply to RHS single family housing loans or to CF loans sold without insurance in the private sector. These CF loans will be serviced in the private sector and future revisions to this subpart no longer apply to such loans. In addition, this subpart does not apply to Water and Waste Programs of the Rural Utilities Service, Watershed loans, Resource Conservation and Development loans, which are serviced under part 1782 of this title.

Subpart B—Management of Property

10. Revise the introductory text of § 1955.51 to read as follows:

§ 1955.51 Purpose.

This subpart delegates authority and prescribes policies and procedures for the Rural Housing Service (RHS), Rural Business-Cooperative Service (RBS), and Farm Service Agency (FSA), herein referred to as ''Agency,'' and references contained in this subpart to the Farmers Home Administration (FmHA) are synonymous with ''Agency.'' This subpart does not apply to RHS single family housing loans or community program loans sold without insurance to the private sector. These community program loans will be serviced by the private sector and future revisions and this subpart no longer apply to such loans. In addition, this subpart does not apply to Water and Waste Programs of the Rural Utilities Service, Watershed loans, Resource Conservation and Development loans, which are serviced under part 1782 of this title. This subpart does cover:

* * * * *

Subpart C—Disposal of Inventory Property

11. Revise § 1955.101 to read as follows:

§ 1955.101 Purpose.

This subpart delegates program authority and prescribes policies and procedures for the sale of inventory property including real estate, related real estate rights and chattels. It also covers the granting of easements and rights-of-way on inventory property. Credit sales of inventory property to ineligible (nonprogram (NP)) purchasers will be handled in accordance with subpart J of part 1951 of this chapter, except Community and Business Programs (C&BP) and Multi-Family Housing (MFH) which will be handled in accordance with this subpart. In addition, credit sales of Single-Family Housing (SFH) properties converted to MFH will be handled in accordance with this subpart. This subpart does not apply to SFH inventory property. In addition, this subpart does not apply to Water and Waste Programs of the Rural Utilities Service, Watershed loans, Resource Conservation and Development loans, which are serviced under part 1782 of this title.

PART 1956—DEBT SETTLEMENT

12. The authority citation for part 1956 continues to read as follows:

Authority: 5 U.S.C. 301; 7 U.S.C. 1981; 31 U.S.C 3711; 42 U.S.C. 1480.

Subpart C—Debt Settlement—Community and Business Programs

13. Amend § 1956.101 by adding the following sentence to the end of the section:

§ 1956.101 Purpose.

* * * In addition, this subpart does not apply to Water and Waste Programs of the Rural Utilities Service, Watershed loans, Resource Conservation and Development loans, which are serviced under part 1782 of this title.

Dated: October 7, 2004.

Gilbert Gonzalez,

Acting Under Secretary, Rural Development.

[FR Doc. 04–25247 Filed 11–12–04; 8:45 am]

BILLING CODE 3410–15–P

DEPARTMENT OF AGRICULTURE

Rural Business-Cooperative Service

7 CFR Part 4280

RIN 0570–AA50

Renewable Energy Systems and Energy Efficiency Improvements Grant, Guaranteed Loan, and Direct Loan Program

AGENCY: Rural Business-Cooperative Service, USDA.

ACTION: Proposed rule: extension of comment period.

SUMMARY: The Rural Business-Cooperative Service (RBS) is extending the deadline of November 4, 2004, for submitting comments regarding the proposed Renewable Energy Systems and Energy Efficiency Improvements Grant, Guaranteed Loan, and Direct Loan Program. The program will assist farmers, ranchers, and small rural businesses to purchase renewable energy systems and make energy efficiency improvements. The proposed rule was published in the **Federal Register** on October 5, 2004 (69 FR 59650). This extension will allow additional time for the public to submit comments.

DATES: Comments must be submitted by December 15, 2004.

ADDRESSES: You may submit comments to this rule by any of the following methods:

Agency Web Site: *http://rdinit.usda.gov/regs/*. Follow instructions for submitting comments on the Web site.

E-Mail: *comments@usda.gov*. Include the RIN No. 0570–AA50 in the subject line of the message.

Federal eRulemaking Portal: *http://www.regulations.gov*. Follow the instructions for submitting comments.

Mail: Submit written comments via the U.S. Postal Service to the Branch Chief, Regulations and Paperwork Management Branch, U.S. Department of Agriculture, STOP 0742, 1400 Independence Avenue, SW., Washington, DC 20250–0742.

Hand Delivery/Courier: Submit written comments via Federal Express Mail or another courier service requiring a street address to the Branch Chief, Regulations and Paperwork Management Branch, U.S. Department of Agriculture, 300 7th Street, SW., 7th Floor, Washington, DC 20024.

All written comments will be available for public inspection during regular working hours at 300 7th Street, SW., 7th Floor, address listed above.

FOR FURTHER INFORMATION CONTACT: Georg A. Shultz, Special Advisor for Renewable Energy Policy and Programs, Office of the Deputy Administrator Business Programs, U.S. Department of Agriculture, Mail Stop 3220, 1400 Independence Ave., SW., Washington, DC 20250–3220, telephone: (202) 720–2976.

SUPPLEMENTARY INFORMATION: RBS published the notice of proposed rule making with a 30-day comment period. The reason for this limited time for comments was based primarily on the need to have a published final rule in time for the implementation of the program in fiscal year (FY) 2005. The Agency felt that since the program outlined in the proposed rule is similar

in scope as the Notices of Funds Availability (NOFA) for the grant program published in FY 2003 and FY 2004 and the Agency's current Business and Industry Guaranteed Loan Program forms the basis of the proposed guaranteed loan program, that a 30-day period would be sufficient. The additional 30-day comment period will delay publication of the final rule a commensurate time. The delay in publication will create additional time constraints on applicants. It will also constrain the time for processing the applications, including meeting environmental assessment requirements. RBS is extending the comment period in response to numerous requests from the public for additional time to comment.

Dated: November 5, 2004.

Gilbert Gonzalez,

Acting Under Secretary, Rural Development.

[FR Doc. 04–25239 Filed 11–12–04; 8:45 am]

BILLING CODE 3410–XY–P

DEPARTMENT OF COMMERCE

Bureau of Industry and Security

15 CFR Parts 732, 736, 740, 744, 752, 764, and 772

[Docket No. 040915266–4313–02]

RIN 0694–AC94

Revised ''Knowledge'' Definition, Revision of ''Red Flags'' Guidance and Safe Harbor

AGENCY: Bureau of Industry and Security, Commerce.

ACTION: Proposed rule; reopening of comment period.

SUMMARY: This notice reopens the comment period on a proposed rule that would revise the knowledge definition and the ''red flags'' guidance as well as create a safe harbor from knowledge based violations in the Export Administration Regulations.

DATES: Comments must be received by December 15, 2004.

ADDRESSES: Send comments on this proposed rule to: The Federal eRulemaking Portal: *http://www.regulations.gov,* via e-mail to *rpd2@bis.doc.gov,* fax them to 202–482–3355, or on paper to Regulatory Policy Division, Office of Exporter Services, Room 2705, U.S. Department of Commerce, Washington, DC 20230. Refer to Regulation Identification Number 0694–AC94 in all comments.

FOR FURTHER INFORMATION CONTACT: For further information regarding this proposed rule, contact: William Arvin, Office of Exporter Services, at *warvin@bis.doc.gov,* fax 202–482–3355 or telephone 202–482–2440.

SUPPLEMENTARY INFORMATION: On October 13, 2004, the Bureau of Industry and Security published a proposed rule that would revise the Export Administration Regulations in three ways: Revise the knowledge definition, revise the ''red flags'' guidance; and create a safe harbor from certain knowledge based violations. The deadline for public comments was November 12, 2004 (69 FR 60829). The Bureau is now reopening the comment period until December 15, 2004, to allow the public more time to comment on this proposed rule.

Dated: November 9, 2004.

Eileen Albanese,

Director, Office of Exporter Services.

[FR Doc. 04–25309 Filed 11–12–04; 8:45 am]

BILLING CODE 3510–33–M

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 1

[REG–129771–04]

RIN 1545–BD49

Guidance Under Section 951 for Determining Pro Rata Share; Hearing Cancellation

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Cancellation of notice of public hearing on proposed rulemaking.

SUMMARY: This document cancels a public hearing on proposed regulations under section 951(a) of the Internal Revenue Code (Code) that provide guidance for determining a United States shareholder's pro rata share of a controlled foreign corporation's (CFC's) subpart F income, previously excluded subpart F income withdrawn from investment in less developed countries, previously excluded subpart F income withdrawn from foreign base company shipping operations, and amounts determined under section 956.

DATES: The public hearing originally scheduled for November 18, 2004, at 10 a.m., is cancelled.

FOR FURTHER INFORMATION CONTACT: Sonya M. Cruse of the Publications and Regulations Branch, Legal Processing Division, Associate Chief Counsel (Procedures and Administration), at (202) 622–4693 (not a toll-free number).

SUPPLEMENTARY INFORMATION: A notice of proposed rulemaking and notice of public hearing that appeared in **Federal Register** on Friday, August 6, 2004, (69 FR 47822), announced that a public hearing was scheduled for November 18, 2004, at 10 a.m., in the IRS Auditorium, Internal Revenue Service Building, 1111 Constitution Avenue, NW., Washington, DC. The subject of the public hearing is under section 951(a) of the Internal Revenue Code.

The public comment period for these regulations expired on November 4, 2004. The notice of proposed rulemaking and notice of public hearing, instructed those interested in testifying at the public hearing to submit a request to speak and an outline of the topics to be addressed. As of Tuesday, November 9, 2004, no one has requested to speak. Therefore, the public hearing scheduled for November 18, 2004, is cancelled.

Cynthia E. Grigsby,

Acting Chief, Publications and Regulations Branch, Legal Processing Division, Associate Chief Counsel, (Procedures and Administration).

[FR Doc. 04–25324 Filed 11–9–04; 3:46 pm]

BILLING CODE 4830–01–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Chapter I

[USCG–2004–19615]

Exclusion Zones for Marine LNG Spills

AGENCY: Coast Guard, DHS.

ACTION: Request for public comments; correction.

SUMMARY: The Coast Guard published a document in the **Federal Register** on November 3, 2004, requesting comments on a petition for rulemaking from the City of Fall River. That document contained an incorrect docket number for the submission of comments.

FOR FURTHER INFORMATION CONTACT: If you have questions on this notice, please call Commander John Cushing at 202–267–1043, or e-mail *JCushing@comdt.uscg.mil.* If you have questions on viewing or submitting material to the docket, please call Ms. Andrea M. Jenkins, Program Manager, Docket Operations, telephone 202–366–0271.

Correction

In the **Federal Register** of November 3, 2004, in FR Doc. 04–24454, on page

63979, the docket number is incorrect. The docket number is corrected to read (USCG–2004–19615) each place that it appears.

Dated: November 8, 2004.

David L. Nichols,

Commander, U.S. Coast Guard, Acting Chief, Office of Regulations, and Administrative Law.

[FR Doc. 04–25254 Filed 11–12–04; 8:45 am]

BILLING CODE 4910–15–P

DEPARTMENT OF THE INTERIOR

National Park Service

36 CFR Part 7

RIN 1024–AC93

Pictured Rocks National Lakeshore, Personal Watercraft Use

AGENCY: National Park Service, Interior.

ACTION: Proposed Rule.

SUMMARY: The National Park Service (NPS) is proposing to designate areas where personal watercraft (PWC) may be used in Pictured Rocks National Lakeshore, Michigan. This proposed rule implements the provisions of the NPS general regulations authorizing park areas to allow the use of PWC by promulgating a special regulation. The NPS *Management Policies 2001* require individual parks to determine whether PWC use is appropriate for a specific park area based on an evaluation of that area's enabling legislation, resources and values, other visitor uses, and overall management objectives.

DATES: Comments must be received by January 14, 2005.

ADDRESSES: Comments on the proposed rule should be mailed to N8391 Sand Point Road, P.O. Box 40 Munising, Michigan 49862–0040. Comments may also be sent by e-mail to *PIRO@den.nps.gov*. If you comment by e-mail, please include ''PWC rule'' in the subject line and your name and return address in the body of your Internet message.

For additional information see ''Public Participation'' under **SUPPLEMENTARY INFORMATION** below.

FOR FURTHER INFORMATION CONTACT: Kym Hall, Special Assistant, National Park Service, 1849 C Street, NW., Room 3145, Washington, DC 20240. Phone: (202) 208–4206. E-mail: *Kym_Hall@nps.gov.*

SUPPLEMENTARY INFORMATION:

Background

Additional Alternatives

The information contained in this proposed rule supports implementation of the modified preferred alternative for Pictured Rocks National Lakeshore in the Environmental Assessment (EA) published July, 2002, and the errata sheet published October, 2003. The errata sheet corrects factual information in the EA as well as provides the analysis of the modified preferred alternative. The public should be aware that two other alternatives including a no-PWC alternative were presented in the EA and one alternative was modified in the subsequent errata sheet. Those alternatives should also be reviewed and considered when making comments on this proposed rule.

Personal Watercraft Regulation

On March 21, 2000, the National Park Service published a regulation (36 CFR 3.24) on the management of personal watercraft (PWC) use within all units of the national park system (65 FR 15077). This regulation prohibits PWC use in all national park units unless the NPS determines that this type of water-based recreational activity is appropriate for the specific park unit based on the legislation establishing that park, the park's resources and values, other visitor uses of the area, and overall management objectives. The regulation prohibits PWC use in all park units effective April 20, 2000, except a limited exception was provided for 21 parks, lakeshores, seashores, and recreation areas. The regulation established a 2-year grace period following the final rule publication to give these 21 park units time to consider whether PWC use should be allowed. Accordingly, on April 22, 2002, Pictured Rocks National Lakeshore closed for PWC use.

Description of Pictured Rocks National Lakeshore

Pictured Rocks National Lakeshore is situated in the north-central section of Michigan's Upper Peninsula, along the southern shore of Lake Superior. The eastern half of the Upper Peninsula is bounded by Lakes Superior, Michigan, and Huron. There are a variety of other national parks in the upper Great Lakes, including Apostle Islands National Lakeshore and Isle Royal National Park on Lake Superior, and Sleeping Bear Dunes and Indiana Dunes National Lakeshores on Lake Michigan. Canadian provincial parks are also located on Lake Superior.

The national lakeshore stretches from Munising to Grand Marais, approximately 40 miles to the northeast. The shoreline consists of narrow sandy beaches, sandstone cliffs, and a perched sand dune system. The sandy shoreline is susceptible to erosion from natural weather conditions.

Pictured Rocks National Lakeshore was authorized in 1966. The lakeshore is noted for its multicolored sandstone cliffs, beaches, sand dunes, waterfalls, inland lakes, wildlife, and forested shoreline. Attractions include a lighthouse and former Coast Guard life-saving stations, along with old farmsteads and orchards. The lakeshore is a year-round recreational destination where hiking, camping, hunting, nature study, and winter activities abound.

Purpose of Pictured Rocks National Lakeshore

As formulated during the Pictured Rocks general management planning process, the purpose of the national lakeshore includes the following:

Preserve a portion of the Great Lakes shoreline for its geographic, scientific, scenic, and historic features, and its associated ecological processes.

Provide opportunities for public benefit in recreation, education, enjoyment, and inspiration.

Protect the character and use of the shoreline zone while allowing economic utilization of the inland buffer zone's renewable resources.

Significance of Pictured Rocks National Lakeshore

As stated in the national lakeshore's Draft General Management Plan / Wilderness Study/Environmental Impact Statement, Pictured Rocks National Lakeshore is significant because:

Pictured Rocks National Lakeshore preserves and affords public access to a spectacular and diverse segment of the Lake Superior shoreline.

Unmatched in their scenic value, the 200-foot high Pictured Rocks cliffs rise perpendicularly from Lake Superior, creating a rock mosaic of form, color, and texture, which is enhanced by cascading waterfalls.

Grand Sable Dunes, perched atop 300-foot-high sand banks above Lake Superior, is one of two perched dune systems on the Great Lakes; within these dunes live unique plant communities resulting from geomorphic processes.

Twelve miles of unspoiled and undeveloped Lake Superior beach contrast with the Pictured Rocks cliffs and Grand Sable Dunes.

Bedrock geology and glacial landforms provide significant topographic relief marked by streams, inland lakes, and a diversity of associated vegetation.

The shoreline offers extraordinary and inspirational scenic vistas of Lake

Superior, which has the largest surface area of any fresh water lake on earth.

Pictured Rocks National Lakeshore offers a variety of affordable year-round recreational opportunities for appropriate public use.

Within a distinct area, the lakeshore contains a spectrum of cultural resources focused on the human use of Lake Superior and its shoreline.

Lying in a transition zone between boreal and eastern hardwood forest, the lakeshore's scientifically recognized assemblage of flora and fauna is representative of associations unique to the Lake Superior Basin.

Pictured Rocks is the only national park system area with a legislated buffer zone.

Authority and Jurisdiction

Under the National Park Service's Organic Act of 1916 (Organic Act) (16 U.S.C. 1 *et seq.*) Congress granted the NPS broad authority to regulate the use of the Federal areas known as national parks. In addition, the Organic Act (16 U.S.C. 3) allows the NPS, through the Secretary of the Interior, to ''make and publish such rules and regulations as he may deem necessary or proper for the use and management of the parks * * *''.

16 U.S.C. 1a–1 states, ''The authorization of activities shall be conducted in light of the high public value and integrity of the National Park System and shall not be exercised in derogation of the values and purposes for which these various areas have been established * * *''.

As with the United States Coast Guard, NPS's regulatory authority over waters subject to the jurisdiction of the United States, including navigable waters and areas within their ordinary reach, is based upon the Property and Commerce Clauses of the U.S. Constitution. In regard to the NPS, Congress in 1976 directed the NPS to ''promulgate and enforce regulations concerning boating and other activities on or relating to waters within areas of the National Park System, including waters subject to the jurisdiction of the United States * * *'' (16 U.S.C. 1a–2(h)). In 1996 the NPS published a final rule (61 FR 35136, July 5, 1996) amending 36 CFR 1.2(a)(3) to clarify its authority to regulate activities within the National Park System boundaries occurring on waters subject to the jurisdiction of the United States.

PWC Use at Pictured Rocks National Lakeshore

PWC use in Pictured Rocks National Lakeshore began around 1990. Before the ban, use was only allowed on Lake Superior, and it was relatively low. Restrictions on inland lakes precluded PWC use on those lakes. Pictured Rocks National Lakeshore has jurisdiction on the surface water of Lake Superior extending 0.25 mile from the shoreline. This proposed rule would only apply to the waters under the lakeshore's jurisdiction. In addition, Michigan's Personal Watercraft Safety Act of 1998 (Public Act 116) stipulates regulations for PWC use. One of the regulations is that personal watercraft cannot operate within 200 feet of the shoreline unless traveling perpendicular to shoreline at no-wake speed.

Before the ban, PWC operation on Lake Superior was concentrated between Sand Point and Chapel Beach, along the Lake Superior shoreline. The eastern side of the park had little PWC use. Rivers and streams within Pictured Rocks National Lakeshore are not accessible to personal watercraft due to extremely small size, shallow depths, and rocky bottoms. On inland lakes within the Lakeshore boundaries, the size of powerboat engines is restricted to two- and four-stroke internal combustion engines of 50 hp or less, essentially eliminating PWC use.

Before the ban was imposed, most PWC users at the park were from within 100 miles of the lakeshore. Based on staff observations, some users come from other parts of Michigan, Wisconsin, and Minnesota, and perhaps Ohio and Illinois. There are many other areas for water-based recreation in this portion of the Upper Peninsula, including State parks, national forests, and other lakes with public access. Such areas include other portions of Lake Superior (excluding the shore of Grand Island), many lakes within the Escanaba River and Lake Superior State Forests, several lakes within the Hiawatha National Forest, Manistique Lake, South Manistique Lake, and Lake Michigan.

To document actual PWC use and to provide peak usage information, staff conducted a survey at the Sand Point launch July 4–8, 2001. During the five-day survey, small craft warnings prohibited personal watercraft on two days. PWC use for the remaining three days ranged from 8 to 13 personal watercraft each day. Thus, the peak number of personal watercraft that were operating before the ban in the lakeshore was 13 per day—6.6 from the Sand Point launch and 6.6 from the Munising boat ramp.

Before the ban, because personal watercraft were also launched from the Munising boat ramp on the west end of the lakeshore, the city was contacted to determine launch numbers. However, specific data were not available. Based on discussions with lakeshore staff, the number of personal watercraft launched from Munising was assumed to be the same as the number launched from Sand Point. Based on the analysis of the survey and assumptions, 6.6 personal watercraft would be launched from the Munising boat ramp each day during July and August weekends. All of these personal watercraft would likely travel within the lakeshore's jurisdiction.

Grand Marais, on the east end of the lakeshore, also has boat launch facilities. According to city staff, very few personal watercraft are launched—perhaps 12 all summer, for an average of 1 personal watercraft every seven days. This analysis assumes that on average no personal watercraft would be launched from Grand Marais during July and August.

The low PWC numbers are primarily a result of the cold water temperature, cool ambient air temperature, changeable weather conditions, and heavy winds and wave action. The average PWC trip within Pictured Rocks National Lakeshore lasted between three and five hours, from mid morning to mid or late afternoon. State regulations restrict operations to the hours of 8 a.m. to one hour before sunset. Most PWC users cruised and sometimes raced along the shoreline, explored the rock cliffs up close, jumped the wakes of tour boats (which make 4–5 foot swells), and traveled to beach destinations and spent the day or afternoon on the beach. Fewer PWC users assembled in pontoons and did short trips or went to beach areas. A very small number may have done day trips between Munising and Grand Marais (40+ miles). Only a few users asked about PWC camping opportunities.

Before the ban, PWC users were distributed throughout the lakeshore. According to NPS staff, most personal watercraft were operated on the west end of the lakeshore. This is consistent with the launch locations and predicted launch numbers. Few PWC operators traveled the entire length of the lakeshore due to the long distance, rough waters, and potential for changing weather.

Generally, there is very little information specific to visitor concerns about PWC use. Visitor surveys were conducted for the winter of 1999–2000 and for the summer of 2000 (with questions specific to PWC use in the national lakeshore). A majority of the respondents to the survey supported or strongly supported restricting PWC use to designated areas. No PWC accidents have been observed or reported to NPS staff. Five incident reports have been documented, one for operating too close

to other motorcraft, two for operating too close to swimmers, and two for operating illegally on inland lakes. There are no observations or reports related to natural resource concerns.

Resource Protection and Public Use Issues

Pictured Rocks National Lakeshore Environmental Assessment

The environmental assessment was available for public review and comment for the period August 1 through November 15, 2004. An errata sheet was prepared to address the changes to alternative B, the preferred alternative. To request a copy of the document and the errata sheet contact Superintendent, Pictured Rocks National Lakeshore, N8391 Sand Point Road, P.O. box 40, Munising, MI 49862–0040. A copy of the Environmental Assessment and the errata sheet may also be found at *http://www.nps.gov/piro.*

The purpose of the environmental assessment was to evaluate a range of alternatives and strategies for the management of PWC use at Pictured Rocks to ensure the protection of park resources and values while offering recreational opportunities as provided for in the National Lakeshore's enabling legislation, purpose, mission, and goals. The assessment assumed alternatives would be implemented beginning in 2002 and considered a 10-year period, from 2002 to 2012. In addition, the environmental assessment defines such terms as ''negligible'' and ''adverse.'' In this document, these terms are used to describe the environmental impact. Refer to the EA for complete definitions.

The environmental assessment evaluates three alternatives addressing the use of personal watercraft at Pictured Rocks National Lakeshore. The errata sheet modifies one of the alternatives, Alternative B. Each alternative is described below:

Alternative A—Under alternative A, PWC use would continue as was provided and managed within Pictured Rocks National Lakeshore before the ban. PWC use would be unrestricted on Lake Superior from the lakeshore's 0.25-mile jurisdictional boundary to the lakeshore's shoreline. Launch and retrieval of personal watercraft would be permitted only at the Sand Point boat ramp on Lake Superior. PWC users would be able to land anywhere along the shoreline. PWC users would continue to abide by Michigan's Personal Watercraft Safety Act of 1998 (Public Act 116) and related regulations.

Alternative B—Alternative B was modified by the errata dated October 2003. Under the modified alternative B, PWC use would be allowed to operate on the waters of Lake Superior within the boundaries of Pictured Rocks National Lakeshore from the western boundary of the lakeshore up to the east end of Miners Beach.

PWC use would be allowed under the following conditions: Personal watercraft may only be launched from a designated launch site at Sand Point, PWC users may beach their craft only on Miners Beach, and PWC users may not launch or operate in any other area of the lakeshore. The superintendent of the park may temporarily limit, restrict, or terminate access to areas designated for PWC use after taking into consideration public health and safety, natural and cultural resource protection, and other management activities and objectives. PWC use would be restricted at specific locations during the permitted use of ethnographic resources. Boat patrols would be conducted in the vicinity of the ethnographic resource use in order to reduce the potential for PWC-related intrusion into the ceremonial activity. PWC users would continue to abide by Michigan's Personal Watercraft Safety Act of 1998 (Public Act 116) and related regulations, as identified in alternative A. This alternative would allow PWC use along the Lake Superior shoreline within the western end of the park, covering approximately 8 miles of shoreline. The numbers of personal watercraft would not be restricted.

No-Action Alternative—Under the no-action alternative, the National Park Service would take no action to reinstate the use of personal watercraft at Pictured Rocks National Lakeshore and no special rule would be promulgated to continue personal watercraft use. Under this alternative, NPS would continue to prohibit personal watercraft use at Pictured Rocks begun on April 22, 2002.

Alternative B is the park's preferred alternative because it would best fulfill the park responsibilities as trustee of the sensitive habitat; ensure safe, healthful, productive, and aesthetically and culturally pleasing surroundings; and attain a wider range of beneficial uses of the environment without degradation, risk of health or safety, or other undesirable and unintended consequences.

As previously noted, NPS will consider the comments received on this proposal, as well as the comments previously received on the Environmental Assessment [as modified by the errata sheet]. In the final rule, the NPS will implement one of these alternatives as proposed, or choose a different alternative or combination of alternatives. Therefore, the public should review and consider the other alternatives contained in the Environmental Assessment [as modified by the errata sheet] when making comments on this proposed rule.

The following summarizes the predominant resource protection and public use issues associated with reinstating PWC use at Pictured Rocks National Lakeshore. Each of these issues is analyzed in the *Pictured Rocks National Lakeshore, Personal Watercraft Use Environmental Assessment* as modified by the errata sheet.

Water Quality

Most research on the effects of personal watercraft on water quality focuses on the impacts of two-stroke engines, and it is assumed that any impacts caused by these engines also apply to the personal watercraft powered by them. There is general agreement that two-stroke engines discharge a gas-oil mixture into the water. Fuel used in PWC engines contains many hydrocarbons, including benzene, toluene, ethylbenzene, and xylene (collectively referred to as BTEX) and polyaromatic hydrocarbons (PAH). PAH also are released from boat engines, including those in personal watercraft. These compounds are not found appreciably in the unburned fuel mixture, but rather are products of combustion. Discharges of these compounds—BTEX and PAH—have potential adverse effects on water quality. A common gasoline additive, methyl tertiary butyl ether (MTBE) is not used in Michigan.

A typical conventional (*i.e.*, carbureted) two-stroke PWC engine discharges as much as 30% of the unburned fuel mixture directly into the water. At common fuel consumption rates, an average two-hour ride on a personal watercraft may discharge 3 gallons of fuel into the water. According to the California Air Resources Board, an average personal watercraft can discharge between 1.2 and 3.3 gallons of fuel during one hour at full throttle. However, hydrocarbon (HC) discharges to water are expected to decrease substantially over the next 10 years due to mandated improvements in engine technology.

PWC use would continue within the lakeshore, with a shift in location due to restrictions east of Miners Beach. Overall numbers of personal watercraft would remain similar to the number before the ban, with maximum use projected to increase from 13 per day in 2002 to 16 per day in 2012. For example, the estimated use in 2002 if PWC were allowed would have been 52

PWC-hours per day in the designated use area. Daily peak operation times would increase in 2012 to 64 PWC-hours in the designated use area. Water quality impacts east of Miners Beach would be reduced compared to before the ban, since PWC use would not be allowed in this area.

PWC users would operate within the designated use area because of the closure of other areas to the east and proximity to the launch facility at Sand Point. The Sand Point area would have the highest use and highest pollutant loads. This location also tends to have shallower waters that extend for some distance offshore. Over the next 10 years PWC use in this area is projected to increase from 13 to 16 machines per day.

The calculated threshold volumes for pollutants emitted by personal watercraft and boats would range from 0 to 240 acre-feet for the ecological criteria. The 1-methyl naphthalene volume for Sand Point (240 acre-feet) would be less than 1% of the volume available. These pollutant concentrations are well below the water quality benchmarks and would likely not be detectable. Cumulative ecological impacts under this proposal would be negligible.

Threshold volumes for the human health criteria range from 0 to 10,800 acre-feet. Benzene emissions in the Sand Point area would have the highest concentrations and would require 45% of the total water volume available within the 0.25-mile jurisdictional boundary for dilution. Benzene levels would be below the human health criterion. Similar to before the ban, dilution with adjacent waters and volatilization would occur and therefore cumulative human health based impacts would be negligible to minor. If the State water quality standard for benzene was used in place of the EPA criterion, estimated human health impacts from benzene would be even lower.

Total PAH concentrations in the designated use area with boating activity would equal or exceed 0.1 µg/L in 2002 and 2012. Although the calculated levels are well below aquatic life benchmarks, the concentrations could have a minor to moderate adverse impact to aquatic life due to phototoxic effects.

Future (2012) pollutant loads would decrease, despite increased boating traffic, due to reductions in engine emissions. Impact levels for cumulative actions would be negligible to moderate, depending on the location and pollutant type. All effects would be short term and would occur during the times of heaviest use.

In conclusion, based on analyses for individual pollutants, this proposal would have negligible to minor adverse effects on water quality due to continued PWC use. No impacts would occur east of Miners Beach where PWC use would be restricted under this proposed rule. While all pollutant loads would be well below benchmarks and criteria, PAH concentrations in the Sand Point segment and the western Cliffs segment could have negligible to moderate adverse phototoxic effects on aquatic life.

Cumulative impacts from PWC and motorized boat use would range from negligible to moderate. No impacts would occur in the Beaver Basin segment. Total PAH concentrations could be a concern for aquatic life, due to potential phototoxicity. Benzene concentrations could be detectable, but are expected to remain below the human health criterion. By 2012 impacts would be reduced substantially through improved emission controls.

Air Quality

Personal watercraft emit various compounds that pollute the air. In the two-stroke engines commonly used in personal watercraft, the lubricating oil is used once and is expelled as part of the exhaust; and the combustion process results in emissions of air pollutants such as volatile organic compounds (VOC), nitrogen oxides (NO_X), particulate matter (PM), and carbon monoxide (CO). Personal watercraft also emit fuel components such as benzene that are known to cause adverse health effects. Even though PWC engine exhaust is usually routed below the waterline, a portion of the exhaust gases go into the air. These air pollutants may adversely impact park visitor and employee health, as well as sensitive park resources.

For example, in the presence of sunlight VOC and NO_X emissions combine to form ozone. Ozone causes respiratory problems in humans, including cough, airway irritation, and chest pain during inhalations. Ozone is also toxic to sensitive species of vegetation. It causes visible foliar injury, decreases plant growth, and increases plant susceptibility to insects and disease. Carbon monoxide can affect humans as well. It interferes with the oxygen carrying capacity of blood, resulting in lack of oxygen to tissues. NO_X and PM emissions associated with PWC use can also degrade visibility. NO_X can also contribute to acid deposition effects on plants, water, and soil. However, because emission estimates show that NO_X from personal watercraft are minimal (less than 5 tons per year), acid deposition effects attributable to personal watercraft use are expected to be minimal.

Under this proposed rule the number of personal watercraft used daily in the lakeshore would follow similar trends as before the ban, ranging from 13 in 2002 to 16 in 2012. The impacts of continued PWC use within the lakeshore, but with restrictions east of Miners Beach, would be the negligible, since the emissions would all be less than 50 tons/year. All pollutant loads would be less than 20 tons/year, with negligible to moderate impact levels.

As stated above, the number of personal watercraft operating within Pictured Rocks National Lakeshore would be similar to the number before the ban, except that PWC use would be prohibited east of Miners Beach. Therefore, PWC-related activities would result in negligible adverse impacts for all pollutants and would range from negligible to moderate adverse for air quality impact levels.

Soundscapes

Daily PWC use levels would be similar to the number before the ban, with a slight change in the area of use. Under this proposal there would be an estimated 13 personal watercraft per day in the designated use area. No PWC use would be allowed east of Miners Beach.

In most cases, personal watercraft would be dispersed along 8 miles of the lakeshore so that operating craft would be infrequent at any given location. At the areas that have the highest visitor use, such as Sand Point, PWC noise would be diluted by the sounds from wind, waves, other visitors, and motorboats. In general, the use of personal watercraft would result in negligible adverse impacts where other users are concentrated, such as at overlooks and beaches. Within the designated PWC use area, PWC noise would be heard frequently but would not be overly disruptive to visitors because of the high degree of activity that occurs within the area. Thus, PWC noise would have a moderate adverse impact on the soundscapes in the area of designated use.

Backcountry users, particularly in the Beaver Basin segment and along the North Country National Scenic Trail, tend to be more sensitive to sound levels and PWC activity. The intolerance to PWC noise by backcountry users was documented in the summer 2000 visitor survey. Under this proposed rule personal watercraft would be prohibited east of Miners Beach. Backcountry users in this area might still hear infrequent PWC noise since personal watercraft could still

operate outside the 0.25-mile boundary. Thus, eliminating PWC use from the eastern portions of the lakeshore would have minor beneficial impacts to the soundscape because related noise would be less frequent and at a greater distance from shore.

Overall, this proposed rule would have a minor beneficial effect east of Miners Beach and a moderate adverse effect near Sand Point and Miners Beach on days when PWC use was relatively heavy. Negligible impacts would occur when use was occasional and distanced from other park users, for example, PWC users operating far from shore. Moderate adverse impacts would occur mainly where PWC use would conflict with other quieter uses, such as fishing, beach uses, or backcountry camping. In general, the impact to those seeking a quiet visitor experience would most likely be short-term and minor because PWC use would not be constant throughout the day and because the enjoyment of the typical visitor activities in the area would not be compromised. Overall, this proposal would result in a net minor beneficial to moderate adverse impact on the soundscape of Pictured Rocks National Lakeshore. All impacts would be temporary, since noise would usually be for limited times.

Therefore, noise from personal watercraft would continue to have short- and long-term, moderate adverse impacts in the area of designated use. Impact levels would be related to the number of personal watercraft operating, as well as the sensitivity of other visitors. Eliminating PWC use east of Miners Beach would have minor beneficial impacts.

Wildlife and Wildlife Habitat

Some research suggests that personal watercraft affect wildlife by interrupting normal activities. This is thought to be caused by PWC speed, noise, and access. Flight response is the most likely impact of PWC use; the most likely occurrence of PWC-induced flight would be on Lake Superior. Impacts to sensitive species at Pictured Rocks, such as loons, peregrine falcons, and piping plovers, are documented under ''Threatened, Endangered, or Special Concern Species.''

The number of PWC users in the lakeshore would be similar to the number before the ban, except use would be prohibited east of Miners Beach. Wildlife impacts under this proposal would be similar to those that existed before the ban on PWC use. Due to the low habitat productivity and lack of colonial wildlife along the lakeshore, as well as the low number of personal watercraft in use, impacts to wildlife and wildlife habitat due to PWC activity would be negligible at most locations. Closing eastern portions of the lakeshore to PWC use would have negligible beneficial impacts. Over the next 10 years impacts would continue to be negligible since PWC numbers would not increase substantially. All wildlife impacts would be temporary.

Therefore, due to the 200′ distance that PWC users are required to operate at flat wake speed in proximity to the shoreline, impacts on wildlife and wildlife habitat would be negligible at most locations. Prohibiting PWC use east of Miners Beach would have negligible beneficial impacts.

Threatened, Endangered, or Special Concern Species

The same issues described for PWC use and general wildlife also pertain to special concern species. Potential impacts from personal watercraft include inducing flight and alarm responses, disrupting normal behaviors and causing stress, degrading habitat quality, and potentially affecting reproductive success. Special status species at the recreation area include Federal or State listed threatened, endangered, or candidate species.

The Endangered Species Act (16 U.S.C 1531 *et seq.*) mandates that all Federal agencies consider the potential effects of their actions on species that are listed as threatened or endangered. If the National Park Service determines that an action may adversely affect a Federally listed species, consultation with the U.S. Fish and Wildlife Service is required to ensure that the action will not jeopardize the species' continued existence or result in the destruction or adverse modification of critical habitat. The animal species at Pictured Rocks National Lakeshore that have the potential to be affected by this proposed rule include the federally listed piping plover and the State listed peregrine falcon and common loon. Plant species include the federally listed pitcher's thistle and the State listed Lake Huron tansy.

This proposal would allow continued PWC use from the western park boundary to the east end of Miners Beach. PWC use would be prohibited east of Miners Beach. Potential effects would be similar to those that existed before the ban and would be limited to interactions with wildlife farther than 200 feet from shore or to personal watercraft landing on shore.

Piping Plover—PWC use would not be allowed within the Grand Sable segment, where potential habitat exists, and there would be no effect on the piping plover. If plovers ever became established in the western end of the lakeshore, then mitigating actions could be required to minimize any adverse effect from PWC use.

Common Loon and Peregrine Falcon—Interactions between personal watercraft and loons or falcons would have the same impacts as before the ban and would not likely adversely affect peregrine falcons or loons. Interactions between personal watercraft and loons or falcons would have the same impacts as before the ban and would not likely adversely affect peregrine falcons or loons.

Pitcher's Thistle and Lake Huron Tansy—PWC use would not be allowed within the Grand Sable segment, where these plants are known to exist. Therefore, this proposal would affect the pitcher's thistle or the Lake Huron tansy. Restoration activities proposed for 2002 would have a beneficial effect on the thistle and the tansy.

Overall, PWC use would have no effect on the piping plover, the pitcher's thistle, or the Lake Huron tansy, and would not be likely to adversely affect the common loon or the peregrine falcon since interactions would be extremely limited.

Cumulative effects for PWC users and other visitors would be similar to before the ban on PWC use and would not likely adversely affect concerned species or their habitat. PWC use would have no effect in the eastern portions of the lakeshore.

Piping Plover—There has been no evidence of plover use in the national lakeshore since 1992. PWC use or motorized boating would not be allowed in areas where critical plover habitat has been designated in the eastern end of the lakeshore. No direct effect on the piping plover is anticipated. If plovers started using habitat within Pictured Rocks National Lakeshore, then PWC and visitor activity would have the potential for adverse effects, and mitigating measures would be taken.

Therefore, PWC use would have no cumulative effect on the piping plover, the pitcher's thistle, or the Lake Huron tansy and would not be likely to adversely affect the common loon or the peregrine falcon since interactions would be extremely limited.

Shoreline Vegetation

PWC are able to access areas that other types of watercraft may not, which may cause direct disturbance to vegetation. Indirect impact on shoreline vegetation may occur through trampling if operators disembark and engage in activities on shore. In addition, wakes created by personal watercraft may

affect shorelines through erosion by wave action. The proposed rule aims to limit these disturbances to the shoreline areas.

PWC use under the proposed rule would continue to be allowed in the designated use area but use would be prohibited east of Miners Beach. PWC impacts to shoreline vegetation would be similar to those before the ban, since the number of PWC users would be comparable, although use areas would be modified. Impacts to vegetation east of Miners Beach would be negligible and beneficial since users would no longer have access to shoreline areas. Continued PWC use in other areas would have negligible adverse impacts to sensitive shoreline vegetation over the short and long term, with no perceptible changes in plant community size, integrity, or continuity.

Therefore, PWC use would have negligible adverse impacts in the designated uea area over the short and long term because there have been no perceptible changes to plant community size, integrity or continuity, and none are expected in the future (2012). PWC restrictions east of Miners Beach would result in negligible beneficial impacts to shoreline vegetation.

Visitor Experience

The proposed rule would provide park visitors with a high-quality experience and manage potential conflicts between PWC use and other park visitors. PWC use under this proposal would continue to be allowed in the designated use area and PWC use would be prohibited east of Miners Beach. Of the 13 to 16 personal watercraft operating in the lakeshore during peak use, these restrictions would affect an estimated five to six PWC operators by changing their location of use. Additionally, PWC operation would be restricted at certain locations during the permitted use of ethnographic resources.

Impact on PWC Users—By prohibiting PWC use east of Miners Beach, there would be no use at Twelvemile Beach. Additionally, more PWC riders would stay within the west end of the park, between Munising and Miners Beach. Most PWC users (estimated at 60%) would have little or no noticeable change in their location of operation. They could, however, notice more personal watercraft operating within the 8 miles of the shoreline open to PWC use. Voluntarily extending operations farther from shore would likely offset this increase in density. Under this proposal PWC users would be limited in their location of operation and could be affected by a slight increase in density of use. As a result, visitors who use personal watercraft at Pictured Rocks National Lakeshore would experience moderate adverse impacts.

Impact on Frontcountry Visitors—Swimmers, hikers, and other visitors to the Sand Point, Miners Beach, and Miners Castle areas would have slightly more contact with PWC operators than before the ban because PWC use would only be allowed along this stretch of the lakeshore and would be prohibited east of Miners Beach. The increased amount of contact would not be noticeable in comparison to existing conditions since most activities occur in this stretch of the lakeshore. PWC activity near Sand Point, Miners Beach, and Miners Castle would have negligible adverse impacts on the experiences of swimmers, hikers, and other visitors because under State regulations personal watercraft must be operated at no-wake speed within 200 feet of the shore and may only travel perpendicular to the shore.

Visitors east of Miners Beach would no longer have contact with PWC users within the lakeshore's 0.25-mile jurisdiction. Visitors to Chapel Beach and Twelvemile Beach, in particular, tend to look for quieter experiences. Therefore, this proposal would have a negligible beneficial impact to visitors east of Miners Beach.

Impact on Backcountry Visitors—Backcountry visitors east of Miners Beach would have decreased contact with PWC users, resulting in a moderate beneficial impact to their experiences. PWC restrictions would particularly enhance the experiences of wilderness visitors in the Beaver Basin segment. Visitors along the North Country National Scenic Trail within the Sand Point segment and the western one mile of the Cliffs segment would continue to be occasionally affected by PWC use, with a moderate adverse impact.

Motorized boats and other visitors would continue to interact, with impacts the same as before the ban on PWC use. Cumulative impacts related to the use of personal watercraft, motorized boats, and other visitor activities would be negligible over the short and long term because there would be little noticeable change in the visitor experience for most visitors. Backcountry visitors east of Miners Beach would have moderate beneficial impacts because of decreased impacts from PWC use. Most visitors would continue to be satisfied with their experiences at Pictured Rocks National Lakeshore.

Therefore, PWC users would be limited in their location of operation within the national lakeshore and could notice a slight increase in the density of use in the vicinity of Sand Point. As a result, they would experience moderate adverse impacts. Restricting PWC use east of Miners Beach would have negligible beneficial impacts on the experiences of most other visitors in the short and long term, and it would have long-term, moderate, beneficial impacts on those visitors desiring backcountry experiences with natural ''quiet.'' The level of PWC use would remain relatively low at lakeshore locations. When related to other visitor activities, PWC use would not appreciably limit the critical characteristics of visitor experiences.

Visitor Conflict and Safety

The proposed rule would minimize or reduce the potential for PWC user accidents and improve safety between PWC users and other water recreationists. This proposed rule assumes that PWC operations would be similar to before the ban, except that PWC use would be discontinued east of Miners Beach. As a result, the watercraft that normally operate in the eastern portions of the national lakeshore would be relocated to the western portion of the lakeshore.

Personal Watercraft/Swimmer Conflicts—Impacts would be similar to before the PWC ban since the overall number of personal watercraft operating within the lakeshore would not change. PWC user/swimmer interactions would increase slightly in the Sand Point segment and the western one mile of the Cliffs segment because of a shift in PWC use from other locations. However, under State regulations PWC operators must travel at no-wake speed within 200 feet of the shore and only perpendicular to the shore. The change in location for PWC operation would not be noticeable to other visitors and would continue to result in minor adverse impacts. In the remaining lakeshore locations there would be little or no conflict between PWC users and swimmers. No conflicts would occur east of Miners Beach, resulting in a negligible beneficial impact to these visitors.

Overall, PWC use would continue to have negligible to minor adverse impacts on most swimmers at Pictured Rocks National Lakeshore. Beneficial impacts would occur east of Miners Beach. Impacts would be perceptible to a relatively small number of visitors at localized areas, primarily at Sand Point and Miners Beach.

Personal Watercraft/Other Boat Conflicts—Impacts would be similar to before the ban. Overall, PWC use would continue to have minor adverse impacts on other motorized boat users at Pictured Rocks National Lakeshore.

Impacts would be perceptible to a relatively small number of visitors at localized areas, primarily at the Sand Point launch.

Cumulative impacts would be similar to before the ban on PWC use. The natural separation of use between the various lakeshore visitors reduces the potential for conflicts. For this reason, the cumulative impact of the various user groups on visitor conflicts and safety would be negligible to minor over the short and long term. Beneficial impacts would occur east of Miners Beach. Impacts would be perceptible to a relatively small number of visitors at localized areas, primarily at the Sand Point beach.

Therefore, continued PWC use would have short- and long-term, minor, adverse impacts on visitor conflicts and safety, particularly in the Sand Point area, due to the number of visitors and boats present on high use days. Conflicts at other locations would remain negligible because use is lower and conflicts would be less likely to occur. Conflicts would be eliminated east of Miners Beach, resulting in negligible, beneficial impacts.

The Proposed Rule

Under the proposed rule in § 7.32 PWC use would be allowed to operate on the waters of Lake Superior within the boundaries of Pictured Rocks National Lakeshore from the western boundary of the lakeshore up to the east end of Miners Beach. This proposed rule would allow PWC use along the Lake Superior shoreline within the western end of the park, covering approximately 8 miles of shoreline. PWC use would be allowed under the following conditions:

Personal watercraft may only be launched from a designated launch site at Sand Point.

PWC users may beach their craft on Miners Beach, however no launching or retrieving of the craft may occur at Miners Beach.

PWC users may not launch or operate in any other area of the lakeshore.

The superintendent may temporarily limit, restrict, or terminate access to areas designated for PWC use after taking into consideration public health and safety, natural and cultural resource protection, and other management activities and objectives.

PWC use would be restricted at specific locations during the permitted use of ethnographic resources. Boat patrols would be conducted in the vicinity of the ethnographic resource use in order to reduce the potential for PWC-related intrusion into the ceremonial activity.

PWC users must comply with the requirements of the Michigan Personal Watercraft Safety Act of 1998 (Public Act 116), including the requirement to operate at flat wake speed within 200′ of the shoreline, and related regulations.

Compliance with Other Laws

Regulatory Planning and Review (Executive Order 12866)

This document is a significant rule and has been reviewed by the Office of Management and Budget under Executive Order 12866.

(1) This rule will not have an effect of $100 million or more on the economy. It will not adversely affect in a material way the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities. The National Park Service has completed the report ''Economic Analysis of Personal Watercraft Regulations in Pictured Rocks National Lakeshore'' (RTI, International, November 2004).

(2) This rule will not create a serious inconsistency or otherwise interfere with an action taken or planned by another agency. Actions taken under this rule will not interfere with other agencies or local government plans, policies or controls. This rule is an agency specific rule.

(3) This rule does not alter the budgetary effects of entitlements, grants, user fees, or loan programs or the rights or obligations of their recipients. This rule will have no effects on entitlements, grants, user fees, or loan programs or the rights or obligations of their recipients. No grants or other forms of monetary supplements are involved.

(4) This rule does raise novel legal or policy issues. This rule is one of the special regulations being issued for managing PWC use in National Park Units. The National Park Service published general regulations (36 CFR 3.24) in March 2000, requiring individual park areas to adopt special regulations to authorize PWC use. The implementation of the requirement of the general regulation continues to generate interest and discussion from the public concerning the overall effect of authorizing PWC use and National Park Service policy and park management.

Regulatory Flexibility Act

The Department of the Interior certifies that this rulemaking will not have a significant economic effect on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*). This certification is based on a report entitled report ''Economic Analysis of Personal Watercraft Regulations in Pictured Rocks National Lakeshore'' (RTI, International, November 2004).

Small Business Regulatory Enforcement Fairness Act (SBREFA)

This rule is not a major rule under 5 U.S.C. 804(2), the Small Business Regulatory Enforcement Fairness Act. This proposed rule:

a. Does not have an annual effect on the economy of $100 million or more.

b. Will not cause a major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions.

c. Does not have significant adverse effects on competition, employment, investment, productivity, innovation, or the ability of U.S.-based enterprises to compete with foreign-based enterprises.

Unfunded Mandates Reform Act

This rule does not impose an unfunded mandate on State, local, or tribal governments or the private sector of more than $100 million per year. The rule does not have a significant or unique effect on State, local or tribal governments or the private sector. This rule is an agency specific rule and does not impose any other requirements on other agencies, governments, or the private sector.

Takings (Executive Order 12630)

In accordance with Executive Order 12630, the rule does not have significant takings implications. A taking implication assessment is not required. No taking of personal property will occur as a result of this rule.

Federalism (Executive Order 13132)

In accordance with Executive Order 13132, the rule does not have sufficient Federalism implications to warrant the preparation of a Federalism Assessment. This proposed rule only affects use of NPS administered lands and waters. It has no outside effects on other areas by allowing PWC use in specific areas of the park.

Civil Justice Reform (Executive Order 12988)

In accordance with Executive Order 12988, the Office of the Solicitor has determined that this rule does not unduly burden the judicial system and meets the requirements of sections 3(a) and 3(b)(2) of the Order.

Paperwork Reduction Act

This regulation does not require an information collection from 10 or more

parties and a submission under the Paperwork Reduction Act is not required. An OMB Form 83–I is not required.

National Environmental Policy Act

As a companion document to this NPRM, NPS has issued the *Personal Watercraft Use Environmental Assessment for Pictured Rocks National Lakeshore* and subsequent errata sheet. The environmental assessment was available for public review and comment for the period August 1 through November 15, 2004. To request a copy of the document and errata sheet contact Superintendent, Pictured Rocks National Lakeshore, N8391 Sand Point Road, P.O. Box 40, Munising, MI 49862–0040. A copy of the Environmental Assessment and errata sheet may also be found at www.nps.gov/piro.

Government-to-Government Relationship With Tribes

In accordance with the President's memorandum of April 29, 1994, ''Government to Government Relations with Native American Tribal Governments'' (59 FR 22951) and 512 DM 2, we have evaluated potential effects on Federally recognized Indian tribes and have determined that there are no potential effects.

Clarity of Rule

Executive Order 12866 requires each agency to write regulations that are easy to understand. We invite your comments on how to make this rule easier to understand, including answers to questions such as the following: (1) Are the requirements in the rule clearly stated? (2) Does the rule contain technical language or jargon that interferes with its clarity? (3) Does the format of the rule (grouping and order of sections, use of headings, paragraphing, *etc.*) aid or reduce its clarity? (4) Would the rule be easier to read if it were divided into more (but shorter) sections? (A ''section'' appears in bold type and is preceded by the symbol ''§ '' and a numbered heading; for example [§ 7.32 Pictured Rocks National Lakeshore] (5) Is the description of the rule in the ''Supplementary Information'' section of the preamble helpful in understanding the proposed rule? What else could we do to make the rule easier to understand?

Send a copy of any comments that concern how we could make this rule easier to understand to: Office of Regulatory Affairs, Department of the Interior, Room 7229, 1849 C Street, NW., Washington, DC 20240. You may also e-mail the comments to this address: *Exsec@ios.doi.gov.*

Drafting Information: The primary authors of this regulation are: Larry Hach, Chief Ranger, Pictured Rocks National Lakeshore; Sarah Bransom, Environmental Quality Division; and Kym Hall, Special Assistant.

Public Participation

Comments on the proposed rule should be mailed to N8391 Sand Point Road, P.O. Box 40, Munising, MI 49862–0040. Comments may also be sent by e-mail to *PIRO@den.nps.gov.* If you comment by e-mail, please include ''PWC rule'' in the subject line and your name and return address in the body of your Internet message.

Our practice is to make comments, including names and addresses of respondents, available for public review during regular business hours. Individual respondents may request that we withhold their home address from the rulemaking record, which we will honor to the extent allowable by law. If you wish us to withhold your name and/or address, you must state this prominently at the beginning of your comment. However, we will not consider anonymous comments. We will make all submissions from organizations or businesses, and from individuals identifying themselves as representatives or officials or organizations or businesses, available for public inspection in their entirety.

List of Subjects in 36 CFR Part 7

District of Columbia, National Parks, Reporting and recordkeeping requirements.

In consideration of the foregoing, the National Park Service proposes to amend 36 CFR part 7 as follows:

PART 7—SPECIAL REGULATIONS, AREAS OF THE NATIONAL PARK SYSTEM

1. The authority for Part 7 continues to read as follows:

Authority: 16 U.S.C. 1, 3, 9a, 460(q), 462(k); Sec. 7.96 also issued under DC Code 8–137(1981) and DC Code 40–721 (1981).

2. Amend § 7.32 by adding paragraph (d) to read as follows:

§ 7.32 Pictured Rocks National Lakeshore.

* * * * *

(d) *Personal Watercraft (PWC).* (1) PWC are allowed on the waters within Pictured Rocks National Lakeshore, from the western boundary of the lakeshore to the east end of Miners Beach.

(2) PWC may only be launched from a designated launch site at Sand Point.

(3) At Sand Point Beach and Miners Beach, PWC users may only beach their craft.

(4) The Superintendent may temporarily limit, restrict, or terminate access to the areas designated for PWC use after taking into consideration public health and safety, natural and cultural resource protection, and other management activities and objectives.

Dated: November 4, 2004.

Paul Hoffman,

Deputy Assistant Secretary, Fish and Wildlife and Parks.

[FR Doc. 04–25318 Filed 11–12–04; 8:45 am]

BILLING CODE 4310–70–P

POSTAL RATE COMMISSION

39 CFR Part 3001

[Docket No. RM2005–1; Order No. 1423]

Periodic Reporting Rule

AGENCY: Postal Rate Commission.

ACTION: Advance notice of proposed rulemaking.

SUMMARY: This document addresses a dispute that has arisen over the Postal Service's compliance with certain periodic reporting rules. These rules are intended to facilitate participation in Commission proceedings by providing the public with data and information on cost methodologies and other matters. This notice describes the dispute and invites comments on this development, including suggestions on possible rule changes.

DATES: *Initial Comments:* December 6, 2004; *Reply Comments:* January 6, 2005.

FOR FURTHER INFORMATION CONTACT: Stephen L. Sharfman, General Counsel, (202) 789–6818.

SUPPLEMENTARY INFORMATION:

Regulatory History

68 FR 2272, January 16, 2003.
68 FR 65348, November 19, 2003.

Summary

The Postal Rate Commission amended its Rules Applicable to the Filing of Reports by the U.S. Postal Service in its Order No. 1386, issued November 3, 2003. That order updated the rules to reflect new data systems and methodologies, and increased the amount of information the Postal Service was to submit to assist the Commission and foster effective public participation in Administrative Procedure Act (APA) hearings pursuant to 39 U.S.C. 3624.

The Postal Service opposed expansion of its obligations under 39 CFR

3001.102, Filing of Reports, in the rulemaking docket leading to the adoption of Order No. 1386. Although it initially complied with some of its new obligations, the Postal Service has now informed the Commission that after consideration at the ''highest level'' of postal management, it has determined that it will not comply with Commission rules that require the reporting of new methodologies and data used in the preparation of its annual Cost and Revenue Analysis (CRA) report.

In support of its action, the Postal Service reiterated several legal contentions fully considered and rejected by the Commission in its rulemaking. However, the primary motivating factor leading to the Postal Service announcement that it would not comply with the rules seems to be the Commission practice of making materials filed in compliance with its rules available to the public.

The Commission requests that interested persons provide comments on this controversy, including suggestions for adjustments to Commission rules designed to reconcile the conflicting interests outlined in this Notice. Comments should be provided by December 6, 2004. Reply comments may be submitted by January 6, 2005.

Background

Over the years, postal ratemaking has become increasingly complex. The ability to computerize information and apply econometrics to large data bases has led to more sophisticated analyses of postal costs, volumes, and revenues. The Commission, and to an even greater extent mailers and other interested participants in Postal Rate Commission proceedings, have had growing difficulty in reviewing multiple new complex analyses in the context of proceedings that must, by statute, be completed in 10 months. 39 U.S.C. 3624(c)(1).

The Postal Service supports its requests for rate increases with testimony from 40+ witnesses, a number of whom sponsor technical analyses that have been in preparation for many months. Participants must review this material, develop their criticisms, and present any suggested alternative analyses approximately half way through a case to allow other participants and the Commission to evaluate their views. The Commission is charged with reviewing every analysis presented, getting clarifications as needed, and preparing a technically sound, comprehensive decision.

Commission conclusions must be confined to materials in the evidentiary record. Participants have complained that the process becomes ineffective and one-sided if only the Postal Service has time sufficient to analyze data and prepare persuasive evidence.

Following the most recent rate case, the Postal Service and Postal Rate Commission jointly sponsored a Ratemaking Summit to obtain public input on ways to make the ratemaking process more streamlined and less burdensome for all involved. The Summit took place in May and June, 2002, and involved written comments followed by two, separate full day discussion sessions.

Attention was given both to how the Postal Service planned and implemented rate changes, and how to improve the current rate case process. The majority of comments addressing the rate case process focused on the difficulty of responding adequately to multiple new complex technical presentations within the 10-month timeframe. Participants emphasized they do not have the resources to address several major technical studies simultaneously.

The most widely supported solution was to find a way to provide participants with more timely access to annual cost and volume data, as well as any changes in the methodologies the Postal Service uses to aggregate and distribute that data in preparing its annual reports. It has been the Postal Service's consistent practice to withhold from the public both the basic cost and volume data underlying its aggregate results, and any changes to its analytic methodologies, until it submits an omnibus rate request.

Recent Amendments to the Periodic Reporting Rules

A short time after the Ratemaking Summit, the Commission issued a notice of proposed rulemaking, in which it sought comments on whether to update and expand its Rules Applicable to the Filing of Reports by the U.S. Postal Service. These rules had not been revised for over a decade and no longer fully reflected existing operating and data collection practices. The Commission is directed by 39 U.S.C. 3603 to implement such rules as it finds necessary and proper to enable it to carry out its statutory functions. That section specifically provides such rules ''shall not be subject to any change or supervision by the Postal Service.''

All those who submitted either comments or reply comments, with the exception of the Postal Service, urged the Commission to amend its periodic reporting rules to facilitate analysis between rate cases. The Postal Service has opposed parts of these proposals, raising legal arguments (set forth below) and expressing concern that compliance would be burdensome, and that it might face time-consuming questions about new analytic methods underlying its published summary reports.

The Commission followed APA processes, resolving every issue raised. It narrowed its initial proposal somewhat in light of the Postal Service's burden arguments, but it retained several proposed amendments to the periodic reporting rules providing access to new data collection systems and estimating methods. The Commission found that updating the periodic reporting rules would result in favor of key improvements:

(1) Help the Commission and the public to evaluate the soundness of the cost, volume and revenue estimates on which existing rates were based;

(2) Inform the Commission and the public about new data sets and estimation techniques incorporated by the Postal Service each year into the Cost and Revenue Analysis (CRA) report it currently provides;

(3) Allow the public to participate more meaningfully in Commission cases; and

(4) Enable the Commission to expedite the processing of rate, classification, and complaint cases.

In November 2003 the Commission amended its periodic reporting rules. The Postal Service has complied with some parts of the new rule, but it now has refused to provide data and methodologies used to develop the majority of the cost attributions reported in its Cost and Revenue analysis. The Attachment to this Order lists the information the Postal Service has not provided.

The Postal Service Position

The Postal Service explained its views in detailed filings in Docket RM2003–3. All of these filings may be accessed on the Commission Web site, *http://www.prc.gov.* The most recent Postal Service statement, in which it announced it would not provide required information, may also be found there on the ''Daily Listing'' for September 17, 2004.

The Postal Service advances two main arguments in support of its position that the Commission is not authorized to require periodic reports of this nature. First, it contends that Commission authority is limited to acting in response to Postal Service requests for rate or classification decisions, and other strictly limited specific functions set forth in the Act. The Postal Service argues that the Commission does not

have broad investigative or oversight authority, and the Service has implied that the amended rules are an attempt by the Commission to expand its authority and oversee operations in a manner not contemplated by the statute.

Second, the Postal Service contends that Congress does not want it to have to make information of this nature public ''indiscriminately.'' The Act includes a special test applicable to Freedom of Information Act (FOIA) requests. The Postal Service does not have to provide ''information of a commercial nature'' which ''under good business practice would not be publicly disclosed'' in response to a FOIA request. 39 U.S.C. 410(c)(2). The Postal Service correctly observes that private businesses in the United States seldom disclose detailed information about their operating costs.

The Postal Service argues that because it is standard Commission practice to post public documents on its Web site, including data received as periodic reports, the Service should not provide such detailed information to the Commission. The Postal Service seems to concede that the Commission might have use for these materials, and for explanations of changes since the most recent rate case, but it contends that allowing internet access to this information would be contrary to Congress' vision of the Postal Service following good business practices.

The Current Commission Position

The Commission has not found either Postal Service argument persuasive, as explained fully in Order No. 1386. The Commission has concluded that its responsibility under section 3603 to establish rules to carry out its functions under the Act does provide the authority to assure that sufficient information is available in a timely fashion to facilitate meaningful public participation and to enable the Commission to provide informed recommendations in response to Postal Service rate and classification requests.

The Commission also has concluded that information required by its rules is not equivalent to a citizen's FOIA request. While citizens can file a FOIA request seeking information on any topic without any showing of need, the Commission's rules focus on information needed to carry out its statutory functions. The Act requires public participation in all Commission proceedings, and thus contemplates public access to relevant data. In past rate cases, the Postal Service has made all of the contested information available without suggesting that there was any need to restrict public access to it.

The Commission always has recognized that when the Postal Service or any other participant provides items for use in a Commission proceeding that it shows to be trade secrets or other sensitive business information, and that disclosure of this information could result in commercial harm, such items should be made subject to appropriate protective conditions. Similarly, the Commission has been willing to accommodate in its periodic reporting rules, Postal Service requests that specific information be protected as commercially sensitive, after balancing the asserted risk of harm against the needs of the public to remain informed. See Docket No. RM89–3, Order No. 839, at 7–8 (deferring filing dates for billing determinants of competitive products).

Comments

The Postal Service has indicated its interest in further exploring the possibility of ways to refine procedures for controlling dissemination of information provided as periodic reports. This might be accomplished through additions to rule 102. Those responding to this notice are invited to advise on the most important policies and principles that should guide the Commission in evaluating potential action in regard to this situation. Commenters also may suggest procedures for obtaining a desired outcome or specific proposals for changes to Commission rules.

Ordering Paragraphs

It is ordered:

1. Interested persons are invited to submit comments on the Commission's Advance Notice of Proposed Rulemaking on or before December 6, 2004. Any reply comments should be submitted by January 6, 2005.

2. The Secretary shall cause this Advance Notice of Proposed Rulemaking to be published in the **Federal Register**.

Attachment

Materials Required by Rule 102 That the Postal Service Has Not Provided

1. The In-Office Cost System (IOCS) data for FY 2003 used to distribute attributable mail processing and in-office carrier costs to classes of mail in the Cost and Revenue Analysis (CRA) report.

2. The City Carrier Cost System (CCCS) data for FY 2003 used to distribute attributable city carrier costs to classes of mail in the CRA.

3. The Rural Carrier Cost System (RCCS) data for 2003 used to distribute attributable rural carrier costs to classes of mail in the CRA.

4. The National Mail Count data for 2003. These data are used to determine attributable rural carrier costs.

5. MODS input data used to estimate mail processing cost variabilities by activity.

6. SAS computer programs showing how FY 2003 attributable mail processing costs were estimated and distributed to mail classes in the CRA.

7. Revenue, Pieces, and Weight reports by rate category for the first three quarters of FY 2004.

By the Commission.

Issued: November 8, 2004.

Steven W. Williams,

Secretary.

[FR Doc. 04–25298 Filed 11–12–04; 8:45 am]

BILLING CODE 7710–FW–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 720

[OPPT–2003–0058; FRL–7342–2]

RIN 2070–AJ04

TSCA Inventory Nomenclature for Enzymes and Proteins

AGENCY: Environmental Protection Agency (EPA).

ACTION: Advance Notice of Proposed Rulemaking (ANPRM).

SUMMARY: This ANPRM alerts interested parties that EPA is considering new procedures and regulations for naming enzymes and proteins when listing such substances on the Toxic Substances Control Act (TSCA) Chemical Substances Inventory (Inventory). More specifically, this ANPRM outlines four identification elements that EPA currently believes are appropriate for use in developing unique TSCA Inventory nomenclature for proteinaceous enzymes. This ANPRM also solicits public comment on several specific questions relating to this initiative.

DATES: Comments must be received on or before December 15, 2004.

ADDRESSES: Submit your comments, identified by docket ID number OPPT–2003–0058, by one of the following methods:

- *Federal eRulemaking Portal*: *http://www.regulations.gov/*. Follow the on-line instructions for submitting comments.
- *Agency Website*: *http://www.epa.gov/edocket/*. EDOCKET, EPA's electronic public docket and

comment system, is EPA's preferred method for receiving comments. Follow the on-line instructions for submitting comments.

- *E-mail: oppt.ncic@epa.gov*.
- *Mail:* Document Control Office (7407M), Office of Pollution Prevention and Toxics (OPPT), Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460–0001.
- *Hand delivery/courier*: OPPT Document Control Office (DCO), EPA East Bldg., Rm. 6428, 1201 Constitution Ave., NW., Washington, DC, Attention: Docket ID number OPPT–2003–0058. The DCO is open from 8 a.m. to 4 p.m., Monday through Friday, excluding legal holidays. The telephone number for the DCO is (202) 564–8930. Such deliveries are only accepted during the Docket's normal hours of operation, and special arrangements should be made for deliveries of boxed information.

Instructions: Direct your comments to docket ID number OPPT–2003–0058. EPA's policy is that all comments received will be included in the public docket without change and may be made available on-line at *http://www.epa.gov/edocket/*, including any personal information provided, unless the comment includes information claimed to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Do not submit information that you consider to be CBI or otherwise protected through EDOCKET, regulations.gov, or e-mail. The EPA EDOCKET and the Federal regulations.gov websites are ''anonymous access'' systems, which means EPA will not know your identity or contact information unless you provide it in the body of your comment. If you send an e-mail comment directly to EPA without going through EDOCKET or regulations.gov, your e-mail address will be automatically captured and included as part of the comment that is placed in the public docket and made available on the Internet. If you submit an electronic comment, EPA recommends that you include your name and other contact information in the body of your comment and with any disk or CD-ROM you submit. If EPA cannot read your comment due to technical difficulties and cannot contact you for clarification, EPA may not be able to consider your comment. Electronic files should avoid the use of special characters, any form of encryption, and be free of any defects or viruses. For additional information about EPA's public docket visit EDOCKET on-line or see the **Federal Register** of May 31, 2002 (67 FR 38102) (FRL–7181–7).

Docket: All documents in the docket are listed in the EDOCKET index at *http://www.epa.gov/edocket/*. Although listed in the index, some information is not publicly available, i.e., CBI or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, is not placed on the Internet and will be publicly available only in hard copy form. Publicly available docket materials are available either electronically in EDOCKET or in hard copy at the OPPT Docket, EPA Docket Center (EPA/DC), EPA West, Rm. B102, 1301 Constitution Ave., NW., Washington, DC. The Public Reading Room is open from 8:30 a.m. to 4:30 p.m., Monday through Friday, excluding legal holidays. The EPA Docket Center Reading Room telephone number is (202) 566–1744, and the telephone number for the OPPT Docket, which is located in the EPA Docket Center, is (202) 566–0280.

FOR FURTHER INFORMATION CONTACT: *For general information contact*: Colby Lintner, Regulatory Coordinator, Environmental Assistance Division (7408M), Office of Pollution Prevention and Toxics, Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460–0001; telephone number: (202) 554–1404; e-mail address: *TSCA-Hotline@epa.gov*.

For technical information contact: James Alwood, Chemical Control Division, (7405M), Office Pollution Prevention and Toxics, Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460–0001; telephone number: (202) 564–8974; e-mail address: *alwood.jim@epa.gov*.

SUPPLEMENTARY INFORMATION:

I. General Information

A. Does this Action Apply to Me?

You may be potentially affected by this action if you manufacture, import, process, or use chemical substances which are subject to TSCA jurisdiction. Potentially affected entities may include, but are not limited to:

- Chemical manufacturers (NAICS 325), e.g., persons manufacturing, importing, processing, or using chemicals for commercial purposes.
- Petroleum and coal product industries (NAICS 324), e.g., persons manufacturing, importing, processing, or using chemicals for commercial purposes.

This listing is not intended to be exhaustive, but rather provides a guide for readers regarding entities likely to be affected by this action. Other types of entities not listed in this unit could also be affected. The North American Industrial Classification System (NAICS) codes have been provided to assist you and others in determining whether this action might apply to certain entities. To determine whether you or your business may be affected by this action, you should carefully examine the applicability provisions in title 40 of the Code of Federal Regulations (CFR) at 40 CFR 720.22. If you have any questions regarding the applicability of this action to a particular entity, consult the technical person listed under **FOR FURTHER INFORMATION CONTACT**.

B. How Can I Access Electronic Copies of this Document and Other Related Information?

In addition to EDOCKET (*http://www.epa.gov/edocket/*), you may access this **Federal Register** document electronically through the EPA Internet under the ''**Federal Register**'' listings at *http://www.epa.gov/fedrgstr/*. A frequently updated electronic version of 40 CFR part 720 is available on E-CFR Beta Site Two at *http://www.gpoaccess.gov/ecfr/*.

C. What Should I Consider as I Prepare My Comments for EPA?

1. *Submitting CBI*. Do not submit this information to EPA through EDOCKET, regulations.gov, or e-mail. Clearly mark the part or all of the information that you claim to be CBI. For CBI information in a disk or CD ROM that you mail to EPA, mark the outside of the disk or CD ROM as CBI and then identify electronically within the disk or CD ROM the specific information that is claimed as CBI. In addition to one complete version of the comment that includes information claimed as CBI, a copy of the comment that does not contain the information claimed as CBI must be submitted for inclusion in the public docket. Information so marked will not be disclosed except in accordance with procedures set forth in 40 CFR part 2.

2. *Tips for preparing your comments*. When submitting comments, remember to:

i. Identify the rulemaking by docket ID number and other identifying information (subject heading, **Federal Register** date and page number).

ii. Follow directions—The Agency may ask you to respond to specific questions or organize comments by referencing a CFR part or section number.

iii. Explain why you agree or disagree; suggest alternatives and substitute language for your requested changes.

iv. Describe any assumptions and provide any technical information and/or data that you used.

v. If you estimate potential costs or burdens, explain how you arrived at your estimate in sufficient detail to allow for it to be reproduced.

vi. Provide specific examples to illustrate your concerns, and suggest alternatives.

vii. Explain your views as clearly as possible, avoiding the use of profanity or personal threats.

viii. Make sure to submit your comments by the comment period deadline identified.

II. Background

A. What Action is the Agency Taking?

This ANPRM is alerting stakeholders that EPA is considering changing procedures and requirements for naming enzymes and proteins for the purpose of listing those substances on the TSCA Inventory. Specifically, EPA has identified four elements that it currently believes are appropriate for use in creating unique and unambiguous identities for proteinaceous enzymes on the TSCA Inventory. Through this ANPRM, EPA is also soliciting public comment on the scientific appropriateness and technical feasibility of using the identification elements summarized herein.

B. What is the Agency's Authority for Taking this Action?

Section 8(b) of TSCA requires EPA to ''compile, keep current, and publish a list of each chemical substance which is manufactured or processed in the United States'' (the TSCA Inventory). In order to fulfill this requirement, EPA must continuously update and keep current various types of information, including, but not limited to, the information used to identify any new chemical substance that is reported to be manufactured or processed in the United States. EPA also makes corrections, when necessary, of previously reported information on the TSCA Inventory.

C. TSCA Inventory Background

As stated above, TSCA section 8(b) requires EPA to compile, keep current, and publish a list of chemical substances which are manufactured (including imported) or processed in the United States. This listing, known as the ''TSCA Inventory,'' informs the public of which chemical substances are being manufactured, imported, or processed in the United States for commercial purposes. For the TSCA Inventory to accurately inform the public, it must be continuously and accurately updated as new information becomes available. The updating process includes adding to the Inventory the identities of new chemical substances that are being introduced into U.S. commerce and corrections when necessary of the identities of previously reported substances. The Agency has developed policies regarding the identification of chemical substances for the purpose of assigning a unique description of each substance on the TSCA Inventory. Published nomenclature guidance is currently available for polymeric substances, substances containing varying carbon chain lengths, complex reaction products, mixtures, and chemical substances of unknown or variable compositions. Approximately 81,500 chemical substances, as defined in section 3 of TSCA, are on the TSCA Inventory at this time.

In its implementation of TSCA, EPA defines chemical substances as either ''existing'' chemicals or ''new'' chemicals. The only way to determine if a substance is new or existing is by consulting the TSCA Inventory. Any substance that is listed on the TSCA Inventory is an existing chemical, otherwise it is a new chemical. If a substance is a new chemical, generally it can be manufactured or imported for non-exempt commercial purposes only when a Premanufacture Notice (PMN) is submitted at least 90 days before the manufacture or import of such substance begins (see section 5(a) of TSCA and 40 CFR part 720). During this 90-day review period EPA will evaluate the proposed manufacture, processing, use, distribution in commerce, and disposal of the substance, and if necessary, prohibit or limit any activity that may result in an unreasonable risk of injury to human health or the environment. A new chemical substance also can be manufactured or imported if it is subject to an exemption from full premanufacture reporting, for example a Low Volume Exemption or a Test Marketing Exemption (see 40 CFR part 723 and 40 CFR 720.38). In addition a new chemical substance is excluded from premanufacture reporting under certain conditions such as manufacture or import of small quantities for research and development or if the substance does not meet the TSCA definition of chemical substance as defined in 40 CFR part 720.3(e) (see 40 CFR 720.30).

D. Inventory Listings of Enzymes

When EPA promulgated the TSCA Inventory Reporting Regulations of 1977 (42 FR 64572, December 23, 1977), the Agency did not provide specific guidance regarding how complex biological compounds should be identified. However, EPA did publish the TSCA Candidates List to provide examples of the types of substances that would be reportable for the Inventory. That list included enzymes. As a result, approximately 150 enzymes were reported and listed on the TSCA Inventory without specific agency guidance regarding how they should be unambiguously identified. The original Inventory listings for non-enzymatic proteins and other complex biological compounds are based on information originally reported to EPA that varies widely in the type and specificity of information included.

The enzymes currently on the TSCA Inventory are identified by a Chemical Abstract Services (CAS) Registry Number and Chemical Abstracts 9th Collective Index Name. The names assigned to these enzymes by EPA vary in the type and specificity of information included due to wide variation in the type and amount of information originally reported to EPA. For some enzymes, the name is broad, defining only the most generic catalytic activity of the enzyme (e.g., proteinase).

As a result of the existing broad and generic TSCA Inventory enzyme listings, it has been difficult for EPA to determine whether enzyme substances are new and distinct, or covered under existing listings. In most cases, newly developed enzymes appear to be subsumed under one of the current broad and generic TSCA Inventory enzyme listings, which means that, although they are newly developed, they appear to be existing chemicals. This, in turn, means that EPA is reviewing very few new enzymes under section 5 of TSCA, despite the ongoing innovation in this field as to the specificity and functions of commercially available enzymes. Under the existing nomenclature system, therefore, EPA may not be addressing all of the newly developed enzymes and considering the potential risks that may be associated with these substances under section 5 of TSCA. A more specific nomenclature system would allow EPA to assess newly developed enzymes and take actions needed to prevent potential unreasonable risks to health and the environment that may be associated with these substances under section 5 of TSCA before they occur.

In addition, the broad TSCA Inventory enzyme listings, the lack of clear reporting guidelines, and the absence of policy concerning what structural variation or changes trigger reporting, also make it difficult for manufacturers to determine whether enzyme substances are new or covered under existing listings. Recognizing that enzyme listings on the Inventory were broad, EPA developed an interim policy that manufacturers of enzymes should contact EPA regarding submission of a *bona fide* intent to manufacture before producing any enzyme. EPA also routinely advised submitters of a Notice of Bona Fide Intent to Manufacture that the Agency may modify the method of listing enzymes on the Inventory and that this could require reporting at a higher level of detail than is required at present. This case-by-case determination creates uncertainty and an unnecessary burden for both the Agency and PMN submitters. More specific guidelines for identifying enzymes on the TSCA Inventory would make the process of deciding whether an enzyme is new or existing more predictable and transparent.

In order to more effectively meet its statutory obligation under TSCA to prevent unreasonable risk to human health and the environment and to maintain a complete and accurate list of all chemical substances manufactured, imported, or processed, EPA believes it is necessary to refine its policies with regard to enzyme identification reporting requirements. The timely development of identification reporting guidelines for enzymes is essential, given the increasing use of enzymes in commerce, the wide variety of enzymes that are being produced, and the development of new and different manufacturing techniques.

III. Identification Elements

A. Description of Identification Elements

EPA has identified four elements that it currently believes are appropriate to use in combination to create unambiguous listings for proteinaceous enzymes on the TSCA Inventory:

1. Function.
2. Source.
3. Processing.
4. Amino acid sequence.

EPA believes that no individual element provides sufficient identification information by itself. Rather, EPA anticipates that all four elements will provide useful and necessary information for the unambiguous identification of proteinaceous enzymes and that some combination of these and/or additional identification elements may be appropriate for other enzymes and proteins.

The function of an enzyme refers to its catalytic activity. The internationally accepted nomenclature conventions of the Nomenclature Committee of the International Union of Biochemistry and Molecular Biology (NC-IUBMB) describe and differentiate enzymes based on catalytic activity. Function, or catalytic activity, could be incorporated as an element of chemical identity of an enzyme on the TSCA Inventory using this standard enzyme nomenclature.

Source refers to the organism from which the gene encoding the enzyme was derived and the organism or manufacturing platform (e.g., tissue culture) in which the enzyme is produced. The two sources may be the same or differ when the enzyme gene from one organism is introduced through genetic engineering into a different organism or through the use of a synthetic sequence.

Processing refers to procedures used to isolate the enzyme from the production organism or manufacturing platform, procedures used to purify it, or any chemical reactions to which the enzyme is subjected to produce the final product.

The amino acid sequence of an enzyme or protein is known as its primary structure. The amino acid sequence is a systematic representation of the linear chain of amino acids connected via amide bonds that produce a polypeptide.

An example of enzyme nomenclature using these identification elements would be neopullulanase (*Enzyme Commission* 3.2.1.135), produced by *Bacillus stearothermophilus*, treated with acetic acid, with amino acid sequence:

BILLING CODE 6560–50–S

Position #																										
1	M	R	K	E	A	I	Y	H	R	P	A	D	N	F	A	Y	A	Y	D	S	E	T	L	H	L	R	L	R	T	K
31	K	D	D	I	D	R	V	E	L	L	H	G	D	P	Y	D	W	Q	N	G	A	W	Q	F	Q	M	M	P	M	R
61	K	T	G	S	D	E	L	F	D	Y	W	F	A	E	V	K	P	P	Y	R	R	L	R	Y	G	F	V	L	Y	S
91	G	E	E	K	L	V	Y	T	E	K	G	F	Y	F	E	V	P	T	D	D	T	A	Y	Y	F	C	F	P	F	L
121	H	R	V	D	L	F	E	A	P	D	W	V	K	D	T	V	W	Y	Q	I	F	P	E	R	F	A	N	G	N	P
151	S	I	S	P	E	G	S	R	P	W	G	S	E	D	P	T	P	T	S	F	F	G	G	D	L	Q	G	I	I	D
181	H	L	D	Y	L	V	D	L	G	I	T	G	I	Y	L	T	P	I	F	R	S	P	S	N	H	K	Y	D	T	A
211	D	Y	F	E	V	D	P	H	F	G	D	K	E	T	L	K	T	L	I	D	R	C	H	E	K	G	I	R	V	M
241	L	D	A	V	F	N	H	C	G	Y	E	F	A	P	F	Q	D	V	W	K	N	G	E	S	S	K	Y	K	D	W
271	F	H	I	H	E	F	P	L	Q	T	E	P	R	P	N	Y	D	T	F	R	F	V	P	Q	M	P	K	L	N	T
301	A	N	P	E	V	K	R	Y	L	L	D	V	A	T	Y	W	I	R	E	F	D	I	D	G	W	R	L	D	V	A
331	N	E	I	D	H	E	F	W	R	E	F	R	Q	E	V	K	A	L	K	P	D	V	Y	I	L	G	E	I	W	H
361	D	A	M	P	W	L	R	G	D	Q	F	D	A	V	M	N	Y	P	F	T	D	G	V	L	R	F	F	A	K	E
391	E	I	S	A	R	Q	F	A	N	Q	M	M	H	V	L	H	S	Y	P	N	N	V	N	E	A	A	F	N	L	L
421	G	S	H	D	T	S	R	I	L	T	V	C	G	G	D	I	R	K	V	K	L	L	F	L	F	Q	L	T	F	T
451	G	S	P	C	I	Y	Y	G	D	E	I	G	M	T	G	G	N	D	P	E	C	R	K	C	M	V	W	D	P	M
481	Q	Q	N	K	E	L	H	Q	H	V	K	Q	L	I	A	L	R	K	Q	Y	R	S	L	R	R	G	E	I	S	F
511	L	H	A	D	D	E	M	N	Y	L	I	Y	K	K	T	D	G	D	E	T	V	L	V	I	I	N	R	S	D	Q
541	K	A	D	I	P	I	P	L	D	A	R	G	T	W	L	V	N	L	L	T	G	E	R	F	A	A	E	A	E	T
571	L	C	T	S	L	P	P	Y	G	F	V	L	Y	A	I	E	H	W												

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This is one version of enzyme nomenclature using these four identification elements. Actual nomenclature would vary widely depending on use of all four elements, nomenclature used for each element, and the level of detail ultimately used for each element.

B. Issues for Public Comment

EPA is soliciting comments on all aspects of the discussion presented in this document regarding nomenclature issues for enzymes and proteins, for purposes of listing these chemical substances on the TSCA Inventory. EPA is particularly interested in receiving comments on the following topics.

EPA has identified four elements (listed in Unit III.A.), that it currently believes are appropriate to derive unique nomenclature for the purpose of unambiguously listing proteinaceous enzymes on the TSCA Inventory. EPA is seeking comments on the scientific appropriateness of using these identification elements, the level of detail necessary to create specific, unambiguous TSCA Inventory listings, the technical feasibility of providing such information, and any additional or alternative elements that could be used to identify proteinaceous enzymes on the TSCA Inventory.

Are the identification elements proposed for proteinaceous enzymes scientifically appropriate and sufficiently comprehensive for non-proteinaceous enzymes and non-enzymatic proteins? Are there additional or alternative identification elements that should be used in creating TSCA Inventory listings for non-proteinaceous enzymes and non-enzymatic proteins?If so, what are these alternatives, and why is it believed that these alternatives are preferable.

IV. Do Any Statutory or Executive Order Reviews Apply to this Action?

Under Executive Order 12866, entitled *Regulatory Planning and Review* (58 FR 51735, October 4, 1993), it has been determined that this ANPRM is a ''significant regulatory action'' under section 3(f) of the Executive order. The Agency therefore submitted this document to OMB for the 10-day review period afforded under this Executive order. Any changes made in response to OMB comments during that review have been documented in the docket as required by the Executive order.

Since this ANPRM does not impose or propose any requirements, and instead seeks comments and suggestions for the Agency to consider in developing a subsequent notice of proposed rulemaking, the various other review requirements that apply when an agency imposes requirements do not apply to this action.

As part of your comments on this ANPRM you may include any comments or information that you have regarding these requirements. In particular, any comments or information that would help the Agency to assess the potential impact of a rule on small entities pursuant to the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 *et seq.*); to consider voluntary consensus standards pursuant to section 12(d) of the National Technology Transfer and Advancement Act of 1995 (NTTAA), Public Law 104–113, section 12(d) (15 U.S.C. 272 note); or to consider environmental health or safety effects on children pursuant to Executive Order 13045, entitled *Protection of Children from Environmental Health Risks and Safety Risks* (62 FR 19885, April 23, 1997). The Agency will consider such comments during the development of any subsequent notice of proposed rulemaking as it takes appropriate steps to address any applicable requirements.

List of Subjects in 40 CFR Part 720

Environmental protection, Chemicals, Hazardous substances, Reporting and recordkeeping requirements.

Dated: November 1, 2004.

Michael O. Leavitt,

Administrator.

[FR Doc. 04–25307 Filed 11–12–04; 8:45 am]

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FEDERAL COMMUNICATIONS COMMISSION

47 CFR Parts 2 and 80

[WT Docket No. 04–344; RM–10821; FCC 04–207]

Maritime Communications

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: In this document, the Commission initiates a rulemaking proceeding to identify the electromagnetic spectrum that should be used for maritime Automatic Identification Systems (AIS) in the United States and its territorial waters. AIS is an important tool for enhancing maritime safety and homeland security, and the Commission is concerned that recent developments may have created uncertainty in the maritime community regarding the very high frequency (VHF) channels to be used for AIS, and that this in turn could impede efforts to expedite the broad deployment of AIS. The Commission has received conflicting petitions and other pleadings on this subject from the National Telecommunications and Information Administration (NTIA), which is representing the interests of the Federal Government, including the United States Coast Guard (USCG or Coast Guard) and the Department of Transportation (including the Saint Lawrence Seaway Development Corporation) in this matter, and from MariTEL, Inc. (MariTEL), the licensee of all nine of the maritime VHF Public Coast (VPC) station service areas. Based on these petitions and pleadings, as well as responsive comments from other stakeholders in the maritime community, the Commission proposes to designate VHF maritime Channels 87B and 88B for exclusive AIS use domestically, in keeping with the international allocation of those channels for AIS, because the Commission tentatively concludes that the use of those channels will best secure to the United States the maritime safety and homeland security benefits of AIS. In addition, the Commission tentatively concludes that it should deny MariTEL's pending petitions that conflict with this proposal.

DATES: Submit comments on or before December 30, 2004, and reply comments are due on or before January 31, 2005.

FOR FURTHER INFORMATION CONTACT: Jeffrey Tobias, *Jeff.Tobias@FCC.gov*, Public Safety and Critical Infrastructure Division, Wireless Telecommunications Bureau, (202) 418–0680, or TTY (202) 418–7233.

SUPPLEMENTARY INFORMATION: This is a summary of the Federal Communications Commission's Notice of Proposed Rulemaking (''NPRM'') in WT Docket No. 04–344, FCC 04–207, adopted on August 26, 2004, and released on October 15, 2004. The full text of this document is available for inspection and copying during normal business hours in the FCC Reference Center, 445 12th Street, SW., Washington, DC 20554. The complete text may be purchased from the Commission's copy contractor, Best Copy and Printing, Inc., 445 12th Street, SW., Room CY–B402, Washington, DC 20554. The full text may also be downloaded at: *http://www.fcc.gov.* Alternative formats are available to persons with disabilities by contacting Brian Millin at (202) 418–7426 or TTY (202) 418–7365 or at *bmillin@fcc.gov.*

1. Section 80.371(c)(3) of the Commission's Rules, 47 CFR 80.371(c)(3), directs the licensee of VHF Public Coast Service Areas (VPCSAs) 1–9, *i.e.*, MariTEL, and the Coast Guard to negotiate in good faith to select two narrowband offset channel pairs to be dedicated to AIS use, and specifies that if an agreement cannot be reached, the Coast Guard may petition the Commission to select the channel pairs. Although MariTEL and the Coast Guard did in fact reach an agreement to designate frequencies 157.375 MHz and 161.975 MHz for AIS and executed a Memorandum of Agreement (MOA) to that effect, MariTEL later exercised its right to terminate the MOA. Following termination of the MOA, NTIA petitioned the Commission on behalf of the Coast Guard to select Channels 87B and 88B for AIS and to work with NTIA to reallocate the channels for exclusive AIS use nationwide on a shared Federal Government/non-Federal Government basis. After reviewing various proposals submitted by MariTEL and NTIA, including their technical submissions, and the comments filed in response to a number of public notices relating to this matter, the Commission tentatively agrees with NTIA and the Coast Guard, as well as the vast majority of commenters, that the public interest would be served by designating Channels 87B and 88B for exclusive AIS use in the nine maritime VPCSAs. The Commission therefore grants the petition for rulemaking filed by NTIA on October 24, 2003, RM–10821 to the extent that it seeks initiation of a rulemaking proceeding to consider this issue, denies the Emergency Petition for Declaratory Ruling filed by MariTEL on October 15, 2003, and adopts the instant *Notice of Proposed Rule Making* in which it proposes to designate Channels 87B and 88B for exclusive AIS use in the nine maritime VPCSAs.

2. Designating Channels 87B and 88B for AIS in the United States and its territorial waters would permit seamless worldwide AIS operations. If the United States were to designate channels other than 87B and 88B for AIS, vessels entering United States waters would have to switch to those alternative channels, instead of being able to use the same channels that were employed in international waters. Commenters indicate that requiring such switching would increase the risk of vessel collisions. If ships must switch channels as they approach and transit an AIS ''fence'' between international and United States waters, there is a risk that they will disappear temporarily from the screens of vessel traffic management systems as well as from the screens of AIS receivers located on the bridges of vessels.

3. Further, domestic use of Channels 87B and 88B for AIS would facilitate the speedy and efficient deployment of AIS, allowing the United States to take full advantage of existing AIS standards and infrastructure. Mandating the use of other channels could prolong implementation schedules for future PAWSS installations and delay full implementation of AIS as a component of homeland security because of the need for additional technical analysis, possible design changes, and conceivably more extensive shore infrastructure to accommodate AIS channel shifting. In addition, AIS operations on Channels 87B and 88B already have been deployed in, for example, the Saint Lawrence Seaway. A switch to other channels on the United States side would not only necessitate a costly reconfiguration of the AIS network on the Seaway but, more importantly, would compromise the ability of the United States to coordinate with Canada in monitoring vessel traffic on the Seaway and in other areas, since Canada uses Channels 87B and 88B for AIS. In addition to implementation delays and coordination difficulties, the use of channels other than 87B and 88B would affect the United States adversely because it would cause the U.S. Government to expend considerably more time, money and resources to

implement a domestic AIS infrastructure.

4. Designating specific channels for AIS should provide greater regulatory certainty, which in turn should encourage investment in AIS technology. Calling for another round of negotiations between the Coast Guard and MariTEL to identify channels for AIS would likely result in greater delay before this critical issue could be definitively resolved, and the resultant uncertainty could retard the pace of AIS deployment in the United States. Further, a resolution premised on a new MOA between the parties would still leave open the possibility that either party would terminate that future MOA, returning us to the present predicament. Specifically designating AIS channels in the Commission's Rules, in contrast, would eliminate that possibility. Therefore, the Commission sees important public interest benefits in designating specific channels for AIS, and the record developed thus far overwhelmingly militates in favor of designating Channels 87B and 88B for this purpose rather than any other channels.

5. After reviewing the parties' technical submissions, the Commission also tentatively concludes that there is no basis in public policy or equity either to forego designating Channels 87B and 88B for AIS in order to protect MariTEL's interests or to provide some mechanism to compensate MariTEL if it does so. The Commission believed that the action it proposes here is essential to public safety, a reasonable regulatory response to changed circumstances, does not limit the licensed VPC spectrum available for MariTEL's proposed data offerings to any greater degree than would the designation of four narrowband offset channels, does not unfairly undermine MariTEL's reasonable investment-backed expectations, and does not undermine the integrity of the Commission's auction process. The Commission invites comment on these tentative conclusions as well as on its overall proposal. In addition, the Commission encourages the Coast Guard and Maritel to cooperate in an effort to avoid interference to and from AIS and VPC operations, and to take reasonable measures to remedy any instances of interference that occur. Although the Commission does not propose here to mandate any particular type of cooperative interference mitigation measures, it seeks comment on whether there are specific actions it could take to facilitate such collaboration.

6. The Commission also tentatively concludes that it should not adopt MariTEL's proposal to serve as the AIS frequency coordinator. MariTEL's proposed fees for providing AIS frequency coordination would create an unwarranted disincentive for voluntary carriage of AIS equipment. The effectiveness of AIS as a tool in service of maritime safety and homeland security is directly proportional to the percentage of vessels that operate with AIS. Creating a disincentive for voluntary AIS carriage should be considered only if there are equally weighty reasons in favor of it. Here, there is no apparent countervailing public interest benefit in MariTEL's proposal to act as AIS frequency coordinator that could justify a measure that would discourage fitting vessels with AIS equipment. In addition, the proposed fees would unfairly burden the owners and operators of vessels subject to mandatory AIS carriage requirements, who must already shoulder the costs of purchasing and installing AIS equipment to fulfill the requirement.

7. The Commission also declines to propose adoption of MariTEL's proposal for shared use of Channels 87B and 88B, as set forth in MariTEL's submission of February 9, 2004. The public interest benefits of adopting this proposal are unclear, and do not outweigh the clear disadvantages of the proposal. First, the MariTEL sharing proposal would permit MariTEL to use on a shared basis not only Channel 87B but also the Federal Government channel 88B. The Commission is not empowered to give MariTEL any rights to use a Federal Government channel, and NTIA has not indicated any readiness to do so. Second, the MariTEL sharing proposal is premised in part on the Commission adopting regulations precluding the reception and use of AIS transmissions except by MariTEL, the Coast Guard and ship stations. However, precluding other entities from acquiring and using AIS information, or allowing such access and use only upon payment to MariTEL, could inhibit domestic implementation of AIS, could preclude beneficial public/private cooperative arrangements between the Coast Guard and private maritime associations, and could otherwise impede efficient AIS implementation. Finally, the MariTEL sharing proposal calls for the Commission to modify the technical requirements for AIS devices in order to prevent interference from AIS operations on Channels 87B and 88B to adjacent channel VPC channels. The AIS technical requirements are based on the international standards, and the Commission tentatively concludes that it should not revise those requirements unilaterally, and effectively abandon the standards-setting efforts to date, solely at the behest of and for the benefit of a single company. This is especially so because some of the mandatory AIS carriage deadlines have come into effect, and it is at best uncertain that the Commission could develop new technical requirements soon enough to give vessel operators a reasonable opportunity to come into compliance.

I. Procedural Matters

A. Ex Parte Rules—Permit-But-Disclose Proceeding

8. This is a permit-but-disclose notice and comment rulemaking proceeding. Ex parte presentations are permitted, except during the Sunshine Agenda period, provided they are disclosed as provided in the Commission's rules.

B. Comment Dates

9. Pursuant to sections 1.415 and 1.419 of the Commission's rules, 47 CFR 1.415, 1.419, interested parties may file comments on or before December 30, 2004 and reply comments on or before January 31, 2005. Comments may be filed using the Commission's Electronic Comment Filing System (ECFS) or by filing paper copies.

10. Comments filed through the ECFS can be sent as an electronic file via the Internet to *http://www.fcc.gov/e-file/ecfs.html.* Generally, only one copy of an electronic submission must be filed. If multiple docket or rulemaking numbers appear in the caption of this proceeding, however, commenters must transmit one electronic copy of the comments to each docket or rulemaking number referenced in the caption. In completing the transmittal screen, commenters should include their full name, Postal Service mailing address, and the applicable docket or rulemaking number. Parties may also submit an electronic comment by Internet e-mail. To get filing instructions for e-mail comments, commenters should send an e-mail to *ecfs@fcc.gov,* and should include the following words in the body of the message, ''get form <your e-mail address>.'' A sample form and directions will be sent in reply. Parties who choose to file by paper must file an original and four copies of each filing. If more than one docket or rulemaking number appears in the caption of this proceeding, commenters must submit two additional copies for each additional docket or rulemaking number. All filings must be addressed to the Commission's Secretary, Marlene H. Dortch, Office of the Secretary, Federal Communications Commission, 445 12th

St., SW., Washington, DC 20554. Filings can be sent first class by the U.S. Postal Service, by an overnight courier or hand and message-delivered. Hand and message-delivered paper filings must be delivered to 236 Massachusetts Avenue, NE., Suite 110, Washington, DC 20002. Filings delivered by overnight courier (other than U.S. Postal Service Express Mail and Priority Mail) must be sent to 9300 East Hampton Drive, Capitol Heights, MD 20743.

11. Parties who choose to file by paper should also submit their comments on diskette. These diskettes should be submitted to: Jeffrey Tobias, Wireless Telecommunications Bureau, 445 12th St., SW., Room 3–A432, Washington, DC 20554. Such a submission should be on a 3.5 inch diskette formatted in an IBM compatible format using Microsoft Word or compatible software. The diskette should be accompanied by a cover letter and should be submitted in ''read only'' mode. The diskette should be clearly labeled with the commenter's name, proceeding (including the docket number in this case, WT Docket No. 04–344), type of pleading (comment or reply comment), date of submission, and the name of the electronic file on the diskette. The label should also include the following phrase ''Disk Copy—Not an Original.'' Each diskette should contain only one party's pleadings, preferably in a single electronic file. In addition, commenters should send diskette copies to the Commission's copy contractor, Best Copy and Printing, Inc., 445 12th St., SW., Room CY–B402, Washington, DC 20554.

C. Paperwork Reduction Act

12. This document does not contain proposed information collection(s) subject to the Paperwork Reduction Act of 1995 (PRA), Public Law 104–13. In addition, therefore, it does not contain any new or modified ''information collection burden for small business concerns with fewer than 25 employees,'' pursuant to the Small Business Paperwork Relief Act of 2002, Public Law 107–198, *see* 44 U.S.C. 3506(c)(4).

II. Initial Regulatory Flexibility Analysis

13. As required by the Regulatory Flexibility Act (RFA), the Commission has prepared this present Initial Regulatory Flexibility Analysis (IRFA) of the possible significant economic impact on small entities by the policies and rules proposed in the *Notice of Proposed Rule Making* in WT Docket No. 04–344 (*NPRM*). Written public comments are requested on this IRFA. Comments must be identified as responses to the IRFA and must be filed by the deadlines for comments on the *NPRM* as provided in paragraph 70, *supra*, of the item. The Commission will send a copy of the *NPRM*, including the IRFA, to the Chief Counsel for Advocacy of the U.S. Small Business Administration. In addition, the *NPRM* and IRFA (or summaries thereof) will be published in the **Federal Register**.

A. Need for, and Objectives of, the Proposed Rules

14. In the *NPRM*, we seek comment on rule amendments that are intended to identify the spectrum that should be used for maritime Automatic Identification Systems (AIS) in the United States and its territorial waters. AIS is an important tool for enhancing maritime safety and homeland security, and we are concerned that recent developments may have created uncertainty in the maritime community regarding the very high frequency (VHF) channels to be used for AIS, and that this in turn could impede efforts to expedite the broad deployment of AIS domestically. In the *NPRM*, we propose to designate VHF maritime Channels 87B and 88B for AIS use domestically, in keeping with the international allocation of those channels for AIS, because we believe the use of those channels will best secure to the United States the maritime safety and homeland security benefits of AIS.

B. Legal Basis for Proposed Rules

15. The proposed action is authorized under sections 1, 4(i), 302, 303(f) and (r), and 332 of the Communications Act of 1934, as amended, 47 U.S.C. 1, 154(i), 302, 303(f) and (r), and 332.

C. Description and Estimate of the Number of Small Entities To Which the Proposed Rules Will Apply

16. The RFA directs agencies to provide a description of and, where feasible, an estimate of the number of small entities that may be affected by the proposed rules, if adopted. The RFA defines the term ''small entity'' as having the same meaning as the terms ''small business,'' ''small organization,'' and ''small governmental jurisdiction.'' In addition, the term ''small business'' has the same meaning as the term ''small business concern'' under the Small Business Act. A small business concern is one which: (1) Is independently owned and operated; (2) is not dominant in its field of operation; and (3) satisfies any additional criteria established by the Small Business Administration (SBA).

17. Small businesses in the aviation and marine radio services use a very high frequency (VHF) marine or aircraft radio and, as appropriate, an emergency position-indicating radio beacon (and/or radar) or an emergency locator transmitter. The Commission has not developed a small business size standard specifically applicable to these small businesses. For purposes of this analysis, the Commission uses the SBA small business size standard for the category ''Cellular and Other Telecommunications,'' which is 1,500 or fewer employees. Between December 3, 1998 and December 14, 1998, the Commission held an auction of 42 VHF Public Coast (VPC) licenses in the 157.1875–157.4500 MHz (ship transmit) and 161.775–162.0125 MHz (coast transmit) bands. For purposes of the auction, the Commission defined a ''small'' business as an entity that, together with controlling interests and affiliates, has average gross revenues for the preceding three years not to exceed fifteen million dollars. In addition, a ''very small'' business is one that, together with controlling interests and affiliates, has average gross revenues for the preceding three years not to exceed three million dollars. There are approximately 10,672 licensees in the Marine Coast Service, and the Commission estimates that almost all of them qualify as ''small'' businesses under the above special small business size standards.

D. Description of Projected Reporting, Recordkeeping, and Other Compliance Requirements

18. There are no projected reporting, recordkeeping or other compliance requirements.

E. Steps Taken To Minimize Significant Economic Impact on Small Entities, and Significant Alternatives Considered

19. The RFA requires an agency to describe any significant alternatives that it has considered in reaching its proposed approach, which may include the following four alternatives: (1) The establishment of differing compliance or reporting requirements or timetables that take into account the resources available to small entities; (2) the clarification, consolidation, or simplification of compliance or reporting requirements under the rule for small entities; (3) the use of performance, rather than design standards; and (4) an exemption from coverage of the rule, or any part thereof, for small entities.

In the *NPRM*, we request comment on the proposal to designate Channels 87B and 88B for exclusive AIS use. We

describe here, and seek comment on, possible alternatives to imposing these new rules that might minimize the economic impact on small entities. First, we ask commenters to consider the interference impact on MariTEL, Inc., licensee of the nine maritime VPC service areas, or on any incumbent site-based VPC licensees or any Economic Area (EA) VPC licensees of the proposed designation of Channels 87B and 88B for AIS exclusively. We tentatively conclude that the proposed designation of Channels 87B and 88B for AIS should not have an adverse effect on MariTEL's use of its VPC channels to a materially greater extent, if at all, than would designation of two narrowband offset channel pairs of the Commission's choosing from the 156–162 MHz VHF maritime band. We request comment on this tentative conclusion. In addition, commenters are asked if incumbent site based VPC operations can co-exist on a non-interference basis with AIS and, if not, should the Commission require that that these operations be migrated to other spectrum and/or should the licensees be compensated in some way.

20. Commenters are requested to identify potential means of minimizing or eliminating any adverse economic impact on any small entities, particularly VPC licensees that qualify as small entities, if Channels 87B and 88B are designated for AIS use. Such means may include, but are not limited to, exemptions, grandfathering protection, or geographic limitations on the use of Channels 87B and 88B for AIS. Additionally or alternatively, we seek comment on whether we could provide replacement spectrum for licensees who may find themselves unable to continue using their licensed VPC channels because of our proposal. For example, we might be able to modify their licenses to provide other channels in lieu of Channels 87B and 88B. We also could designate channels other than Channels 87B and 88B for AIS use in the United States as a means of minimizing any adverse economic impact on these licensee. We note, however, that mandating use of channels other than Channels 87B and 88B for AIS use in the United States may have an adverse economic impact on vessel operators and radio equipment manufacturers that qualify as small entities by, for example, increasing the cost of AIS equipment, causing premature obsolescence of AIS equipment already installed on vessels, or leaving manufacturers with stranded inventory. Accordingly, commenting parties, and particularly commenting parties who favor adopting an alternative to the Commission's proposal, are asked to address the potential economic impact of that alternative on small entities.

21. In Appendix D of the *NPRM*, we list all of the incumbent site-based licensees that currently operate within VHF Public Coast Service Areas (VPCSAs) 1–9 on the channels which we are proposing to designate for exclusive AIS use. We assume for purposes of this IRFA that some or all of these licensees qualify as small entities. We specifically invite these licensees to address the expected economic impact on them of our proposal, and to suggest alternatives or additions to our proposal that would minimize that impact, including but not limited to the methods discussed in the preceding paragraph.

22. We also note that there are incumbent licensees operating on the specified channels in inland areas. We do not anticipate any significant adverse effect on any such licensee due to the geographic limitations of our proposal, *i.e.*, our limiting the AIS set-aside to areas near major navigable waterways. Commenters who believe differently are asked to describe the expected adverse economic impact on incumbent inland licensees operating on these or adjacent channels, and to provide suggested methods of minimizing any such impact. In addition, we note that, although we are proposing only to designate Channels 87B and 88B for AIS in the nine maritime VPCSAs, we have not foreclosed the possibility of designating those channels for AIS on a nationwide basis. Accordingly, inland licensees and other interested parties should address the possible economic impact on small entities if we were to designate Channels 87B and 88B for AIS in inland areas as well as the nine maritime VPCSAs.

F. Federal Rules That May Duplicate, Overlap, or Conflict With the Proposed Rules

None.

III. Ordering Clauses

23. The Commission's Consumer Information Bureau, Reference Information Center, SHALL SEND a copy of this NPRM, including the Initial Regulatory Flexibility Analysis, to the Chief Counsel for Advocacy of the Small Business Administration.

List of Subjects in 47 CFR Parts 2 and 80

Communications equipment, Radio.

Federal Communications Commission.

Marlene H. Dortch,

Secretary.

Proposed Rules

For the reasons discussed in the preamble, the Federal Communications Commission proposes to amend 47 CFR parts 2 and 80 as follows:

PART 2—FREQUENCY ALLOCATIONS AND RADIO TREATY MATTERS; GENERAL RULES AND REGULATIONS

1. The authority citation for part 2 continues to read as follows:

Authority: 47 U.S.C. 154, 302a, 303, and 336, unless otherwise noted.

2. Section 2.106, the Table of Frequency Allocations, is amended as follows:

a. Revise pages 30 and 31.

b. In the list of United States (US) Notes, add note USxxx and remove note US223.

§ 2.106 Table of Frequency Allocations.

The revisions and additions read as follows:

* * * * *

BILLING CODE 6712–01–P

156.7625-156.8375 MARITIME MOBILE (distress and calling) 5.111 5.226		5.226 5.227 US77 US106 US107 US266	5.226 5.227 US77 US106 US107 US266 NG117	
156.8375-174 FIXED MOBILE except aeronautical mobile	156.8375-174 FIXED MOBILE	157.0375-157.1875 MARITIME MOBILE 5.226 US214 US266 G109	157.0375-157.1875 5.226 US214 US266	Private Land Mobile (90)
		157.1875-157.45 5.226 US266	157.1875-157.45 LAND MOBILE MARITIME MOBILE 5.226 US266 NG111	Maritime (80) Private Land Mobile (90)
		157.45-161.575 5.226 US266	157.45-161.575 FIXED LAND MOBILE 5.226 US266 NG6 NG28 NG70 NG111 NG112 NG124 NG148 NG155	Public Mobile (22) Maritime (80) Private Land Mobile (90)
		161.575-161.625 5.226 US77	161.575-161.625 MARITIME MOBILE 5.226 US77 NG6 NG17	Public Mobile (22) Maritime (80)
		161.625-161.775 5.226	161.625-161.775 LAND MOBILE 5.226 NG6	Public Mobile (22) Auxiliary Broadcasting (74)
		161.775-162.0125 5.226 US266 **USxxx**	161.775-162.0125 LAND MOBILE MARITIME MOBILE 5.226 US266 **USxxx** NG6	Public Mobile (22) Maritime (80) Private Land Mobile (90)
5.226 5.229	5.226 5.230 5.231 5.232	See next page for 162.0125-174 MHz		See next page for 162.0125-174 MHz

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162.0125-322 MHz (VHF/UHF)					Page 31
International Table			United States Table		FCC Rule Part(s)
Region 1	Region 2	Region 3	Federal Government	Non-Federal Government	
See previous page for 156.8375-174 MHz			162.0125-173.2 FIXED MOBILE 5.226 US8 US11 US13 US216 US300 US312 **USxxx** G5	162.0125-173.2 5.226 US8 US11 US13 US216 US300 US312 **USxxx**	Auxiliary Broadcasting (74) Maritime (80) Private Land Mobile (90)
			173.2-173.4	173.2-173.4 FIXED Land mobile	Private Land Mobile (90)
			173.4-174 FIXED MOBILE G5	173.4-174	
174-223 BROADCASTING	174-216 BROADCASTING Fixed Mobile 5.234	174-223 FIXED MOBILE BROADCASTING	174-216	174-216 BROADCASTING NG115 NG128 NG149	Broadcast Radio (TV) (73) Auxiliary Broadcasting (74)
	216-220 FIXED MARITIME MOBILE Radiolocation 5.241 5.242		216-220 Fixed Mobile Radiolocation 5.241 G2 US210 US229	216-220 FIXED MOBILE except aeronautical mobile US210 US229 NG152 NG173	Maritime (80) Private Land Mobile (90) Personal Radio (95) Amateur (97)
	220-225 AMATEUR FIXED MOBILE Radiolocation 5.241		220-222 FIXED LAND MOBILE Radiolocation 5.241 G2 US335	220-222 FIXED LAND MOBILE US335	Private Land Mobile (90)
5.235 5.237 5.243		5.233 5.238 5.240 5.245	222-225 Radiolocation 5.241 G2	222-225 AMATEUR	Amateur (97)

United States (US) Notes

* * * * *

USxxx The bands 161.9625–161.9875 MHz (AIS 1 with its center frequency at 161.975 MHz) and 162.0125–162.0375 MHz (AIS 2 with its center frequency at 162.025 MHz) are allocated to the maritime mobile service on a primary basis for Federal and non-Federal Government use in VHF Public Coast Station Areas (VPCSAs) 1–9. In these areas, the maritime mobile service shall be used exclusively for Automatic Identification Systems (AIS). In VPCSAs 10–42, the band 161.9625–161.9875 MHz is allocated to the maritime mobile service on a primary basis for exclusive non-Federal Government use and the 162.0125–162.0375 MHz is allocated to the fixed and mobile services on a primary basis for exclusive Federal Government use. See 47 CFR 80.371(c)(1)(ii) for the definitions of VPCSAs.

* * * * *

PART 80—STATIONS IN THE MARITIME SERVICES

3. The authority citation for part 80 continues to read as follows:

Authority: Secs. 4, 303, 307(e), 309, and 332, 48 Stat. 1066, 1082, as amended; 47 U.S.C. 154, 303, 307(e), 309, and 332, unless otherwise noted. Interpret or apply 48 Stat. 1064–1068, 1081–1105, as amended; 47 U.S.C. 151–155, 301–609; 3 UST 3450, 3 UST 4726, 12 UST 2377.

4. Section 80.5 is amended by adding an entry for ''Automatic Identification Systems (AIS)'' in alphabetical order to read as follows:

§ 80.5 Definitions.

* * * * *

Automatic Identification Systems (AIS). A maritime navigation safety communications system standardized by the International Telecommunication Union (ITU) that provides vessel information, including the vessel's identity, type, position, course, speed, navigational status and other safety-related information automatically to appropriately equipped shore stations, other ships, and aircraft; receives automatically such information from similarly fitted ships; monitors and tracks ships; and exchanges data with shore-based facilities.

* * * * *

5. Section 80.13 is amended by revising paragraph (c) to read as follows:

§ 80.13 Station license required.

* * * * *

(c) A ship station is licensed by rule and does not need an individual license issued by the FCC if the ship station is not subject to the radio equipment carriage requirements of any statute, treaty or agreement to which the United States is signatory, the ship station does not travel to foreign ports, and the ship station does not make international communications. A ship station licensed by rule is authorized to transmit radio signals using a marine radio operating in the 156–162 MHz band, any type of AIS, any type of EPIRB, and any type of radar installation. All other transmissions must be authorized under a ship station license. Even though an individual license is not required, a ship station licensed by rule must be operated in accordance with all applicable operating requirements, procedures, and technical specifications found in this part.

6. Section 80.371 is amended by revising paragraphs (c)(1)(i), (c)(2) and (c)(3) to read as follows:

§ 80.371 Public correspondence frequencies.

* * * * *

(c) *Working frequencies in the marine VHF 156–162 MHz band.* (1)(i) The frequency pairs listed in the following table are available for assignment to public coast stations for public correspondence communications with ship stations and units on land.

WORKING CARRIER FREQUENCY PAIRS IN THE 156–162 MHZ BAND [1]

Channel designator	Carrier frequency (MHz)	
	Ship transmit	Coast transmit
24	157.200	161.800
84	157.225	161.825
25	157.250	161.850
85 [2]	157.275	161.875
26	157.300	161.900
86	157.325	161.925
27	157.350	161.950
87 [3]	157.375	157.375
28	157.400	162.000
88 [4]	157.425	157.425

[1] For special assignment of frequencies in this band in certain areas of Washington State, the Great Lakes and the east coast of the United States pursuant to arrangements between the United States and Canada, *see* subpart B of this part.

[2] The frequency pair 157.275/161.875 MHz is available on a primary basis to ship and public coast stations. In Alaska it is also available on a secondary basis to private mobile repeater stations.

[3] Within VHF Public Coast Station Areas (VPCSAs) 1 through 9 listed in the table in paragraph (c)(1)(ii) of this section, the frequency 161.975 MHz may be used only for Automatic Identification System communications.

[4] Within that portion of VHF Public Coast Station Areas (VPCSAs) 1 through 9 listed in the table in paragraph (c)(1)(ii) of this section within 120 km (75 miles) of the United States/Canada border, in the area of the Great Lakes, the Saint Lawrence Seaway, and the Puget Sound and the Strait of Juan de Fuca and its approaches, the frequency 157.425 MHz is available for use by ship stations for public correspondence communications and the frequency 162.025 MHz is available only for Automatic Identification System communications. One hundred twenty kilometers (75 miles) from the United States/Canada border 157.425 MHz is available for intership and commercial communications. Outside the Puget Sound area and its approaches and the Great Lakes, 157.425 MHz is available for communications between commercial fishing vessels and associated aircraft while engaged in commercial fishing activities.

* * * * *

(2) Any recovered channel pairs will revert automatically to the holder of the VPCSA license within which such channels are included, except the channel pairs listed in the table in paragraph (c)(1)(i) of this section. Those channel pairs, and any channel pairs recovered where there is no VPCSA licensee, will be retained by the Commission for future licensing.

(3) VPCSA licensees may not operate on Channel 228B (162.0125 MHz), which is available for use in the Coast Guard's Ports and Waterways Safety System (PAWSS). In addition, VPCSA licensees in VPCSAs 1–9 may not operate on Channel AIS 1 (161.975 MHz) or Channel AIS 2 (162.025 MHz), which are designated in those areas exclusively for Automatic Identification Systems (AIS), except to transmit and receive AIS communications to the same extent, and subject to the same limitations, as other shore stations participating in AIS.

* * * * *

7. Section 80.373 is amended by revising paragraph (j) to read as follows:

§ 80.373 Private communications frequencies.

* * * * *

(j) *Frequencies for portable ship stations.* VHF frequencies authorized for stations authorized carrier frequencies in the 156.275 MHz to 157.450 MHz and 161.575 MHz to 162.025 MHz bands may also be authorized as marine utility stations. Marine-utility stations on shore must not cause interference to any Automatic Identification System, VHF or coast station, VHF or UHF land mobile base station, or U.S. Government station.

8. Section 80.393 is added to read as follows:

§ 80.393 Frequencies for AIS stations.

Automatic Identification Systems (AIS) is a maritime broadcast service provided by both the United States

Coast Guard and Commission licensees. The simplex channels at 161.975 MHz (AIS 1) and 162.025 MHz (AIS 2), each with a 25 kHz bandwidth, may be authorized in VHF Public Coast Station Areas 1–9 for AIS. These areas are codified at 47 CFR 80.371(c)(1)(ii). In accordance with the Maritime Transportation Security Act, the United States Coast Guard regulates AIS carriage requirements for non-Federal Government ships. These requirements are codified at 33 CFR 164.46, 401.20.

[FR Doc. 04–25289 Filed 11–12–04; 8:45 am]

BILLING CODE 6712–01–P

Notices

Federal Register
Vol. 69, No. 219
Monday, November 15, 2004

This section of the FEDERAL REGISTER contains documents other than rules or proposed rules that are applicable to the public. Notices of hearings and investigations, committee meetings, agency decisions and rulings, delegations of authority, filing of petitions and applications and agency statements of organization and functions are examples of documents appearing in this section.

DEPARTMENT OF AGRICULTURE

Forest Service

Bridger-Teton National Forest-Wyoming—Kemmerer and Greys River Ranger Districts; Lincoln County, WY Salt Pass Grazing Allotments Environmental Impact Statement.

AGENCY: Forest Service, USDA.

ACTION: Notice of intent to prepare an environmental impact statement.

SUMMARY: The Department of Agriculture, Forest Service, will prepare An Environmental Impact Statement (EIS) to analyze the effects of domestic livestock grazing in the Salt Pass area. The Salt Pass Grazing Allotments (composed of Giraffe, Lower Salt, Porcupine, Smiths Fork, Buckskin Knoll, Lake Alice, North Salt River, South Salt River domestic sheep allotments and Trespass domestic cattle allotment) are located in Township 28, 29, 30 North, and Range 116, 117, 118, 119 West; Sixth Principal Meridian. The allotments are located entirely within Lincoln County. The allotments are located on two ranger districts, Kemmerer and Greys River. The Kemmerer Ranger District administers all the allotments except North Salt River and South Salt River, which are administered by the Greys River Ranger District.

DATES: Comments concerning the scope of the analysis must be received by December 17, 2005. The draft environmental impact statement is expected in April 2005 and the final environmental impact statement is expected by July 2005.

ADDRESSES: Send written comments to: Russ Bacon, District Ranger, Kemmerer Ranger District, P.O. Box 31, Kemmerer, Wyoming 83101. For further information, mail correspondence to *mailroom_r4_bridger_teton@fs.fed.us* and on the subject line put only ''Salt Pass Allotments''.

FOR FURTHER INFORMATION CONTACT: Russ Bacon, Kemmerer District Ranger, Kemmerer Ranger District, P.O. Box 31, Kemmerer, Wyoming 83101 or phone (307) 877-4415.

SUPPLEMENTARY INFORMATION:

Purpose and Need for Action

This proposal, in part, is to comply with Public Law 104–19, section 504(a): establish and adhere to a schedule for the completion of National Environmental Policy Act (NEPA) of 1969 (42 U.S.C. 4321 *et seq.*) analysis and decision on all grazing allotments within the National Forest System unit for which NEPA is needed (Pub. L. 104–19, General Provision 1995). Upon completion of the NEPA analysis and decisions for the allotments, the terms and conditions of the existing grazing permits will be modified, as necessary, to conform to such NEPA analysis. In addition, the purpose of the proposed action is to improve range condition and trend and achieve desired conditions within the project area through livestock grazing.

Proposed Action

The proposed action is to authorize continued livestock grazing, provide analysis and data to update allotment management plans (AMPs), and allow livestock grazing that meets or moves existing resources conditions toward desired conditions on National Forest grazing allotments while complying with applicable statutes. Adaptive management, which allows flexibility during the implementation of the grazing strategy, would allow managers to make adjustments and corrections to management based on monitoring.

Possible Alternatives

Grazing as Currently Permitted: Although allotment management plans (AMP's) would be prepared for each of the nine allotments, the grazing management practices specified for the allotments with existing AMP's would not be changed. In addition, no new utilization standards would be initiated to move existing resource conditions in the project area toward the desired future conditions (DFC's) specified in the Forest Plan.

No Grazing by Domestic Livestock (No grazing alternative): This would eliminate livestock grazing in the project area. This alternative was developed to demonstrate the effects that eliminating livestock grazing would have on the environment and to more clearly illustrate the potential effects of implementing other alternatives. Under this alternative, domestic livestock grazing on all nine allotments within the project area would be phased out over several years as existing Term Grazing Permits expire.

Responsible Official

Russell Bacon, District Forest Ranger, Kemmerer Ranger District, P.O. Box 31, Kemmerer, Wyoming 83101 and Charlene Bucha-Gentry, District Forest Ranger, Greys River Ranger District, P.O. Box 339, Afton, Wyoming 83110.

Nature of Decision To Be Made

The decision, which is based on this analysis, will be to decide if livestock will be allowed to graze on the allotment complex, either through the implementation of the proposed action, or an alternative to the proposed action. The decision would include any mitigation measures needed in addition to those prescribed in the Forest Plan.

Scoping Process

Forest Service is seeking information, comments, and assistance from individuals, organizations, tribal governments, and federal, state, and local agencies interested in or affected by this project. This analysis is for nine grazing allotments. The decision will have limited environmental effects outside the allotment boundaries, and the economic impacts are localized. Public participation will be solicited by notifying in person and/or by mail known interested affected publics. News releases will be used to give the public general notice. Public participation activities would include requests for written comments. The first formal opportunity to comment is to respond to this notice of intent, which initiates the scoping process (40 CFR 1501.7). Scoping includes: (1) Identifying potential issues, (2) narrowing the potential issues and identifying significant issues of those that have been covered by prior environmental review, (3) exploring alternatives in addition to No Action, and (4) identifying potential environmental effects of the proposed action and alternatives.

Preliminary Issues

The Forest Service has identified the following potential issues. Your input is especially valuable here. It will help us determine which of these merit detailed analysis. It will also help identify additional issues related to the proposed action that may not be listed here.

- Effects of grazing on soil erosion and productivity.
- Effects of grazing on watershed condition and function.
- Effects of grazing on the life cycle of the Bonneville and Snake River cutthroat trout.

Comment Requested

This notice of intent initiates the scoping process which guides the development of the environmental impact statement.

Early Notice of Importance of Public Participation in Subsequent Environmental Review: A draft environmental impact statement will be prepared for comment. The comment period on the draft environmental impact statement will be 45 days from the date the Environmental Protection Agency publishes the notice of availability in the **Federal Register**.

The Forest Service believes, at this early stage, it is important to give reviewers notice of: several court rulings related to public participation in the environmental review process. First, reviewers of draft environmental impact statements must structure their participation in the environmental review of the proposal so that it is meaningful and alerts an agency to the reviewer's position and contention. *Vermont Yankee Nuclear Power Corp* v. *NRDC*, 435 U.S. 519, 533 (1978). Also, environmental objections that could be raised at the draft environmental impact statement stage but that are not raised until after completion of the final environmental impact statement may be waived or dismissed by the courts. *City of Angoon* v. *Hodel*, 803 F.2d 1016, 1022 (9th Cir. 1986) and *Wisconsin Heritages, Inc.* v. *Harris*, 490 F. Supp. 1334, 1338 (E.D. Wis. 1980). Because of these court rulings, it is very important that those interested in this proposed action participate by the close of the 45 day comment period so that substantive comments and objections are made available to the Forest Service at a time when it can meaningully consider them and respond to them in the final environmental impact statement.

To assist the Forest Service in identifying and considering issues and concerns on the proposed action, comments on the draft environmental impact statement should be as specific as possible. It is also helpful if comments refer to specific pages or chapters of the draft statement. Comments may also address the adequacy of the draft environmental impact statement or the merits of the alternatives formulated and discussed in the statement. Reviewers may wish to refer to the Council on Environmental Quality Regulations for implementing the procedural provisions of the National Environmental Policy Act at 40 CFR 1503.3 in addressing these points.

Comments received, including the names and addresses of those who comment, will be considered part of the public record on this proposal and will be available for public inspection.

(Authority: 40 CFR 1501.7 and 1508.22; Forest Service Handbook 1909.15, Section 21.)

Dated: November 4, 2004.

Fred Fouse,

Acting District Ranger.

[FR Doc. 04–25249 Filed 11–12–04; 8:45 am]

BILLING CODE 3410–11–M

DEPARTMENT OF AGRICULTURE

Natural Resources Conservation Service

Notice of Proposed Change to the Natural Resources Conservation Service's National Handbook of Conservation Practices

AGENCY: Natural Resources Conservation Service (NRCS), U.S. Department of Agriculture, Maine State Office.

ACTION: Notice of availability of proposed changes in the NRCS National Handbook of Conservation Practices, Section IV of the Maine State NRCS Field Office Technical Guide (FOTG) located at *http://www.me.nrcs.usda.gov* under ''Draft Standards for Comments'' for review and comment.

SUMMARY: It is the intention of NRCS to issue revised conservation practice standards in its National Handbook of Conservation Practices. These revised standards are the following:

314 Brush Management; 329 Residue Management, Ridge-Till; 340 Cover Crop; 342 Critical Area Planting; 344 Residue Management, Seasonal; 386 Field Border; 511 Forage Harvest Management; 512 Pasture and Hay Planting; 528 Animal Trails and Walkways; 590 Nutrient Management; 557 Row Arrangement.

DATES: Comments will be received for a 30-day period commencing with this date of publication.

FOR FURTHER INFORMATION CONTACT: Inquire in writing to Christopher R. Jones, State Resource Conservationist, Natural Resources Conservation Service (NRCS), 967 Illinois Avenue, Suite #3, Bangor, Maine 04401.

A copy of these standards are available from the above individual.

SUPPLEMENTARY INFORMATION: Section 343 of the Federal Agricultural Improvement and Reform Act of 1966 states that revisions made after enactment of the law to NRCS State Technical Guides used to carry out highly erodible land and wetland provisions of the law shall be made available for public review and comment. For the next 30 days the NRCS will receive comments relative to the proposed changes. Following that period a determination will be made by the NRCS regarding disposition of those comments and a final determination of change will be made.

Dated: November 4, 2004.

Christopher R. Jones,

State Resource Conservationist.

[FR Doc. 04–25246 Filed 11–12–04; 8:45 am]

BILLING CODE 3410–16–P

COMMISSION ON CIVIL RIGHTS

Agenda and Notice of Public Meeting of the Vermont Advisory Committee

Notice is hereby given, pursuant to the provisions of the rules and regulations of the U.S. Commission on Civil Rights that a conference call of the Vermont Advisory Committee will convene at 10:30 a.m. and adjourn at 11 a.m., Tuesday, November, 16, 2004. The purpose of the conference call is to discuss juvenile justice issues in Vermont.

This conference call is available to the public through the following call-in number: 1–800–659–8294, access code: 30141003. Any interested member of the public may call this number and listen to the meeting. Callers can expect to incur charges for calls not initiated using the supplied call-in number or over wireless lines, and the Commission will not refund any incurred charges. Callers will incur no charge for calls using the call-in number over land-line connections. Persons with hearing impairments may also follow the proceedings by first calling the Federal Relay Service at 1–800–977–8339 and providing the Service with the conference call number and access code.

To ensure that the Commission secures an appropriate number of lines for the public, persons are asked to register by contacting Barbara de La

Viez of the Eastern Regional Office at 202–376–7533 by 4 p.m. on Monday, November 15, 2004.

The meeting will be conducted pursuant to the provisions of the rules and regulations of the Commission.

Dated in Washington, DC, November 8, 2004.

Ivy L. Davis,

Chief, Regional Programs Coordination Unit.

[FR Doc. 04–25248 Filed 11–12–04; 8:45 am]

BILLING CODE 6335–01–P

DEPARTMENT OF COMMERCE

Foreign-Trade Zones Board

[Docket 47–2004]

Foreign-Trade 243—Victorville, CA; Application for Expansion

An application has been submitted to the Foreign-Trade Zones (FTZ) Board (the Board) by the Southern California Logistics Airport Authority, grantee of Foreign-Trade Zone 243, requesting authority to expand its zone to include additional sites in the Victorville area, within and adjacent to the Victorville Customs user fee airport and the Los Angeles-Long Beach Customs port of entry. The application was submitted pursuant to the provisions of the Foreign-Trade Zones Act, as amended (19 U.S.C. 81a–81u), and the regulations of the Board (15 CFR Part 400). It was formally filed on October 29, 2004.

FTZ 243 was approved on July 26, 2000 (Board Order 1097, 65 FR 47953, 8/4/00). The general-purpose zone project currently consists of the following site: *Site 1* (1,954 acres) consists of: Parcel 1 (1,943 acres)—Southern California Logistics Airport complex located at 18374 Phantom, Victorville; Parcel 2 (7 acres, 287,060 sq. ft.)—located at 19317 Arenth Avenue, Industry (expires 1/31/05); Parcel 3 (1 acre, 35,283 sq. ft.)—located at 13731 Proctor Avenue, Industry (expires 1/31/05); and, Parcel 4 (3 acres, 156,816 sq. ft.)—located at 3525 Walnut Avenue, Chino (expires 1/31/05).

The applicant is now requesting authority for a major expansion of the zone as described below. The proposal requests authority to expand the zone to include nine additional sites in the cities of Industry, Whittier, Chino and Rialto, California.

Proposed Site 2 (7 acres)—Golden State Foods warehouse located at 19317 Arenth Avenue, Industry (this site will include Site 1-Parcel 2 on a permanent basis);

Proposed Site 3 (4 acres)—Proctor Warehouse located at 13731 Proctor Avenue, Industry (this site will include Site 1-Parcel 3 on a permanent basis);

Proposed Site 4 (179 acres, 13 parcels)—located within the 186-acre Fairway Business Center in the City of Industry;

Proposed Site 5 (318 acres)—Grand Crossing Industrial Park located at the intersection of the Pomona (60) and Orange (57) Freeways in the City of Industry;

Proposed Site 6 (70 acres)—Gateway Pointe Industrial Park located at the intersection of the Pomona (60) and San Gabriel River (605) Freeways in the City of Whittier;

Proposed Site 7 (4 acres)—FBC Industries warehouse facility located at 3525 Walnut Avenue, Chino (this site will include Site 1-Parcel 4 on a permanent basis);

Proposed Site 8 (14 acres, 2 parcels)—Schaefer Warehouse (Parcel 1, 7 acres) located at 5125 Schaefer Avenue and Pacific Warehouse (Parcel 2, 7 acres) located at 5085 Schaefer Avenue, Chino;

Proposed Site 9 (8 acres)—Eucalyptus Warehouse located at 4340 Eucalyptus Avenue, Chino; and,

Proposed Site 10 (91 acres)—located within the 138-acre ProLogis Park I–210 at the Alder Interchange and Interstate 210 extension in the City of Rialto.

The applicant is also requesting that 11 acres at *Site 1* (Southern California Logistics Airport) be restored to zone status and that Parcels 2, 3 and 4 be granted zone status on a permanent basis as noted above. (A minor boundary modification was approved in December 2003 (A(27f)–60–2003), removing 11 acres from Site 1 (Southern California Logistics Airport) to establish the temporary parcels.) No specific manufacturing requests are being made at this time. Such requests would be made to the Board on a case-by-case basis.

In accordance with the Board's regulations, a member of the FTZ Staff has been designated examiner to investigate the application and report to the Board.

Public comment on the application is invited from interested parties. Submissions (original and 3 copies) shall be addressed to the Board's Executive Secretary at one of the addresses below:

1. *Submissions via Express/Package Delivery Services:* Foreign-Trade Zones Board, U.S. Department of Commerce, Franklin Court Building—Suite 4100W, 1099 14th Street NW., Washington, DC 20005; or

2. *Submissions via the U.S. Postal Service:* Foreign-Trade Zones Board, U.S. Department of Commerce, FCB—Suite 4100W, 1401 Constitution Avenue, NW., Washington, DC 20230.

The closing period for their receipt is January 14, 2005. Rebuttal comments in response to material submitted during the foregoing period may be submitted during the subsequent 15-day period (to January 31, 2005).

A copy of the application and accompanying exhibits will be available for public inspection at the Office of the Foreign-Trade Zones Board's Executive Secretary at the first address listed above, and at the U.S. Department of Commerce, Export Assistance Center, 2940 Inland Empire Boulevard, Suite 121, Ontario, CA 91764.

Dated: November 4, 2004.

Dennis Puccinelli,

Executive Secretary.

[FR Doc. 04–25294 Filed 11–12–04; 8:45 am]

BILLING CODE 3510–D5–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

[I.D. 110904C]

Re-Initiation of Request for Nominations to the Marine Fisheries Advisory Committee (MAFAC)

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice of request for nominations.

SUMMARY: The Marine Fisheries Advisory Committee (the ''Committee) is the only Federal Advisory committee with the responsibility to advise the Secretary of Commerce (Secretary) on all matters concerning living marine resources that are the responsibility of the Department of Commerce. The Committee makes recommendations to the Secretary to assist in the development and implementation of Departmental regulations, policies and programs critical to the mission and goals of the National Marine Fisheries Service. The Committee is composed of leaders in the commercial, recreational, environmental, academic, state, tribal, and consumer interests from the nation's coastal regions.

On June 14, NMFS published a Notice requesting nominees for four vacancies on the Committee. The nomination ran through July 15, 2004, and resulted in the appointment of only two of the vacancies. Therefore, in keeping with the Administration's policy to ensure the Committee reflect a balanced

composition of national interests, expertise and geographic representation, the Administration has decided to reinitiate a request for additional nominations in the hopes of receiving a more diverse selection of qualified candidates to fill the remaining two vacancies in time for the Committee's next meeting in January 2005. The Department of Commerce is seeking up to two highly qualified individuals knowledgeable about fisheries and living marine resources to serve on the Committee.

DATES: Nominations must be postmarked on or before November 30, 2004.

ADDRESSES: Nominations should be sent to Laurel Bryant, Executive Director, MAFAC, Office of Constituent Services, NMFS, 1315 East-West Highway #9508, Silver Spring, Maryland 20910.

FOR FURTHER INFORMATION CONTACT: Laurel Bryant, Executive Director; (301) 713–2379 x171. E-mail: *Laurel.Bryant@noaa.gov*.

SUPPLEMENTARY INFORMATION: The establishment of MAFAC was approved by the Secretary on December 28, 1970, and initially chartered under the Federal Advisory Committee Act, 5, U.S.C. App.2, on February 17, 1971. The Committee meets twice a year with supplementary subcommittee meetings as determined necessary by the Secretary. Individuals serve for a term of three years for no more than two consecutive terms if re-appointed. No less that 15 and no more than 21 individuals may serve on the Committee. Membership is comprised of highly qualified individuals representing commercial and recreational fisheries interests, environmental organizations, academic institutions, governmental, tribal and consumer groups from a balance of geographical regions, including the Hawaiian and the Pacific Islands, and the U.S. Virgin Islands. Nominations are encouraged from all interested parties involved with or representing interests affected by Agency actions in managing living marine resources. Nominees should possess demonstrable expertise in a field related to the management of living marine resources and be able to fulfill the time commitments required for two meetings annually.

A MAFAC member cannot be a Federal agency employee or a member of a Regional Fishery Management Council. Selected candidates must have security checks and complete financial disclosure forms. Membership is voluntary, and except for reimbursable travel and related expenses, service is without pay.

Each submission should include the submitting person's or organization's name and affiliation, a cover letter describing the nominee's qualifications and interest in serving on the Committee, a curriculum vitae or resume of nominee, and no more than three supporting letters describing the nominee's qualifications and interest in serving on the Committee. Self-nominations are acceptable. The following contact information should accompany each nominee's submission: name, address, phone number, fax number, and e-mail address if available.

Nominations should be sent to (see **ADDRESSES**) and nominations must be received by (see **DATES**). The full text of the Committee Charter and its current membership can be viewed at the Agency's web page at *www.nmfs.noaa.gov/mafac.htm*.

Dated: November 9, 2004.

Alan D. Risenhoover,

Deputy Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. 04–25314 Filed 11–12–04; 8:45 am]

BILLING CODE 3510–22–S

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

[I.D. 102904C]

Endangered and Threatened Species; Take of Anadromous Fish

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Receipt of applications to renew and modify permit 1166 and request for comment.

SUMMARY: Notice is hereby given that NMFS has received an application to renew a permit for scientific research from A.A. Rich and Associates (AAR) in San Anselmo, California (1166). The permit would affect federally endangered Sacramento River winter-run Chinook salmon and Southern California steelhead, and threatened Central Valley steelhead, Central California Coast steelhead, and Central California Coast coho salmon. This document serves to notify the public of the availability of the permit applications for review and comment.

DATES: Written comments on the permit applications must be received no later than 5 p.m. Pacific Standard Time on December 15, 2004.

ADDRESSES: E-mailed comments on the permit applications must be sent to FRNpermits.SR@noaa.gov. The applications and related documents are available for review by appointment, for permit 1166: Protected Resources Division, NMFS, 777 Sonoma Avenue, Room 315, Santa Rosa, CA 95404 (ph: 707–575–6097, fax: 707–5783–435).

FOR FURTHER INFORMATION CONTACT: Jeffrey Jahn at phone number 707–575–6097, or e-mail: *Jeffrey.Jahn@noaa.gov*

SUPPLEMENTARY INFORMATION:

Authority

Issuance of permits and permit modifications, as required by the Endangered Species Act of 1973 (16 U.S.C. 1531 1543) (ESA), is based on a finding that such permits/modifications: (1) are applied for in good faith; (2) would not operate to the disadvantage of the listed species which are the subject of the permits; and (3) are consistent with the purposes and policies set forth in section 2 of the ESA. Authority to take listed species is subject to conditions set forth in the permits. Permits and modifications are issued in accordance with and are subject to the ESA and NMFS regulations governing listed fish and wildlife permits (50 CFR parts 222–226).

Those individuals requesting a hearing on an application listed in this notice should set out the specific reasons why a hearing on that application would be appropriate (see ADDRESSES). The holding of such a hearing is at the discretion of the Assistant Administrator for Fisheries, NOAA. All statements and opinions contained in the permit action summaries are those of the applicant and do not necessarily reflect the views of NMFS.

Species Covered in This Notice

This notice is relevant to federally endangered Sacramento River winter-run Chinook salmon (*Oncorhynchus tshawytscha*) and Southern California steelhead (*O. mykiss*), threatened Central Valley steelhead (*O. mykiss*), Central California Coast steelhead (*O. mykiss*), and Central California Coast coho salmon (*O. kisutch*). Application Received

AAR requests to renew and modify a 5–year permit (1166) for take of juvenile Sacramento River winter-run Chinook salmon and Central Valley steelhead to conduct pre-project fish surveys on the San Joaquin River and Old River in California. AAR requests authorization for an estimated annual take of 30 juvenile Sacramento River winter-run Chinook salmon and 80 juvenile Central Valley steelhead, with no more than 5 percent unintentional mortality to result

from capture by beach seine, scale samples, and release of fish.

AAR also requests take of juvenile Central California Coast steelhead and juvenile Central California Coast coho salmon to conduct pre- and post-project fish surveys, relocation activities, and fish monitoring activities in various streams in Marin, Sonoma and Mendocino counties. AAR requests authorization for an estimated annual take of 450 juvenile Central California Coast steelhead, and 50 juvenile Central California Coast coho salmon, with no more than 5 percent unintentional mortality to result from capture (dip net, seine, electrofishing) and release of fish.

In addition, AAR requests take of juvenile Southern California steelhead to conduct fish monitoring activities in Hilton Creek, tributary to the Santa Ynez River in Santa Barbara County. AAR requests authorization for an estimated annual take of 2 juvenile Southern California Coast steelhead with no more than 5 percent unintentional mortality to result from capture (dip net, seine, electrofishing) and release of fish.

Dated: November 9, 2004.

Phil Williams,

Chief, Endangered Species Division, Office of Protected Resources, National Marine Fisheries Service.

[FR Doc. 04–25316 Filed 11–12–04; 8:45 am]

BILLING CODE 3510–22–S

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

[I.D. 052104F]

Endangered and Threatened Species: Take of Threatened West Coast Salmonids

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice of Availability of Draft Environmental Assessment (EA) and Request for Comments.

SUMMARY: Notice is hereby given of the availability of a draft EA for NMFS' June 2004 proposed amendments to the Endangered Species Act (ESA) protective regulations for West Coast threatened salmon and steelhead (*Oncorhynchus* spp.) The ESA protective regulations provide for ''limits'' on ESA prohibitions for specified categories of activities determined to contribute to conserving listed salmonids. The draft EA analyzes the impacts of: (1) revising and simplifying existing protective regulations so that all threatened West Coast salmon and steelhead are subject to the same limits, and (2) revising the current protective regulations so that the section 9 take prohibitions do not apply to adipose-fin-clipped hatchery fish and resident O. mykiss (rainbow trout). NMFS is furnishing this notification to allow other agencies and the public an opportunity to review and comment on the draft EA. All comments received will become part of the public record and will be available for review.

DATES: All comments on the draft EA must be received no later than 5 p.m. Pacific Standard Time on December 15, 2004.

ADDRESSES: Copies of the draft EA are available on the Internet at *http://www.nwr.noaa.gov/1salmon/salmesa/draft4dEA.html*, or upon request (see **FOR FURTHER INFORMATION CONTACT**).

You may submit comments on the draft EA by any of the following methods:

E-mail: The mailbox address for submitting e-mail comments on the draft EA is salmon.draft4dEA@nwr.noaa.gov. Please include in the subject line of the e-mail comment the document identifier ''Draft 4(d) EA''

Mail: Submit written comments and information to Chief, NMFS, Protected Resources Division, 525 NE Oregon Street, Suite 500, Portland, Oregon, 97232–2737. Please identify the comment as regarding the ''Draft 4(d) EA.'' You may hand-deliver written comments to our office at the street address below. Business hours are 8 a.m. to 5 p.m., Monday through Friday, except Federal holidays.

Hand Delivery/Courier: NMFS, Protected Resources Division, 525 NE Oregon Street, Suite 210, Portland, Oregon, 97232–2737. Business hours are noted above.

Fax: 503–230–5435. Please identify the fax comment as regarding the ''Draft 4(d) EA.''

FOR FURTHER INFORMATION CONTACT: NMFS, Northwest Region, Protected Resources Division by phone at (503) 872–2791. Copies of the **Federal Register** notices cited herein and additional salmon-related materials are available on the Internet at *http://www.nwr.noaa.gov*.

SUPPLEMENTARY INFORMATION:

Species Covered in This Notice

The following species and Evolutionarily Significant Units (ESUs) are covered in this notice:

Chinook salmon (*O. tshawytscha*): the Sacramento River winter-run, Central Valley spring-run, California Coastal, Upper Willamette River, Lower Columbia River, Puget Sound, Snake River fall-run, and Snake River spring/summer-run chinook ESUs;

Coho salmon (*O. kisutch*): Southern Oregon/Northern California Coast, Oregon coast, and Lower Columbia River coho ESUs;

Sockeye salmon (*O. nerka*): the Ozette Lake sockeye ESU;

Chum salmon (*O. keta*): the Columbia River and Hood Canal summer-run chum ESUs;

Steelhead and rainbow trout (*O. mykiss*): South-Central California Coast, Central California Coast, California Central Valley, Northern California, Upper Willamette River, Lower Columbia River, Middle Columbia River, Snake River Basin, and Upper Columbia River *O. mykiss* ESUs.

Background

On June 14, 2004, NMFS published proposed ESA listing determinations for 27 ESUs of salmon and *O. mykiss* (69 FR 33101). NMFS proposed threatened status for 23 ESUs in California, Oregon, Washington, and Idaho, and as part of that rulemaking also proposed amendments to the existing 4(d) protective regulations for threatened salmon and steelhead ESUs. The National Environmental Policy Act (NEPA) requires that Federal agencies conduct an environmental analysis of their actions to determine if the actions may affect the human environment. Accordingly, NMFS has prepared a draft EA that analyzes the impacts of the proposed amendments to the 4(d) protective regulations for West Coast salmonids, and is making it available for public review and comment.

This draft EA analyzes two alternatives: (1) No Action (no revision to the current 4(d) protective regulations); and (2) the Proposed Action Alternative (revision and simplification of existing 4(d) protective regulations). The Proposed Action Alternative includes the following amendments:

Apply the 4(d) protections and 14 limits promulgated in 2000 (as modified in the proposed amendments) to three ESUs being newly proposed for threatened status; Apply the same 4(d) protections and 14 limits promulgated in 2000 (as modified in proposed amendments) to all threatened ESUs; Amend an expired 4(d) limit which provided a temporary exemption for ongoing research with pending permit applications during the 2000 4(d) rulemaking, to temporarily exempt ongoing research during the current rulemaking process; Move the

description of the limit for Tribal Resource Management Plans (§ 223.209) so that the text would appear next to the 4(d) rule in the Code of Federal Regulations, improving the clarity of the 4(d) regulations; and Amend the current 4(d) rule so that the section 9(a) take prohibitions apply to anadromous fish with an intact adipose fin only (that is, the take prohibitions and 4(d) protective regulations would not apply to unclipped hatchery fish or resident O. mykiss included in the subject ESUs).

Because the proposed action creates an optional ESA process, the effects that it may generate are limited to those associated with amending the 4(d) protective regulations. The proposed action does not address the potential effects of individual activities or programs that may seek coverage under one of the 4(d) ''limits.'' It is impossible to anticipate the specific impacts of such programs that may be submitted to and approved by NMFS. NMFS will conduct further NEPA analyses as necessary when a specific program is submitted to NMFS for coverage under one of the 4(d) limits for West Coast salmonids.

This notice is provided pursuant to the NEPA regulations (40 CFR 1506.6). The final NEPA determinations will not be completed until after the end of the 30–day comment period and after NMFS has fully considered all comments received during the public comment period.

Authority: 16 U.S.C. 1531 *et seq.*

Dated: November 9, 2004.

Laurie K. Allen,

Director, Office of Protected Resources, National Marine Fisheries Service.

[FR Doc. 04–25313 Filed 11–12–04; 8:45 am]

BILLING CODE 3510–22–S

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

[I.D. 102704]

Taking and Importing of Marine Mammals

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice of affirmative finding renewal.

SUMMARY: The Assistant Administrator for Fisheries, NMFS, (Assistant Administrator) renewed the affirmative finding for the Republic of Ecuador under the Marine Mammal Protection Act (MMPA). This affirmative finding renewal will allow yellowfin tuna and yellowfin tuna products harvested in the eastern tropical Pacific Ocean (ETP), in compliance with the International Dolphin Conservation Program (IDCP) by Ecuadorian-flag purse seine vessels or vessels operating under Ecuadorian jurisdiction, to continue to be imported into the United States. The affirmative finding renewal was based on review of documentary evidence submitted by the Republic of Ecuador and obtained from the Inter-American Tropical Tuna Commission (IATTC) and the Department of State. This finding remains in effect through March 31, 2005.

DATES: Effective April 1, 2004, through March 31, 2005.

FOR FURTHER INFORMATION CONTACT: Regional Administrator, Southwest Region, NMFS, 501 West Ocean Boulevard, Suite 4200, Long Beach, California, 90802–4213; Phone 562–980–4000; Fax 562–980-4018.

SUPPLEMENTARY INFORMATION: The MMPA, 16 U.S.C. 1361 et seq., allows entry into the United States of yellowfin tuna harvested by purse seine vessels in the ETP under certain conditions. Under implementing regulations at 50 CFR 216.24, a nation with purse seine vessels greater than 400 short tons (362.8 metric tons) carrying capacity fishing for tuna in the ETP must have an affirmative finding in order to export such tuna and tuna products to the United States. If requested by the harvesting nation, the Assistant Administrator will determine whether to make an affirmative finding based upon documentary evidence provided by the government of the harvesting nation, the IATTC, or the Department of State. The finding will be reviewed annually to ensure that the nation continues to meet the requirements for an affirmative finding. The requirements must be met in order for the finding to remain valid for the following 12-month period: April 1 through March 31, or for such other period as the Assistant Administrator may determine.

The affirmative finding process requires that the harvesting nation meet several conditions related to compliance with the IDCP. Every 5 years, the government of the harvesting nation must request an affirmative finding and submit the required documentary evidence directly to the Assistant Administrator. A nation may opt to provide information regarding compliance with the IDCP directly to NMFS on an annual basis or to authorize the IATTC to release the information to NMFS in years when NMFS will review and consider whether to issue an affirmative finding determination without an application from the harvesting nation.

An affirmative finding will be terminated, in consultation with the Secretary of State, if the Assistant Administrator determines that the requirements of 50 CFR 216.24(f) are no longer being met or that a nation is consistently failing to take enforcement actions on violations which diminish the effectiveness of the IDCP. Every 5 years, the government of the harvesting nation must request an affirmative finding and submit the required documentary evidence directly to the Assistant Administrator.

As a part of the annual review process set forth in 50 CFR 216.24(f), the Assistant Administrator considered documentary evidence submitted by the Republic of Ecuador and obtained from the IATTC and the Department of State and determined that Ecuador has met the MMPA's requirements to receive an affirmative finding.

After consultation with the Department of State, NMFS renewed the Republic of Ecuador's affirmative finding allowing the continued importation into the United States of yellowfin tuna and products derived from yellowfin tuna harvested in the ETP by Ecuadorian-flag purse seine vessels or vessels operating under Ecuadorian jurisdiction.

The Republic of Ecuador must submit a new application no later than January 2005 for an affirmative finding to be effective for the period April 1, 2005, through March 31, 2006, and the subsequent 4 years.

Dated: November 9, 2004.

Rebecca Lent,

Deputy Assistant Administrator for Regulatory Programs, National Marine Fisheries Service.

[FR Doc. 04–25315 Filed 11–12–04; 8:45 am]

BILLING CODE 3510–22–S

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

[I.D. 101304E]

Issuance of Permit 1493

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration, Commerce.

ACTION: Notice of decision and availability of decision documents on the issuance of ESA research/

enhancement permit 1493 for takes of endangered species.

SUMMARY: This notice advises the public that a scientific research permit to the Bonneville Power Administration (BPA) and the Confederated Tribes and Bands of the Yakama Nation, as their agent, pursuant to the Endangered Species Act of 1973 (ESA), has been issued and that the decision documents are available upon request.

DATES: Permit 1493 was issued on September 15, 2004, subject to certain conditions set forth therein. The permit expires on September 15, 2009.

ADDRESSES: Requests for copies of the decision documents or any of the other associated documents should be directed to the Salmon Recovery Division, NOAA Fisheries, 525 NE Oregon Street, Suite 510, Portland, Oregon 97232. The documents are also available on the Internet at *www.nwr.noaa.gov*.

FOR FURTHER INFORMATION CONTACT: Kristine Petersen, Portland, OR, at phone number: (503) 230–5409, e-mail: *Kristine.Petersen@noaa.gov*

SUPPLEMENTARY INFORMATION: The following species and evolutionarily significant units (ESUs) are covered in the permit:

Steelhead (*Oncorhynchus mykiss*): endangered Upper Columbia River.

Chinook salmon (*O. tshawytscha*): endangered Upper Columbia River spring run.

Issuance of this permit, as required by the ESA, was based on a finding that such permits: (1) were applied for in good faith; (2) will not operate to the disadvantage of the listed species which are the subject of the permits; and (3) is consistent with the purposes and policies set forth in section 2 of the ESA. This permit was issued in accordance with, and is subject to, 50 CFR part 222, the NMFS regulations governing listed species permits.

Dated: November 9, 2004.

Phil Williams,

Chief, Endangered Species Division, Office of Protected Resources, National Marine Fisheries Service.

[FR Doc. 04–25317 Filed 11–12–04; 8:45 am]

BILLING CODE 3510–22–S

COMMODITY FUTURES TRADING COMMISSION

In the Matter of the Intercontinental Exchange, Inc. Petition for Expansion of the Definition of an Eligible Commercial Entity Under Section 1a(11)(C) of the Commodity Exchange Act

AGENCY: Commodity Futures Trading Commission.

ACTION: Order.

SUMMARY: In response to a petition from the Intercontinental Exchange, Inc. (''Intercontinental''), the Commodity Futures Trading Commission (''Commission'' or ''CFTC''), pursuant to section 1a(11)(C) of the Commodity Exchange Act (''Act''), is issuing an order that deems, subject to certain conditions, brokers and traders associated with the International Petroleum Exchange (''IPE''), a recognized investment exchange (''RIE'') located in the United Kingdom (''U.K.''), who are either authorized by the Financial Services Authority (''FSA'') or registered with the IPE,[1] when acting in a proprietary trading capacity, to be an ''eligible commercial entity'' as defined in section 1a(11) of the Act.[2] Accordingly, subject to certain conditions as set forth in the Commission's order, IPE members authorized as commodity brokers by FSA or registered as local traders with IPE, when acting for their own accounts, are permitted to enter into transactions in exempt commodities on exempt commercial markets pursuant to section 2(h)(3) of the Act. In order to participate, the FSA-authorized broker or IPE-registered trader must either be an eligible contract participant, as that term is defined in section 1a(12) of the Act, or have its trades on the exempt commercial market guaranteed by a clearing member that is both a member of an FSA-recognized derivatives clearing organization and is an eligible contract participant.

EFFECTIVE DATE: This order is effective November 15, 2004.

FOR FURTHER INFORMATION CONTACT: Clarence Sanders, Special Counsel, Division of Market Oversight, Commodity Futures Trading Commission, Three Lafayette Centre, 1155 21st Street, NW., Washington, DC 20581. Telephone: (202) 418–5068. Electronic mail: *csanders@cftc.gov.*

SUPPLEMENTARY INFORMATION:

I. Statutory Background

The Commodity Futures Modernization Act of 2000 (''CFMA''), Public Law No. 106–554, was signed into law on December 21, 2000. Under amendments implemented by the CFMA, section 2(h)(3) of the Act authorizes trading in an ''exempt commodity'' [3] on an exempt commercial market (''ECM'') meeting the requirements of section 2(h) (3)–(5). Under those provisions, transactions between an eligible commercial entity (''ECE'') in an exempt commodity on an ECM are exempt from all but certain limited requirements of the Act.[4]

Section 1a(11) of the Act lists those eligible contract participants (''ECP'') [5]

[1] Registration with IPE is not registration with FSA or any other government entity. Criteria and procedures for obtaining membership or trading privileges on IPE are discussed below.

[2] The Commission previously determined to expand ECE eligibility to include, subject to certain conditions, Commission-registered floor brokers and floor traders. *See* 68 FR 2319 (January 16, 2003). That action applied to Commission-registered floor brokers and floor traders conducting business on electronic or open outcry markets. Similarly, this action applies to IPE brokers and local traders conducting business on IPE in either electronic or open outcry trading environments. As used in this **Federal Register** notice and in the prior **Federal Register** notice, the term proprietary trading means trading for one's own account.

[3] Section 1a(14) of the Act defines the term ''exempt commodity'' to mean a commodity that is not an excluded commodity or an agricultural commodity. Section 1a(13) defines the term ''excluded commodity'' to mean, among other things, an interest rate, exchange rate, currency, credit risk or measure, debt instrument, measure of inflation, or other macroeconomic index or measure. Although the term ''agricultural commodity'' is not defined in the Act, section 1a(4) enumerates a non-exclusive list of several agricultural-based commodities and products. The broadest type of commodities that fall into the exempt category are energy and metals products.

[4] Under section 2(h)(3), ECMs are markets that meet the requirements of section 2(h)(3)–(5) by notifying the Commission of their intention to operate a trading facility in reliance on the exemption and by limiting themselves to transactions: (1) In exempt commodities, (2) entered into on a principal-to-principal basis by ECEs, and (3) executed or traded on an electronic trading facility. An ECM is not a registered entity, but is required to notify the Commission of its intention to operate an electronic trading facility in reliance on the exemption set forth in section 2(h)(3). The notification of operation as an ECM must include several certifications and, pursuant to Commission regulation 36.3(c)(3), a representation that it will require each participant to comply with all applicable law and that it has a reasonable basis for believing that authorized participants are ECEs. Section 2(h)(4) reserves, with respect to transactions eligible for the 2(h)(3) exemption, certain provisions of the Act, including certain anti-fraud and anti-manipulation provisions.

[5] Section 1a(12) lists those entities and individuals included within the ECP category. Included generally as ECPs are financial institutions; insurance companies; and investment companies subject to regulation; commodity pools and employee benefit plans subject to regulation and asset requirements; other entities subject to asset requirements or whose obligations are guaranteed by an ECP that meets a net worth requirement; governmental entities; brokers,

P='65585'≤that are qualified to be ECEs.[6] As defined under section 1a(11), floor brokers and floor traders, even if determined to fall within the definition of an ECP, do not, as a category, fall within the statutory definition of an ECE. Thus, commodity brokers and traders, whether conducting business in either electronic or open outcry trading environments, are prohibited from entering into transactions on ECMs.

Section 1a(11)(C) of the Act, however, vests the Commission with discretion to expand the list of entities qualifying as an ECE. Specifically, under that provision, the definition of an ECE shall include ''such other persons as the Commission shall determine appropriate and shall designate by rule, regulation, or order.'' Therefore, a Commission-determination recognizing that IPE brokers and traders, either authorized by FSA or registered with IPE, are considered to be ECEs would permit these entities to enter into exempt commodity transactions on ECMs pursuant to section 2(h)(3) of the Act.

II. The Petition

A. Scope of Request

By letter dated February 9, 2004, Intercontinental requested that the Commission issue an order pursuant to section 1a(11) of the Act that would expand the ECE category to include certain IPE brokers and local traders, who are either authorized by FSA or registered with IPE, thus permitting them to trade on ECMs.[7] Intercontinental operates a commodities trading platform for energy and metals (the ''Intercontinental electronic platform'') and is itself an ECM. Intercontinental also owns IPE, a U.K. futures exchange that trades energy futures products. The Intercontinental electronic platform is used by IPE for its electronic trading system. Intercontinental stated that including IPE brokers and local traders as ECEs would be consistent with the CFMA and would recognize their value as both liquidity providers and market makers.

As more fully described below, Intercontinental's request applies to certain IPE brokers and local traders conducting business on IPE in either electronic or open outcry trading environments.[8] Specifically, Intercontinental proposed that eligible IPE brokers must be located in the U.K., be authorized and regulated by the FSA, and be a member of the IPE. For IPE local traders, Intercontinental proposed that eligible local traders be located in the U.K., be outside the scope of the Financial Services and Markets Act of 2000 (''FSMA''), and be a member of, or registered to, the IPE. Additionally, for both brokers and local traders, Intercontinental proposed that they have, as a part of their business activities, the business of acting as a broker or local trader but need not have any connection or experience in the underlying physical commodity. Finally, Intercontinental proposed that an eligible IPE broker or local trader must be an ECP or, if not an ECP, then the IPE broker or local trader must have its trades on the ECM guaranteed by an entity that is both an ECP and a clearing member of a U.K. recognized clearing organization.

In its petition, Intercontinental noted that the Commission has previously expanded the eligibility criteria for ECE status to include Commission-registered floor brokers and floor traders when acting in a proprietary trading capacity. In this respect, Intercontinental commented that the relief it seeks for IPE brokers and local traders is an appropriate extension of the Commission's previous expansion of the ECE definition. Moreover, Intercontinental contends that the IPE brokers and local traders, much as the CFTC registered floor brokers and floor traders qualifying under the Commission's prior action, are commodity professionals supervised by a central regulator, the FSA, or the IPE. Intercontinental also notes that the IPE brokers and local traders regularly trade on the IPE as part of their business and would utilize ECMs in connection with their trading activities. Intercontinental also observes that the Commission's prior action effectively acknowledges that floor brokers and floor traders are sophisticated market participants who are subject to a comprehensive regulatory scheme, such as that provided under FSA and IPE regulations. Intercontinental concludes that IPE brokers and local traders satisfy similar criteria, including that of having their trades guaranteed by the arrangements put in place by an RIE, and should therefore be eligible for the same type of relief.[9]

B. IPE Brokers

The petition requests that the ECE definition be expanded to include IPE brokers that are located in the UK when acting in a proprietary capacity. The IPE brokers include IPE Floor Members and IPE General Participants. IPE Floor Members may trade in either the open outcry or electronic markets; General Participants are restricted to the electronic market only.

As the petition describes, IPE brokers are firms authorized to transact business on behalf of customers or for the firm's proprietary account.[10] When acting on behalf of customers, the firm's business activities fall within the scope of the FSMA. Thus, a firm conducting such

dealers, and futures commission merchants (''FCM'') subject to regulation and organized as other than natural persons or proprietorships; brokers, dealers, and FCMs subject to regulation and organized as natural persons or proprietorships subject to total asset requirements or whose obligations are guaranteed by an ECP that meets a net worth requirement; floor brokers or floor traders subject to regulation in connection with transactions that take place on or through the facilities of a registered entity or an exempt board of trade; individuals subject to total asset requirements; an investment adviser or commodity trading adviser acting as an investment manager or fiduciary for another ECP, and any other person that the Commission deems eligible in light of the financial or other qualifications of the person.

[6] Section 1a(11) defines the term ECE by listing those entities and individuals considered to be ECEs. Generally, an ECE is an ECP that (1) in connection with its business, demonstrates the ability to make or take delivery of the underlying commodity; incurs risk, in addition to price risk related to the commodity; or is a dealer that regularly provides risk management or hedging services to, or engages in market-making activities with, the foregoing entities with respect to the commodity or derivatives transactions in the commodity; or (2) is other than a natural person or government entity and regularly enters into transactions with respect to the commodity, subject to certain qualification or total asset requirements; or (3) such other persons as the Commission shall determine appropriate.

[7] Intercontinental submitted its notice of operation as an ECM to the Commission on December 27, 2001. Intercontinental is one of 11 ECMs that have submitted notices to the Commission to date.

[8] The two classes denominated as brokers or local traders encompass four separate types of holders of trading privileges on IPE. Within the broker class there are Floor Members and General Participants. Floor Members hold privileges to trade on the IPE floor, whereas General Participants may trade only through the IPE electronic trading system. After establishment by IPE of the General Participant class, Floor Members were eligible to be grandfathered as General Participants. Also new Floor Members can elect to qualify as General Participants. The class denominated as local traders by IPE can similarly be broken down into two separate trader types. These are called Local Members and Individual Participants. Local Members may trade on the IPE floor, but Individual Participants may trade solely through the IPE electronic trading system. During July 2003 IPE introduced a new ''electronic'' membership structure. FSA recognizes all four classes as ''members,'' irrespective of whether the individual class is vested with equity or voting rights. See FSA Handbook Glossary at M8, 01/10/04, which defines a member as ''a person who is entitled, under an arrangement or agreement between him and that body, to use that body's facilities.''

[9] FSA recognition requirements place obligations on an RIE to put in place satisfactory arrangements for securing clearing and settlement services, which generally will be carried out by a Recognized Clearing House.

[10] Although IPE brokers have FSA authorization to conduct transactions on behalf of customers, any relief granted in response to the Intercontinental petition would be solely for their proprietary trading activities.

activities in the UK is subject to regulation by the FSA. Among other qualifying criteria, such firms must obtain FSA authorization prior to engaging in the commodity brokerage business.[11]

As there are two separate trading venues at IPE, conduct of business by IPE brokers may take two different forms. Each IPE floor-based broker (*i.e.*, Floor Members) is represented on the trading floor by one or more individual traders.[12]

General Participants are IPE brokers authorized to conduct business solely on the electronic trading platform. IPE-established eligibility requirements for this class of membership differ from those applicable to floor members. However, both classes of IPE brokers are authorized by FSA and therefore under FSA oversight. When operating on the IPE electronic trading platform, representatives of IPE General Participants are registered with the IPE as a Responsible Individual (''RI'') or, alternatively, are registered with the FSA as an Approved Person linked to a particular General Participant.[13]

C. IPE Local Traders

The petition also requests that the ECE definition be expanded to include IPE local traders located in the UK. Under IPE rules, local traders are authorized to trade for their own account but are prohibited from engaging in customer brokerage. As noted above, IPE local traders as a class are composed of two separate types of holders of trading privileges. These are Local Members and Individual Participants.[14] Qualifying criteria for these two trader classes differ in some respects. Local Members hold privileges to trade on the IPE floor.[15] Individual Participants are authorized to trade solely on the electronic trading platform.[16]

Notably, both Local Members and Individual Participants are outside the scope of the FSMA and therefore need not be authorized by the FSA—either when trading on IPE on behalf of their own account or on behalf of other IPE members.[17] However, both Local Members and Individual Participants must be members of, or registered with, the IPE, and must meet independent qualifying criteria established by IPE under an FSA-recognized regime.[18] The IPE actively monitors Local Member and Individual Participant trading activity, and has authority to impose sanctions for improper trading conduct.[19]

D. Qualifying Experience for Individual Participants

IPE affirms that it will determine whether an applicant has substantial qualifying experience by applying the standards set out under the definition of an Intermediate Customer contained in FSA regulations. In particular, IPE represents that the standards defining an expert private client as an Intermediate Customer found in Rule 4.1.9R of the FSA Conduct of Business (''COB'') sourcebook will be applied as the primary guide in determining the adequacy of an applicant's experience for this purpose.

COB Rule 4.1.9R imposes a two-tiered regulatory structure on financial services firms servicing accounts of expert private clients. This structure is divided between (1) procedural steps in establishing a client relationship with an expert private client and (2) objective steps in determining the adequacy of the expert private client's trading and business experience. More specifically, under FSA regulations, a financial intermediary is required to classify a client in one of three classifications: these are private (''retail'') customer, intermediate customer, or market counterparty.[20] Provisions under COB Rule 4.1.9R, permit a financial services firm to classify a client who would otherwise be a private, or retail, customer as an Intermediate Customer only upon a determination that the client is an ''expert'' private client.

COB 4.1.9R requires a firm to assess the adequacy of a client's experience and knowledge as an expert private client.[21] In this respect, COB Rule

[11] Under the U.K. regulatory regime, FSA also is responsible for approving persons who perform certain ''controlled functions'' for an authorized person. The FSA has specified 27 separate controlled functions, which fall into two main groups. The first of these two groups is the ''significant influence functions'' group, which includes activities carried out by persons in positions having a significant influence over conduct of the firm, such as governing functions (a Board Director or Chief Executive) or required functions (Compliance Officer or Money-Laundering Reporting Officer). The other group is the ''customer functions'' group, which includes persons performing advisory functions or customer trading and investment management functions.

[12] In order to qualify for membership as a Floor member on IPE, an applicant also must meet a schedule of IPE eligibility requirements. Under this schedule, an applicant must (1) be a firm or company, (2) meet IPE requirements on record-keeping, training and fitness of staff and directors, and implement internal procedures to ensure compliance with regulations, (3) meet minimum IPE-established net worth requirements, (4) maintain a properly established office in an IPE-approved location for the conduct of business, (5) have a continuing interest in trading and maintain trading staff on the IPE floor, (6) be a clearing member of LCH.Clearnet or be a party to a clearing agreement with another firm that is a member of LCH.Clearnet, and (7) hold at least one seat on IPE, where the applicant wishes to self-execute transactions on the IPE floor.

[13] Under the applicable schedule of requirements, the applicant must (1) demonstrate fitness to be a member, (2) demonstrate sufficiency of controls and procedures to ensure that employees, agents, and representatives are fit and proper, suitably qualified and experienced, adequately trained, and properly supervised, (3) maintain a properly established office in an IPE-approved location for the conduct of business, (4) meet minimum IPE-established financial standing requirements, (5) be a party to an IPE-prescribed Platform User Agreement, (6) maintain access to the Trading Server via a front end application meeting IPE criteria, (7) be a clearing member of LCH.Clearnet or be a party to a clearing agreement with another firm that is a member of LCH.Clearnet, (8) hold all necessary licenses, authorizations, and consents or qualifies for an exclusion permitting the conduct of business on the Platform in accordance with applicable law and regulation, and (9) identify the location of all RIs, along with related details and information on order routing, upon request from IPE.

[14] A third local trader class, Trade Participant membership, also exists but relief is not being sought for this class. Trade Participants are companies limited to trading for their own account.

[15] To qualify as an IPE Local Member an applicant must (1) demonstrate fitness as a member and an intention to comply with IPE regulations, (2) register with IPE and successfully pass the Registered Floor Trader examination, (3) demonstrate that the applicant will become a party to a clearing agreement with a clearing member of LCH.Clearnet, (4) demonstrate that the applicant is entitled, upon admission to membership, to acquire or lease a minimum of one seat on IPE, (5) demonstrate that the applicant is either a sole trader or a company where 90 percent of issued share capital is owned by the sole trader or 90 percent of voting rights of a non-share capital company is held by the sole trader, and (6) provide any other information or documents requested by IPE.

[16] To demonstrate eligibility an applicant as an Individual Participant must (1) demonstrate fitness as a member and an intention to comply with IPE regulations, (2) register with IPE as an RI and successfully pass the Registered Trader examination, (3) be a party to an IPE-prescribed Platform User Agreement, (4) maintain access to the Trading Server via a front end application meeting IPE criteria, (5) demonstrate that the applicant will become a party to a clearing agreement with a clearing member of LCH.Clearnet, and (6) demonstrate substantial experience trading on a UK futures exchanges, or otherwise meet the Intermediate Customer Standards found in FSA Conduct of Business Rule 4.1.9R.

[17] IPE Local Members and Individual Participants were determined to be outside the scope of FSMA by Order 2001. Local Members and Individual Participants may be individuals or corporations, although in the case of a corporation, 90 percent of the share capital or voting rights must be held by a single member.

[18] FSA confirms that IPE regulations appear to meet the requirements in the FSA sourcebook on Recognized Investment Exchanges and Recognized Clearing Houses.

[19] All IPE members and holders of trading privileges must execute an IPE-prescribed agreement consenting to be bound by IPE rules. *See* IPE Rule B.1.4.

[20] See COB Rule 4.1.4, FSA Handbook, Release 034, September 2004.

[21] Under the first tier, which concerns the establishment of a client relationship, COB Rule 4.1.9R requires that a firm take reasonable care to determine that the client has sufficient experience and understanding, disclose in writing the regulatory protections waived by such classification, provide the client sufficient time to consider the determination, and obtain the client's written consent or otherwise demonstrate that informed consent has been given by the client.

4.1.9R requires that a firm inquire about the client's knowledge, understanding, and awareness of risks in the applicable investments and markets. The rule also requires a firm to consider the length of time the client has been active in the applicable markets, the frequency of dealings, and the extent to which the client has relied on advice. Finally, the rule instructs a firm to inquire about or consider the size and nature of any transactions undertaken for the client, and the client's financial standing, including where appropriate an assessment of the client's net worth and portfolio holdings.

Essentially, IPE has determined to adopt the COB Rule 4.1.9R standards as qualifying criteria for applicants as IPE Individual Participants. Thus, these standards, otherwise imposed upon financial services firms regulated by FSA, will also be part of IPE procedures and serve as a screening device for determining the sufficiency of an applicant's experience and knowledge for admission on the IPE as an Individual Participant. In this respect, IPE confirms that its application of the criteria found in Rule 4.1.9R, to assess experience and knowledge of Individual Participant applicants, will be part of an independent determination made by IPE management. Moreover, IPE represents that any prior status an applicant may have attained as a customer of a financial services firm would not be determinative of eligibility, but that IPE would undertake an independent assessment of the applicant's experience and knowledge under the standards of COB Rule 4.1.9R.

E. Comments

The Intercontinental petition was published in the **Federal Register** for a 15-day public comment period on March 22, 2004.[22] In addition, the **Federal Register** release includes a series of questions posed by the Commission regarding the petition. Those questions focus on whether the petition should be granted; what conditions if any should apply; whether any grant of the petition should be specifically tailored to the Intercontinental ECM or be more broadly applied to other ECMs as well; whether relief should extend to IPE traders with rights to trade only on the IPE electronic platform, or to IPE locals not registered with the FSA and, if so, what standards should apply to evaluate the qualifications of such persons.

In total, the Commission received three comment letters responding to the **Federal Register** notice, two of which were submitted by the New York Mercantile Exchange (''NYMEX'') in letters dated April 7, and May 27, 2004. The other comment was submitted by Intercontinental in a letter dated April 28, 2004. The Intercontinental comment letter primarily responded to issues critically raised in the NYMEX letter of April 7, 2004.

1. NYMEX Comment Letters

The NYMEX comment letters include a generalized critical assessment of the petition. In so doing, the letters characterize the relief being sought as ''broad and unrestricted,'' and argue against the grant of the petition. In arriving at this conclusion, NYMEX emphasizes several different aspects of the IPE institutional and regulatory environment.

In particular, NYMEX sets out its view of the regulatory landscape governing ECMs as one in which statutory exemption is conditioned on the commercial nature of the market. Following this line of reasoning, NYMEX asserts that the IPE electronic traders are best characterized as representing a retail rather than a commercial interest and, on that basis, concludes they should be denied eligibility to obtain trading privileges on ECMs.

In amplifying its objection to a grant of access for IPE electronic traders, NYMEX asserts that granting the petition for IPE electronic traders would open ECM access to a ''potentially large group of unschooled and unsophisticated electronic traders who are not required to be registered here or in the U.K.'' NYMEX further concludes that granting such regulatory relief could impose risks to the integrity of trading on an ECM. Thus, NYMEX concludes that a grant of relief sought by Intercontinental would be contrary to statutory intent and the public interest.

Along a similar line of reasoning, NYMEX questions whether the IPE local traders (both Local Members and Individual Participants) could meet commercial standards justifying access to an ECM. NYYMEX supports this conclusion by arguing that the lack of FSA registration for IPE local traders, combined with a lack of express qualifying and trading participation requirements, raises a question as to whether such traders could serve as effective ''liquidity providers'' on an ECM.

NYMEX also questions whether the petition is imbued with a full understanding of the meaning of ''trading for one's own account'' within the context of obtaining trading access to an ECM.

The NYMEX comments also respond to the Commission's inquiry whether any regulatory response to the petition should be tailored specifically to permit IPE members to trade solely on Intercontinental or should be more broadly designed to permit IPE members to trade on other ECMs as well. Although more generally opposing the grant of the petition, NYMEX, in response to this question, comments that it is unable to identify any factual circumstances that would be unique to Intercontinental's ECM. On this basis, NYMEX concludes there is no need to tailor any hypothetical relief to the specific factual circumstances of the Intercontinental ECM and, in this respect, questions the wisdom of ''creating private definitions for public statutory categories.'' In summary, although NYMEX argues against granting the petition, NYMEX suggests that in any grant of relief the Commission ''may wish to consider allowing such IPE members to trade on other ECMs.''

2. Intercontinental Letter

As noted, Intercontinental submitted a comment letter dated April 28, 2004. That letter generally responds to the issues raised in the NYMEX letter of April 7, 2004. At the outset, Intercontinental notes that the IPE, as an RIE regulated by FSA, is subject to a panoply of FSA requirements, which, according to Intercontinental, are designed to protect the functioning of the market and the interests of users.[23]

Intercontinental also comments that these FSA requirements on member access to an RIE should also be read in conjunction with the rules and requirements independently applied by

[22] 69 FR 13286 (March 22, 2004).

[23] Recognized Investment Exchanges and Recognized Clearing Houses, FSA Handbook, Release 033, July 2004. More specifically, Intercontinental represents that Part 2.7 of the RIE Sourcebook imposes obligations requiring an RIE to restrict membership to applicants (1) over whom it can with reasonable certainty enforce its rules contractually, (2) who have sufficient technical competence to use its facilities, (3) who it is appropriate to admit to membership having regard to the size and sophistication of users of its facilities and the nature of the business effected by means of or cleared through its facilities, and (4) if appropriate who have adequate financial resources in relation to their exposure to the UK recognized body or its central counterparty. See also FSA Handbook Glossary at M8, 01/10/04, which defines a member as ''a person who is entitled, under an arrangement or agreement between him and that body, to use that body's facilities.'' Thus, all holders of IPE trading privileges are deemed ''members,'' and are regulated as such under FSA regulations, irrespective of whether individuals within a particular class of traders hold any equity or voting rights in IPE.

IPE.[24] As a supplement to these rules and requirements, Intercontinental comments that IPE also applies a membership due diligence screening process in which the IPE inquiry seeks information on an applicant's personal history including, but not limited to, the applicant's experience and knowledge of derivatives trading, whether an individual applicant has been registered by another regulatory body, has ever been disciplined by another regulatory body, or been insolvent. Additionally, Intercontinental comments that, as part of the due diligence screening, IPE conducts an identification inquiry under anti-money laundering standards and reviews or confirms all information obtained with appropriate agencies.

With respect to IPE contracts traded on the electric platform, Intercontinental comments that IPE makes available two different training programs for new members before they can access the system. As a consequence of these requirements, Intercontinental maintains that the characterization by NYMEX that IPE electronic traders are ''unschooled and unsophisticated,'' or of a retail nature, is not accurate. On this basis, Intercontinental concludes that the IPE members should be viewed as eligible to access the over-the-counter contracts traded on Intercontinental's ECM.

Intercontinental's comment letter also notes that it is not seeking relief solely for its own ECM, but rather does not oppose broad ECM access for the IPE membership. Intercontinental also acknowledges that relief is being sought solely for ''principal-to-principal'' trading.

While not responding to any aspect of NYMEX's comment letter, Intercontinental did add several clarifications with respect to its relief request. For instance, Intercontinental remarks that its systems are adequate to enforce the requirement that IPE members eligible for relief must be located in the U.K., as it inquires into a participant's physical location by collecting information on a participant's principal business address. Intercontinental also comments that it conducts an anti-money laundering inquiry for privately-owned companies in which the participant must present the company's registered address, as well as collecting the address and telephone number for each user as part of its process for new market users.

[24] These are the same rules and requirements outlined above in Section II.

III. Discussion

Under the CEA, ECMs are commercial markets executing principal-to-principal transactions. In view of the unregulated nature of these markets, Congress intended that access should be confined to professional traders—either ECEs as defined in section 1a(11) or other traders that have an interest in the underlying commodity as part of their business operations, perform a market-making role, or otherwise provide a similar trading function that improves market liquidity.

As noted above the Commission has previously acted to expand the ECE definition to include floor brokers and floor traders registered with the Commission and acting in a proprietary capacity, since these persons operate as knowledgeable, experienced professional traders who historically have provided a trading function that improves market liquidity.[25] The Commission stated in the **Federal Register** notice accompanying that action that in order to qualify as an ECE under the Order, the ''CFTC-registered floor broker or floor trader must be a member of a DCM or otherwise have trading privileges on a DCM * * * [and act] as a floor broker or floor trader, either on a DCM's open outcry market or [perform] an equivalent function on the DCM's electronic market.'' In the **Federal Register** notice, the Commission also acknowledged, as professional traders providing market-making type activities, that the floor broker or floor trader ''need not have any connection to or experience in the underlying physical commodity.'' Finally, the Commission stated that the ''floor broker or floor trader must either be an ECP or have its trades on the ECM guaranteed by a clearing member that is both a member of a CFTC-registered derivatives clearing organization and an ECP.''

Underlying the Commission's prior action was the notion that registration was a proxy for the aforementioned knowledge, experience, and professionalism, and for the provision of a market-making or similar trading function that improves market liquidity.

As outlined above in Section II.A, Intercontinental maintains that its petition seeks relief of a similar nature, and further represents that granting its request would constitute an appropriate extension of the Commission's prior action. Although NYMEX supported the Commission's prior action, NYMEX now opposes the Intercontinental petition for IPE traders. In contrast to Intercontinental's declaration, the comment letters submitted by NYMEX argue that the Intercontinental petition fails to satisfy standards established under the Commission's prior action to include CFTC-registered floor brokers and floor traders in the definition of an ECE.

The Commission believes that granting relief for IPE brokers would comply with the Commission's prior action to expand the ECE category to include CFTC-registered floor brokers and floor traders. IPE brokers, by virtue of having received FSA authorization as a prerequisite to engaging in the conduct of commodity brokerage on IPE, conform to that part of the standards enunciated in the Commission's prior action. The Commission also has entered into an information-sharing arrangement with the FSA.

With respect to IPE floor and electronic local traders, NYMEX correctly concludes that these traders are neither authorized nor approved by FSA, the U.K. regulator with jurisdiction over commodity futures exchanges and other instrumentalities operating in the U.K. financial services industry. Nonetheless, the Commission believes that it is appropriate to include these traders under the ECE category since, as identified above, IPE floor and electronic local traders do have to meet a schedule of criteria in order to establish eligibility as an IPE Local Member or Individual Participant. In order to demonstrate fitness, both IPE Local Members and Individual Participants must, among other things, successfully pass the Registered Trader examination that is administered by IPE.[26]

As either an applicant or an IPE-approved trader, Local Members and Individual Participants must meet a schedule of fees that is essentially the same for both classes of membership. Each applicant is required to pay an application fee of 500 pounds. If accepted to membership, each applicant would then be required to pay an annual subscription fee of 350 pounds per seat or membership. Additionally, each applicant would be subject to an annual minimum activity charge of 1000 pounds, if the applicant failed to trade at least 4000 lots per year.

Other applicable criteria differ for each of these two trader classes, most

[25] 68 FR 2319 (January 16, 2003). The Commission also incorporated floor brokers and floor traders in the definition of an ECE as it relates to trading on a Derivatives Transaction Execution Facility. *See* Commission Regulation 37.1(b), and the discussion thereunder at 66 FR 42256.

[26] *See* IPE Rule G.10(c). The Registered Floor Trader exam tests knowledge of trading behavior and of the rules and regulations of IPE.

notably with respect to evidencing an adequate level of experience and knowledge. Local Members are required to either purchase or lease a seat on IPE and to serve both a trainee and probationary period. While in trainee status, an applicant may only enter a trading pit as an observer.[27] In order to achieve probationary status, an applicant must pass the Registered Trader exam. During the probationary period, an applicant may execute transactions on the exchange, but only under the supervision of another IPE member.[28]

After completion of the probationary period, the applicant's performance is subjected to peer review by other IPE members and the IPE Trading Committee.[29] Final acceptance or denial of membership is conditioned on confirmation of the IPE Trading Committee. Thus, the trainee and probationary periods required of Local Members appear to serve as a training period or apprenticeship preparatory to a new member receiving full floor trading privileges.

For Individual Participants, who only have trading privileges for the IPE electronic system, IPE has implemented other requirements that differ from those applicable to Local Members. Under IPE requirements, as in the case of Local Members, Individual Participants must also show fitness to be a member. However, as outlined above in Section II.C, in addition to successfully passing the Registered Trader Exam, applicants for Individual Participant membership must demonstrate substantial experience trading on a U.K. futures exchange, or otherwise satisfy the standards defining an Intermediate Customer under FSA Conduct of Business Rule 4.1.9R.

According to Intercontinental, electronic trader eligibility is limited to existing IPE-registered traders, to traders at other U.K. exchanges, to other individuals with substantial trading experience on U.K. futures exchanges, or to traders who have successfully passed the Registered Trader exam. Thus, according to Intercontinental, FSA-developed standards under COB Rule 4.1.9R, which define an intermediate customer, are used by IPE as a screening device to differentiate professional from retail experience among applicants.

As the above suggests, criteria set out under COB Rule 4.1.9R are intended for use in determining whether a client would have experience meeting or qualifying at the intermediate customer level. Thus COB Rule 4.1.9R instructs that, in determining a client's experience and knowledge, a firm should inquire about:

1. The client's knowledge, understanding, and awareness of risks in the applicable investments and markets,

2. The length of time the client has been active in these markets, the frequency of dealings, and the extent to which client relied on advice,

3. The size and nature of the transactions undertaken for the client, and

4. The client's financial standing, which may include an assessment of net worth and portfolio.

As a practice that is functionally parallel to that required of financial firms under COB Rule 4.1.9R, Intercontinental has represented that IPE will confine eligibility for admission as an electronic trader to applicants with:

1. Sufficient knowledge and understanding of market and risks,

2. Who were active on such markets for a reasonable length of time,

3. Who have traded in appropriate size and quantity, and

4. Who have appropriate financial standing.

In this respect, IPE confirms that it will apply the criteria found in Rule 4.1.9R applicable to assessing experience and knowledge of an expert private customer as part of an independent determination made by IPE management. Moreover, IPE represents that the prior status an applicant may have attained as a customer of a financial services firm would not be determinative of eligibility, but that IPE would undertake an independent assessment of the applicant's experience and knowledge under the standards of COB Rule 4.1.9R.[30]

As a general matter, IPE also maintains that as an RIE it is organized as a wholesale market and is not open to retail membership. In this regard, IPE points out that FSA rules and standards found in the Recognized Investment Exchange and Clearing House sourcebook (''REC'') impose requirements on types of applicants eligible for membership. Among other things, REC Rule 2.7.3 states that FSA may conduct assessments of whether access to a UK recognized body's facilities is based on criteria designed to protect the orderly functioning of the market and the interests of investors. Further, Rule 2.7.3 states that FSA, in conducting any such assessments, may consider: (a) Whether the RIE limits access as a member to persons over whom it can with reasonable certainty enforce its rules, (b) who have sufficient technical competence to use the market's facilities, (c) whom it is appropriate to admit to membership having regard for the size and sophistication of users of its facilities and the nature of business thereon, and (d) where appropriate, the adequacy of financial resources in relation to a member's exposure to the UK recognized body or central counterparty.[31]

As noted, IPE local traders need not be authorized or approved by FSA as a pre-condition in obtaining trading privileges on IPE. The U.K. approach therefore differs somewhat from that applied under U.S. regulation, where Commission requirements mandate registration with a government body for both floor brokers and floor traders. However, even though qualifying determinations for local traders are reserved to IPE, those procedures are subject to FSA supervision. Thus, notwithstanding the formalistic differences in the treatment of local traders in the U.S. and U.K. regulatory systems, the Commission believes that the U.K. regulatory structure facilitates and enforces a level of regulation for the IPE local traders that meets applicable standards of professionalism established under the Commission's prior action expanding the ECE category to include

[27] *See* IPE Rule 1.3.2.

[28] *See* IPE Rule 1.6.7(f).

[29] Under IPE Rule 1.6.7, the probationary period runs for a period of 90 days unless terminated earlier at the discretion of the IPE Trading Committee.

[30] IPE is posting the Individual Participant application form on its Web site. The application form includes an eligibility requirement in reference to the Intermediate Customer standards under FSA COB 4.1.9R. There are no specific FSA regulations governing an RIE's record-keeping obligations regarding membership applications or documents relating thereto. However, IPE maintains that Money Laundering Regulations 1993 require IPE retention of new client records, including IPE members, for a five-year period following the termination of the business relationship. In the case of an IPE member or holder of trading privileges, the five-year period would run from the date of rejection or resignation from membership.

[31] Administratively, REC Rule 2.7.3 also seeks to ensure that an RIE's membership criteria are objective in their scope and are applied in an objective, non-discriminatory manner. Specifically, for access to electronic markets, REC Rule 2.7.4 provides that the FSA may review an RIE's rules and practices concerning procedures, controls, and security for inputting instructions into the system; the facilities provided and restrictions imposed on clients inputting instructions into the system; practices used to detect, identify, and prevent instructions to the system that breach any relevant restrictions; the quality and completeness of the audit trail; and procedures governing the determination to suspend system trading or member access.

CFTC-registered floor brokers and floor traders.[32]

IV. Conclusion

After consideration of the Intercontinental petition, and the additional material submitted by Intercontinental to accompany the petition, and the comment letters submitted in response to the **Federal Register** notice, the Commission has determined, consistent with the Intercontinental petition, that it is appropriate to issue an order, pursuant to Section 1a(11)(c) of the Act, that includes certain IPE floor and electronic brokers and traders, subject to certain conditions, within the definition of an ECE for eligibility to trade on an ECM.[33] As in the prior action to expand the ECE definition to include CFTC-registered floor brokers and floor traders, either in open outcry or electronic markets, the Commission believes that expanding the definition to include IPE floor and electronic brokers and traders is consistent with the purposes of the CFMA.[34] Moreover, and again as in the prior action, the Commission believes that inclusion of IPE floor and electronic brokers and traders in the definition of an ECE could potentially increase competition and efficiency, and reduce liquidity risk, on ECMs.

As noted above, underlying the Commission's prior action was the notion that registration serves as a proxy for the aforementioned knowledge, experience and professionalism, and for the provision of a market-making or similar trading function that improves market liquidity. Commission action taken here makes a similar finding for IPE floor and electronic brokers and traders with respect to their knowledge, experience and professionalism, and their ability to provide market-making or similar trading functions that improve market liquidity.

The Commission also notes that IPE registration of electronic local traders is based on eligibility pursuant to the Intermediate Customer standards under FSA COB 4.1.9R. The Commission considers the inclusion of this process in IPE registration as a reasonable proxy for an electronic local trader's knowledge, experience, professionalism, and ability to provide a market-making or similar trading function that improves market liquidity. Moreover, the Commission believes that the IPE has the experience and ability to apply the standards in an efficient and prudent manner. The Commission points out that these determinations are based on materials provided by, and/or representations made by, IPE and FSA and, as such, are particular to IPE. If another market or governmental regulator petitioned the Commission for a similar expansion of the ECE definition, an analogous showing to the Commission would be necessary.

The Commission also notes that it has previously expanded the ECE definition for purposes of trading on a DTEF.[35] That action incorporated within the ECE definition registered floor brokers and floor traders, whose trading obligations are guaranteed by a registered FCM, when trading for their own accounts on a DTEF.

In order to qualify as an ECE under the Commission's order, an IPE floor or electronic broker or trader must be a member of IPE or otherwise have trading privileges on IPE and be located in the U.K. Pursuant to those requirements, the qualifying IPE floor or electronic broker or trader also must be authorized by FSA or registered with IPE. The IPE floor or electronic broker or trader must have as a part of its business the business of acting as a commodity broker or local trader, either on IPE's open outcry or electronic market, but need not have any connection to or experience in the underlying physical commodity. The Commission believes that the trading expertise of IPE floor or electronic brokers or traders would be applicable to trading in any commodity product traded on an ECM. Among other things, the ability of an IPE floor or electronic broker or trader to interpret market momentum, and facilitate the adjustment of market prices to new information, is more a function of trading expertise than of experience in the underlying physical commodity.

A qualifying IPE floor or electronic broker or trader must be either an ECP or have its trades on the ECM guaranteed by a clearing member that is both a member of an FSA-recognized derivatives clearing organization and an ECP. The Commission believes that requiring either the IPE floor or electronic broker or trader, or the guarantor thereof, to be an ECP provides sufficient financial backing for the IPE floor or electronic broker or trader and mitigates any credit and collection risk that might otherwise arise. The Commission notes that the guarantor of an IPE floor or electronic broker or trader would be placing its own money at risk, and expects that such guarantor would carefully consider the risk involved in the provision of the guarantee for that particular broker or trader.

V. Cost Benefit Analysis

Section 15 of the Act, as amended by section 119 of the CFMA, requires the Commission to consider the costs and benefits of its action before issuing a new order under the Act. By its terms, section 15 does not require the Commission to quantify the costs and benefits of its action or to determine whether the benefits of the action outweigh the costs. Rather, section 15 simply requires the Commission to ''consider the costs and benefits'' of its order.

Section 15(a) further specifies that the costs and benefits of the proposed order shall be evaluated in light of five broad areas of market and public concern: (1) Protection of market participants and the public; (2) efficiency competitiveness and financial integrity of futures markets; (3) price discovery; (4) sound risk management practices; and (5) other public interest considerations. The Commission may, in its discretion, give greater weight to any one of the five enumerated areas of concern and may, in its discretion, determine that, notwithstanding its costs, a particular order is necessary or appropriate to protect the public interest or to effectuate any of the provisions or to accomplish any of the purposes of the Act.

The subject order is intended to reduce regulatory barriers to permit certain IPE floor or electronic brokers or traders, when acting in a proprietary capacity, to enter into transactions in exempt commodities on ECMs pursuant to section 2(h)(3) of the Act if such entities are either ECPs or have obtained a financial guarantee for such transactions from a clearing member that is both a member of a FSA-registered derivatives clearing organization and an ECP. The Commission has considered the costs and benefits of the order in light of the

[32] The Commission has found the U.K. regulatory program generally comparable to the U.S. framework pursuant to a grant of relief under CFTC regulation 30.10. The review for this determination focused generally upon firms acting in the capacity of futures commission merchants for U.S. customers trading on U.K. exchanges, rather than on proprietary trading by brokers and traders. *See* 68 FR 58583 (October 10, 2003).

[33] As noted, Intercontinental seeks to include in the definition of an ECE four separate types of holders of trading privileges on IPE: the broker class is composed of Floor Members and General Participants and the local trader class is composed of Local Members and Individual Participants.

[34] The Commission's prior action to include CFTC-registered floor brokers and floor traders in the ECE definition specifically acknowledged that the prior action would reach a ''floor broker or floor trader, either on a DCM's open outcry market or [when] performing an equivalent function on the DCM's electronic market.'' *See* 68 FR 2323 (January 16, 2003).

[35] Commission regulation 37.1(b).

specific provisions of section 15(a) of the Act.

A. Protection of Market Participants and the Public

The order would deem certain professional IPE floor or electronic brokers or traders meeting the required conditions who are ECPs, or who have guarantees from clearing members that are members of FSA-registered derivatives clearing organizations and are ECPs, to be ECEs under section 1a(11)(c) and thus permit them to enter into proprietary transactions in exempt commodities on ECMs. Under the Act, ECEs are sophisticated investors who have the financial wherewithal or trading expertise to participate in these markets. Accordingly, there should be no effect on the Commission's ability to protect market participants and the public.

B. Efficiency and Competition

The order is expected to benefit efficiency and competition by, among other things, providing essential trading expertise to the market that enhances price discovery through both the speed and efficiency of market adjustment to new fundamentals and by generally increasing the pool of potential counterparties for participants trading on exempt commercial markets.

C. Financial Integrity of Futures Markets and Price Discovery

The order should have no effect, from the standpoint of imposing costs or creating benefits, on the financial integrity of the futures and options markets. The order should enhance the price discovery function of such markets.

D. Sound Risk Management Practices

The order should have no effect, from the standpoint of imposing costs, on the risk management practices of the futures and options industry. Where an individual or entity is qualified as an ECP, the individual or entity has been deemed under the Act to be sufficiently responsible to execute trades in certain excluded or exempt commodity transactions, and no further mitigation of credit risk is necessary. Moreover, where an individual or entity does not qualify as an ECP, the order requires that a clearing member of an FSA-recognized derivatives clearing organization that is itself an ECP guarantee the trades in order to mitigate the credit and collection risk.

E. Other Public Interest Considerations

The order is consistent with one of the purposes of the Act as articulated in section 3 in that it would promote responsible innovation and fair competition among boards of trade, other markets, and market participants.

VI. Order

Upon due consideration, and pursuant to its authority under section 1a(11)(C) of the Act, the Commission hereby determines that certain professional International Petroleum Exchange (''IPE'') floor or electronic brokers or local traders, who are authorized by the Financial Services Authority (''FSA'') or registered with the IPE, when acting in a proprietary capacity, are appropriate persons as defined in section 1a(11)(C) and, thus, are deemed to be eligible commercial entities and may enter into contracts, agreements or transactions in an exempt commodity on an exempt commercial market under the following conditions:

1. The contracts, agreements, or transactions must be executed on an exempt commercial market that meets the requirements of section 2(h)(3)–(5) of the Act.

2. The IPE floor or electronic broker, denominated as either a Floor Member or General Participant pursuant to IPE membership rules, must be a member of IPE or otherwise have trading privileges on IPE, be located in the U.K., and be subject to the rules of IPE.

3. The IPE local trader, denominated as a Local Member or Individual Participant pursuant to IPE membership rules, must be a member of IPE or otherwise have trading privileges on IPE, be located in the U.K., and be subject to the rules of IPE.

4. The IPE Floor Member or General Participant must be authorized and regulated by the FSA.

5. The IPE Local Member or Individual Participant must be registered with the IPE.

6. The IPE Floor Member, General Participant, Local Member, or Individual Participant must have as a part of its business the business of acting as a professional commodity broker or trader on either the IPE open outcry or electronic markets.

7. The IPE Individual Participant must meet and satisfy the current qualifying standards of an Intermediate Customer pursuant to FSA Conduct of Business (''COB'') Rule 4.1.9R. IPE must notify the Commission of any changes to the standards included in FSA COB Rule 4.1.9R.

8. The IPE Floor Member, General Participant, Local Member, or Individual Participant must be either an eligible contract participant, as that term is defined in section 1a(12) of the Act, or have its trades on the exempt commercial market guaranteed by a clearing member that is a member of an FSA-recognized derivatives clearing organization and is an eligible contract participant.

Issued by the Commission this 8th day of November, 2004, in Washington, DC.

Jean A. Webb,

Secretary of the Commission.

[FR Doc. 04–25282 Filed 11–12–04; 8:45 am]

BILLING CODE 6351–01–P

DEPARTMENT OF DEFENSE

GENERAL SERVICES ADMINISTRATION

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[OMB Control No. 9000–0078]

Federal Acquisition Regulation; Submission for OMB Review; Make-or-Buy Program

AGENCIES: Department of Defense (DOD), General Services Administration (GSA), and National Aeronautics and Space Administration (NASA).

ACTION: Notice of request for comments regarding an extension to an existing OMB clearance (9000–0078).

SUMMARY: Under the provisions of the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35), the Federal Acquisition Regulation (FAR) Secretariat has submitted to the Office of Management and Budget (OMB) a request to review and approve an extension of a currently approved information collection requirement concerning make-or-buy programs. A request for public comments was published at 69 FR 44645, July 27, 2004. No comments were received.

Public comments are particularly invited on: Whether this collection of information is necessary for the proper performance of functions of the FAR, and whether it will have practical utility; whether our estimate of the public burden of this collection of information is accurate, and based on valid assumptions and methodology; ways to enhance the quality, utility, and clarity of the information to be collected; and ways in which we can minimize the burden of the collection of information on those who are to respond, through the use of appropriate technological collection techniques or other forms of information technology.

DATES: Submit comments on or before December 15, 2004.

ADDRESSES: Submit comments regarding this burden estimate or any other aspect

of this collection of information, including suggestions for reducing this burden, to the General Services Administration, FAR Secretariat (VR),1800 F Street, NW, Room 4035, Washington, DC 20405. Please cite OMB Control No. 9000–0078, Make-or-Buy Program, in all correspondence.

FOR FURTHER INFORMATION CONTACT Jerry Zaffos, Contract Policy Division, GSA (202) 208–6091

SUPPLEMENTARY INFORMATION:

A. Purpose

Price, performance, and/or implementation of socio-economic policies may be affected by make-or-buy decisions under certain Government prime contracts. Accordingly, FAR 15.407–2, Make-or-Buy Programs (i) Sets forth circumstances under which a Government contractor must submit for approval by the contracting officer a make-or-buy program, i.e., a written plan identifying major items to be produced or work efforts to be performed in the prime contractor's facilities and those to be subcontracted;

(ii) Provides guidance to contracting officers concerning the review and approval of the make-or-buy programs; and

(iii) Prescribes the contract clause at FAR 52.215–9, Changes or Additions to Make-or-Buy Programs, which specifies the circumstances under which the contractor is required to submit for the contracting officer's advance approval a notification and justification of any proposed change in the approved make-or-buy program.

The information is used to assure the lowest overall cost to the Government for required supplies and services.

B. Annual Reporting Burden

Respondents: 150.

Responses Per Respondent: 3.

Total Responses: 450.

Hours Per Response: 8.

Total Burden Hours: 3,600.

Obtaining Copies of Proposals: Requesters may obtain a copy of the information collection documents from the General Services Administration, FAR Secretariat (VR), Room 4035, Washington, DC 20405, telephone (202) 501–4755. Please cite OMB Control No. 9000–0078, Make-or-Buy Program, in all correspondence.

Dated: November 4, 2004

Laura Auletta,

Director, Contract Policy Division.

[FR Doc. 04–25291 Filed 11–12–04; 8:45 am]

BILLING CODE 6820–EP–S

DEPARTMENT OF DEFENSE

GENERAL SERVICES ADMINISTRATION

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[OMB Control No. 9000–0155]

Submission for OMB Review; Prohibition on Acquisition of Products Produced by Forced or Indentured Child Labor

AGENCIES: Department of Defense (DOD), General Services Administration (GSA), and National Aeronautics and Space Administration (NASA).

ACTION: Notice of request for comments regarding an extension to an existing OMB clearance.

SUMMARY: Under the provisions of the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35), the Federal Acquisition Regulation (FAR) Secretariat will be submitting to the Office of Management and Budget (OMB) a request to review and approve an extension of a currently approved information collection requirement regarding prohibition on acquisition of products produced by forced or indentured child labor. A request for public comments was published at 69 FR 54767 on September 10, 2004. No comments were received.

DATES: Submit comments on or before: December 15, 2004.

ADDRESSES: Submit comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Regulatory Secretariat (VR), General Services Administration, Room 4035, 1800 F Street, NW., Washington, DC 20405. Please cite OMB Control No. 9000–0155, Prohibition on Acquisition of Products Produced by Forced or Indentured Child Labor, in all correspondence.

FOR FURTHER INFORMATION CONTACT Craig R. Goral, Contract Policy Division, GSA (202) 501–3856.

SUPPLEMENTARY INFORMATION:

A. Purpose

This information collection complies with Executive Order 13126, Prohibition on Acquisition of Products Produced by Forced or Indentured Child Labor, signed by the President on June 12, 1999. Executive Order 13126 requires that this prohibition be enforced within the federal acquisition system by means of: (1) A provision that requires the contractor to certify to the contracting officer that the contractor or, in the case of an incorporated contractor, a responsible official of the contractor has made a good faith effort to determine whether forced or indentured child labor was used to mine, produce, or manufacture any product furnished under the contract and that, on the basis of those efforts, the contractor is unaware of any such use of child labor; and (2) A provision that obligates the contractor to cooperate fully in providing reasonable access to the contractor's records, documents, persons, or premises if reasonably requested by authorized officials of the contracting agency, the Department of the Treasury, or the Department of Justice, for the purpose of determining whether forced or indentured child labor was used to mine, produce, or manufacture any product furnished under the contract.

The information collection requirements of the Executive Order are evidenced via the certification requirements delineated at FAR 22.1505, 52.212–3, 52.222–18, and 52.222–19.

To eliminate some of the administrative burden on offerors who must submit the same information to various contracting offices, the Civilian Agency Acquisition Council and the Defense Acquisition Regulations Council (Councils) decided to amend the Federal Acquisition Regulation (FAR) to require offerors to submit representations and certifications electronically via the Business Partner Network (BPN), unless certain exceptions apply. Online Representations and Certifications Application (ORCA) is the specific application on the BPN to replace the paper based Representations and Certifications (Reps and Certs) process. The change to the FAR is being accomplished by FAR Case 2002–024. The clearance associated with this case referenced this OMB Control No. 9000–0155 and reduced the hours of burden by 35%—attributable to mandated use of ORCA. This reduction is already reflected in the figures below.

B. Annual Reporting Burden

Respondents: 500.
Responses Per Respondent: 1.
Hours Per Response: 0.325.
Total Burden Hours: 162.
Obtaining Copies of Proposals: Requesters may obtain a copy of the information collection documents from the General Services Administration, Regulatory Secretariat (VR), 1800 F Street, NW, Room 4035, Washington, DC 20405, telephone (202) 501–4755. Please cite OMB Control No. 9000–0155, Prohibition on Acquisition of Products

Produced by Forced or Indentured Child Labor, in all correspondence.

Dated: September 10, 2004

Laura Auletta,

Director, Contract Policy Division.

[FR Doc. 04–25292 Filed 11–12–04; 8:45 am]

BILLING CODE 6820–EP–S

DEPARTMENT OF DEFENSE

GENERAL SERVICES ADMINISTRATION

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[OMB Control No. 9000–0014]

Federal Acquisition Regulation; Submission for OMB Review; Statement and Acknowledgment (Standard Form 1413)

AGENCIES: Department of Defense (DOD), General Services Administration (GSA), and National Aeronautics and Space Administration (NASA).

ACTION: Notice of request for public comments regarding an extension of an existing OMB clearance (9000–0014).

SUMMARY: Under the provisions of the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35), the Federal Acquisition Regulation (FAR) Secretariat has submitted to the Office of Management and Budget (OMB) a request to review and approve an extension of a currently approved information collection requirement concerning statement and acknowledgment (Standard Form 1413). A request for public comments was published in the **Federal Register** at 69 FR 54135 on September 1, 2004. No comments were received.

Public comments are particularly invited on: Whether this collection of information is necessary for the proper performance of functions of the FAR, and whether it will have practical utility; whether our estimate of the public burden of this collection of information is accurate, and based on valid assumptions and methodology; ways to enhance the quality, utility, and clarity of the information to be collected; and ways in which we can minimize the burden of the collection of information on those who are to respond, through the use of appropriate technological collection techniques or other forms of information technology.

DATES: Comments may be submitted on or before December 15, 2004.

ADDRESSES: Submit comments, including suggestions for reducing this burden to the General Services Administration, FAR Secretariat (VR), 1800 F Street, NW, Room 4035, Washington, DC 20405. Please cite OMB Control No. 9000–0014, Statement and Acknowledgment, Standard Form 1413, in all correspondence.

FOR FURTHER INFORMATION CONTACT Craig Goral, Contract Policy Division, GSA (202) 501–3856.

SUPPLEMENTARY INFORMATION:

A. Purpose

Standard Form 1413, Statement and Acknowledgment, is used by all Executive Agencies, including the Department of Defense, to obtain a statement from contractors that the proper clauses have been included in subcontracts. The form includes a signed contractor acknowledgment of the inclusion of those clause in the subcontract.

B. Annual Reporting Burden

Respondents: 31,500.

Responses Per Respondent: 2.

Total Responses: 63,000.

Hours Per Response: .05.

Total Burden Hours: 3,150.

Obtaining Copies of Proposals: Requesters may obtain a copy of the information collection documents from the General Services Administration, FAR Secretariat (VR), 1800 F Street, NW, Room 4035, Washington, DC 20405, telephone (202) 501–4755. Please cite OMB Control No. 9000–0014, Statement and Acknowledgment, Standard Form 1413, in all correspondence.

Dated: October 28, 2004

Laura Auletta,

Director, Contract Policy Division.

[FR Doc. 04–25293 Filed 11–12–04; 8:45 am]

BILLING CODE 6820–EP–S

DEPARTMENT OF DEFENSE

GENERAL SERVICES ADMINISTRATION

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[OMB Control No. 9000–0018]

Federal Acquisition Regulation; Submission for OMB Review; Certification of Independent Price Determination and Parent Company and Identifying Data

AGENCIES: Department of Defense (DOD), General Services Administration (GSA), and National Aeronautics and Space Administration (NASA).

ACTION: Notice of request for comments regarding an extension to an existing OMB clearance (9000–0018).

SUMMARY: Under the provisions of the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35), the Federal Acquisition Regulation (FAR) Secretariat has submitted to the Office of Management and Budget (OMB) a request to review and approve an extension of a currently approved information collection requirement concerning certification of independent price determination and parent company and identifying data. A request for public comments was published in the Federal Register at 69 FR 53685 on September 2, 2004. No comments were received.

Public comments are particularly invited on: Whether this collection of information is necessary for the proper performance of functions of the FAR, and whether it will have practical utility; whether our estimate of the public burden of this collection of information is accurate, and based on valid assumptions and methodology; ways to enhance the quality, utility, and clarity of the information to be collected; and ways in which we can minimize the burden of the collection of information on those who are to respond, through the use of appropriate technological collection techniques or other forms of information technology.

DATES: Submit comments on or before December 15, 2004.

ADDRESSES: Submit comments regarding this burden or any other aspect of this collection of information, including suggestions for reducing this burden to the General Services Administration, FAR Secretariat (VR), 1800 F Street, NW, Room 4035, Washington, DC 20405.

FOR FURTHER INFORMATION CONTACT: Craig Goral, Contract Policy Division, GSA (202) 501–3856.

SUPPLEMENTARY INFORMATION:

A. Purpose

Agencies are required to report under 41 U.S.C. 252(d) and 10 U.S.C. 2305(d) suspected violations of the antitrust laws (e.g., collusive bidding, identical bids, uniform estimating systems, etc.) to the Attorney General. As a first step in assuring that Government contracts are not awarded to firms violating such laws, offerors on Government contracts must complete the certificate of independent price determination. An offer will not be considered for award where the certificate has been deleted or modified. Deletions or modifications of the certificate and suspected false

certificates are reported to the Attorney General.

B. Annual Reporting Burden

Respondents: 64,250.
Responses Per Respondent: 20.
Total Responses: 1,285,000.
Hours Per Response: .0065.
Total Burden hours: 8,352.
Obtaining Copies of Proposals: Requesters may obtain a copy of the information collection documents from the General Services Administration, FAR Secretariat (VR), Room 4035, 1800 F Street, Washington, DC 20405, telephone (202) 501–4755. Please cite OMB Control No. 9000–0018, Certification of Independent Price Determination and Parent Company and Identifying Data, in all correspondence.

Dated: October 28, 2004

Laura Auletta,

Acting Director, Contract Policy Division.

[FR Doc. 04–25295 Filed 11–12–04; 8:45 am]

BILLING CODE 6820–EP–S

DEPARTMENT OF EDUCATION

Submission for OMB Review; Comment Request

AGENCY: Department of Education.

SUMMARY: The Director, Regulatory Information Management Services, Office of the Chief Information Officer invites comments on the submission for OMB review as required by the Paperwork Reduction Act of 1995.

DATES: Interested persons are invited to submit comments on or before December 15, 2004.

ADDRESSES: Written comments should be addressed to the Office of Information and Regulatory Affairs, Attention: Carolyn Lovett, Desk Officer, Department of Education, Office of Management and Budget, 725 17th Street, NW., Room 10235, New Executive Office Building, Washington, DC 20503, or faxed to (202) 395–6974.

SUPPLEMENTARY INFORMATION: Section 3506 of the Paperwork Reduction Act of 1995 (44 U.S.C. chapter 35) requires that the Office of Management and Budget (OMB) provide interested Federal agencies and the public an early opportunity to comment on information collection requests. OMB may amend or waive the requirement for public consultation to the extent that public participation in the approval process would defeat the purpose of the information collection, violate State or Federal law, or substantially interfere with any agency's ability to perform its statutory obligations. The Director, Regulatory Information Management Services, Office of the Chief Information Officer, publishes that notice containing proposed information collection requests prior to submission of these requests to OMB. Each proposed information collection, grouped by office, contains the following: (1) Type of review requested, *e.g.,* new, revision, extension, existing or reinstatement; (2) title; (3) summary of the collection; (4) description of the need for, and proposed use of, the information; (5) respondents and frequency of collection; and (6) reporting and/or recordkeeping burden. OMB invites public comment.

Dated: November 5, 2004.

Jeanne Van Vlandren,

Director, Regulatory Information Management Services, Office of the Chief Information Officer.

Federal Student Aid

Type of Review: Extension.
Title: Guaranty Agency Financial Report.
Frequency: Monthly, annually.
Affected Public: State, local, or tribal gov't, SEAs or LEAs; businesses or other for-profit.
Reporting and Recordkeeping Hour Burden:
Responses: 612.
Burden Hours: 33,660.
Abstract: The Guaranty Agency Financial Report is used to request payments from and make payments to the Department of Education under the Federal Family Education Loan (FFEL) program authorized by Title IV, Part B of the Higher Education Act (HEA) of 1965, as amended. The report is also used to monitor the agency's financial activities, including activities concerning its Federal fund, operating fund and the agency's restricted account.

Requests for copies of the submission for OMB review; comment request may be accessed from *http://edicsweb.ed.gov,* by selecting the ''Browse Pending Collections'' link and by clicking on link number 2641. When you access the information collection, click on ''Download Attachments'' to view. Written requests for information should be addressed to U.S. Department of Education, 400 Maryland Avenue, SW., Potomac Center, 9th Floor, Washington, DC 20202–4700. Requests may also be electronically mailed to the Internet address *OCIO_RIMG@ed.gov* or faxed to 202–245–6621. Please specify the complete title of the information collection when making your request.

Comments regarding burden and/or the collection activity requirements should be directed to Sheila Carey at her e-mail address *Sheila.Carey@ed.gov.* Individuals who use a telecommunications device for the deaf (TDD) may call the Federal Information Relay Service (FIRS) at 1–800–877–8339.

[FR Doc. 04–25256 Filed 11–12–04; 8:45 am]

BILLING CODE 4000–01–M

ENVIRONMENTAL PROTECTION AGENCY

[AMS–FRL–7837–7]

California State Motor Vehicle Pollution Control Standards; Request for Waiver of Federal Preemption; Opportunity for Public Hearing

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice of opportunity for public hearing and comment.

SUMMARY: The California Air Resources Board (CARB) has notified EPA that it has adopted amendments to the California heavy-duty diesel regulations for 2007 and subsequent model year vehicles and engines (''2007 California Heavy Duty Diesel Engine Standards'') and related test procedures including the not-to-exceed (NTE) and supplemental steady-state tests (''supplemental test procedures'') to determine compliance with applicable standards. By letter dated July 16, 2004, CARB submitted a request that EPA grant a waiver of preemption under section 209(b) of the Clean Air Act (CAA), 42 U.S.C. 7543(b) for these amendments. This notice announces that EPA has tentatively scheduled a public hearing concerning California's request and that EPA is accepting written comment on the request.

DATES: EPA has tentatively scheduled a public hearing concerning CARB's request on December 15, 2004 beginning at 10 a.m. EPA will hold a hearing only if a party notifies EPA by December 6, 2004, expressing its interest in presenting oral testimony. By December 10, 2004, any person who plans to attend the hearing should call David Dickinson at (202) 343–9256 to learn if a hearing will be held. If EPA does not receive a request for a public hearing, then EPA will not hold a hearing, and instead consider CARB's request based on written submissions to the docket. Any party may submit written comments by January 24, 2005.

ADDRESSES: EPA will make available for public inspection at the Air and Radiation Docket and Information Center written comments received from interested parties, in addition to any

testimony given at the public hearing. The official public docket is the collection of materials that is available for public viewing at the Air and Radiation Docket in the EPA Docket Center, (EPA/DC) EPA West, Room B102, 1301 Constitution Ave., NW., Washington, DC. The EPA Docket Center Public Reading Room is open from 8:30 to 4:30 p.m., Monday through Friday, excluding legal holidays. The telephone number for the Public Reading Room is (202) 566–1744, and the telephone number for the Air and Radiation Docket is (202) 566–1743. The reference number for this docket is OAR–2004–0132. Parties wishing to present oral testimony at the public hearing should provide written notice to David Dickinson at the address noted below. If EPA receives a request for a public hearing, EPA will hold the public hearing at 1310 L St, NW., Washington, DC 20005.

FOR FURTHER INFORMATION CONTACT: David Dickinson, Certification and Compliance Division (6405J), U.S. Environmental Protection Agency, 1200 Pennsylvania Ave, NW., Washington, DC 20460. Telephone: (202) 343–9256, Fax: (202) 343–2804, e-mail address: *Dickinson.David@EPA.GOV.* EPA will make available an electronic copy of this Notice on the Office of Transportation and Air Quality's (OTAQ's) homepage (*http://www.epa.gov/otaq/*). Users can find this document by accessing the OTAQ homepage and looking at the path entitled ''Regulations.'' This service is free of charge, except any cost you already incur for Internet connectivity. Users can also get the official **Federal Register** version of the Notice on the day of publication on the primary Web site: (*http://www.epa.gov/docs/fedrgstr/EPA-AIR/*).

Please note that due to differences between the software used to develop the documents and the software into which the documents may be downloaded, changes in format, page length, etc., may occur. Parties wishing to present oral testimony at the public hearing should provide written notice to David Dickinson at: U.S. Environmental Protection Agency, 1200 Pennsylvania Ave., NW., (6405J), Washington, DC 20460. Telephone: (202) 343–9256.

Docket: An electronic version of the public docket is available through EPA's electronic public docket and comment system. You may use EPA dockets at *http://www.epa.gov/edocket/* to submit or view public comments, access the index listing of the contents of the official public docket, and to access those documents in the public docket that are available electronically. Although a part of the official docket, the public docket, the public docket does not include Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Once in the edocket system, select ''search,'' then key in the appropriate docket ID number.

SUPPLEMENTARY INFORMATION:

(A) Background and Discussion

Section 209(a) of the Clean Air Act, as amended (''Act''), 42 U.S.C. 7543(a), provides:

> No State or any political subdivision thereof shall adopt or attempt to enforce any standard relating to the control of emissions from new motor vehicles or new motor vehicle engines subject to this part. No state shall require certification, inspection or any other approval relating to the control of emissions from any new motor vehicle or new motor vehicle engine as condition precedent to the initial retail sale, titling (if any), or registration of such motor vehicle, motor vehicle engine, or equipment.

Section 209(b)(1) of the Act requires the Administrator, after notice and opportunity for public hearing, to waive application of the prohibitions of section 209(a) for any state that has adopted standards (other than crankcase emission standards) for the control of emissions from new motor vehicles or new motor vehicle engines prior to March 30, 1966, if the state determines that the state standards will be, in the aggregate, at least as protective of public health and welfare as applicable federal standards. California is the only state that is qualified to seek and receive a waiver under section 209(b). The Administrator must grant a waiver unless he finds that (A) the determination of the state is arbitrary and capricious, (B) the state does not need the state standards to meet compelling and extraordinary conditions, or (C) the state standards and accompanying enforcement procedures are not consistent with section 202(a) of the Act.

CARB's July 16, 2004, letter to the Administrator notified EPA that it had adopted amendments to its heavy-duty diesel vehicle and engine program. These amendments are to title 13, California Code of Regulations (CCR), section 1958.8. The specific regulatory text and the incorporated document covered by CARB's rulemaking are: section 1956.8, Title 13, CCR as shown in attachment 2 to CARB's July 16, 2004 letter; and the amendments to the related test procedures incorporated in section 1956.8(b), ''California Exhaust Emission Standards and Test Procedures for 1985 and Subsequent Model Heavy-Duty Diesel Engines and Vehicles,'' also shown in attachment 2.

Please provide comment as to whether (a) California's determination that its amendments as referenced in its July 16, 2004, request letter, are at least as protective of public health and welfare as applicable federal standards is arbitrary and capricious, (b) California needs separate standards to meet compelling and extraordinary conditions, and (c) California's standards and accompanying enforcement procedures are consistent with section 202(a) of the Clean Air Act.

Procedures for Public Participation

In recognition that public hearings are designed to give interested parties an opportunity to participate in this proceeding, there are no adverse parties as such. Statements by participants will not be subject to cross-examination by other participants without special approval by the presiding officer. The presiding officer is authorized to strike from the record statements that he or she deems irrelevant or repetitious and to impose reasonable time limits on the duration of the statement of any participant.

If hearing(s) are held, the Agency will make a verbatim record of the proceedings. Interested parties may arrange with the reporter at the hearing(s) to obtain a copy of the transcript at their own expense. Regardless of whether public hearing(s) are held, EPA will keep the record open until January 24, 2005. Upon expiration of the comment period, the Administrator will render a decision on CARB's request based on the record of the public hearing(s), if any, relevant written submissions, and other information that he deems pertinent. All information will be available for inspection at EPA Air Docket. (OAR–2004–0132).

Persons with comments containing proprietary information must distinguish such information from other comments to the greatest possible extent and label it as ''Confidential Business Information'' (CBI). If a person making comments wants EPA to base its decision in part on a submission labeled CBI, then a nonconfidential version of the document that summarizes the key data or information should be submitted for the public docket. To ensure that proprietary information is not inadvertently placed in the docket, submissions containing such information should be sent directly to the contact person listed above and not to the public docket. Information covered by a claim of confidentiality will be disclosed by EPA only to the

extent allowed and by the procedures set forth in 40 CFR part 2. If no claim of confidentiality accompanies the submission when EPA receives it, EPA will make it available to the public without further notice to the person making comments.

Dated: November 8, 2004.

Jeffrey R. Holmstead,

Assistant Administrator, Office of Air and Radiation.

[FR Doc. 04–25304 Filed 11–12–04; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[OPPT–2003–0004; FRL–7687–3]

Access to Confidential Business Information by Science Applications International Corporation

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: EPA has authorized its contractor Science Applications International Corporation (SAIC), of Reston, Virginia, access to information which has been submitted to EPA under sections 4, 5, 6, 8, 12, and 13 of the Toxic Substances Control Act (TSCA). Some of the information may be claimed or determined to be Confidential Business Information (CBI).

DATES: Access to the confidential data will occur no sooner than November 22, 2004.

FOR FURTHER INFORMATION CONTACT: Colby Lintner, Regulatory Coordinator, Environmental Assistance Division (7408M), Office of Pollution Prevention and Toxics, Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460; telephone number: (202) 554–1404; e-mail address: *TSCA–Hotline@epa.gov.*

SUPPLEMENTARY INFORMATION:

I. General Information

A. Does this Notice Apply to Me?

This action is directed to the public in general. This action may, however, be of interest to those persons who are or may be required to conduct testing of chemical substances under TSCA. Since other entities may also be interested, the Agency has not attempted to describe all the specific entities that may be affected by this action. If you have any questions regarding the applicability of this action to a particular entity, consult the person listed under **FOR FURTHER INFORMATION CONTACT**.

B. How Can I Get Copies of this Document and Other Related Documents?

1. *Docket.* EPA has established an official public docket for this action under docket identification (ID) number OPPT–2003–0004. The official public docket consists of the documents specifically referenced in this action, any public comments received, and other information related to this action. Although a part of the official docket, the public docket does not include CBI or other information whose disclosure is restricted by statute. The official public docket is the collection of materials that is available for public viewing at the EPA Docket Center, Rm. B102–Reading Room, EPA West, 1301 Constitution Ave., NW., Washington, DC. The EPA Docket Center is open from 8:30 a.m. to 4:30 p.m., Monday through Friday, excluding legal holidays. The EPA Docket Center Reading Room telephone number is (202) 566–1744 and the telephone number for the OPPT Docket, which is located in EPA Docket Center, is (202) 566–0280.

2. *Electronic access.* You may access this **Federal Register** document electronically through the EPA Internet under the ''**Federal Register**'' listings at *http://www.epa.gov/fedrgstr/*.

An electronic version of the public docket is available through EPA's electronic public docket and comment system, EPA Dockets. You may use EPA Dockets at *http://www.epa.gov/edocket/* to submit or view public comments, access the index listing of the contents of the official public docket, and to access those documents in the public docket that are available electronically. Although not all docket materials may be available electronically, you may still access any of the publicly available docket materials through the docket facility identified in Unit I.B.1. Once in the system, select ''search,'' then key in the appropriate docket ID number.

II. What Action is the Agency Taking?

Under Contract Number EP–W–04–046, SAIC of 11251 Roger Bacon Drive, Reston, VA, will assist EPA by providing expert witness support for a civil administrative hearing, administer the Core TSCA Enforcement Center (CTEC) automated tracking system for TSCA CBI, and perform enforcement inspections. SAIC will also assist in the review and/or collection of information from businesses and could potentially access documents subjects to TSCA CBI claim.

In accordance with 40 CFR 2.306(j), EPA has determined that under Contract Number EP–W–04–046, SAIC will require access to CBI submitted to EPA under sections 4, 5, 6, 8, 12, and 13 of TSCA, to perform successfully the duties specified under the contract.

SAIC personnel will be given information submitted to EPA under sections 4, 5, 6, 8, 12, and 13 of TSCA. Some of the information may be claimed or determined to be CBI.

EPA is issuing this notice to inform all submitters of information under sections 4, 5, 6, 8, 12, and 13 of TSCA, that the Agency may provide SAIC access to these CBI materials on a need-to-know basis only. All access to TSCA CBI under this contract will take place at EPA Headquarters only.

Clearance for access to TSCA CBI under Contract Number EP–W–04–046 may continue until September 30, 2009. Access will commence no sooner than November 22, 2004.

SAIC personnel have signed nondisclosure agreements and will be briefed on appropriate security procedures before they are permitted access to TSCA CBI.

List of Subjects

Environmental protection, Confidential business information.

Dated: November 4, 2004.

Brion Cook,

Director, Information Management Division, Office of Pollution Prevention and Toxics.

[FR Doc. 04–25306 Filed 11–12–04; 8:45 am]

BILLING CODE 6560–50–S

ENVIRONMENTAL PROTECTION AGENCY

[FRL–7837–6]

Notice of Availability of the ''Model Application/Information Request for CERCLA Service Station Dealer Exemption'' Under Section 114(c) of the Comprehensive Environmental Response, Compensation and Liability Act (CERCLA)

AGENCY: Environmental Protection Agency.

ACTION: Notice of availability.

SUMMARY: The U.S. Environmental Protection Agency (EPA) is announcing the availability of the ''Model Application/Information Request for CERCLA Service Station Dealer Exemption.''

DATES: The model was issued on November 8, 2004.

ADDRESSES: The model will be available on EPA's Web site at *http://www.epa.gov/compliance/resources/policies/cleanup/superfund/ssde-mod-appinfo.pdf.*

FOR FURTHER INFORMATION CONTACT: Susan Boushell, EPA's Office of Site Remediation Enforcement, (202) 564–2173 or *boushell.susan@epa.gov.*

SUPPLEMENTARY INFORMATION: On February 3, 2004 (69 FR 5147), EPA published a notice of availability for public comment on the ''Draft Model CERCLA Application/Information Request for Service Station Dealers.'' On July 20, 2004 (69 FR 43412), EPA published a notice of availability for public comment on a revised draft model, entitled ''Draft Model Application/Information Request for CERCLA Service Station Dealer Exemption.'' After careful consideration of the comments received, EPA revised and finalized the model application/information request. The final model is available on EPA's Web site at *http://www.epa.gov/ compliance/resources/policies/cleanup/superfund/ssde-mod-appinfo.pdf.*

Dated: November 8, 2004.

Susan E. Bromm,

Director, Office of Site Remediation Enforcement.

[FR Doc. 04–25305 Filed 11–12–04; 8:45 am]

BILLING CODE 6560–50–P

FEDERAL COMMUNICATIONS COMMISSION

Notice of Public Information Collection(s) Being Submitted to OMB for Review and Approval

November 4, 2004.

SUMMARY: The Federal Communications Commissions, as part of its continuing effort to reduce paperwork burden invites the general public and other Federal agencies to take this opportunity to comment on the following information collection, as required by the Paperwork Reduction Act of 1995, Public Law 104–13. An agency may not conduct or sponsor a collection of information unless it displays a currently valid control number. No person shall be subject to any penalty for failing to comply with a collection of information subject to the Paperwork Reduction Act (PRA) that does not display a valid control number. Comments are requested concerning (a) whether the proposed collection of information is necessary for the proper performance of the functions of the Commission, including whether the information shall have practical utility; (b) the accuracy of the Commission's burden estimate; (c) ways to enhance the quality, utility, and clarity of the information collected; and (d) ways to minimize the burden of the collection of information on the respondents, including the use of automated collection techniques or other forms of information technology.

DATES: Written comments should be submitted on or before December 15, 2004. If you anticipate that you will be submitting comments, but find it difficult to do so within the period of time allowed by this notice, you should advise the contact listed below as soon as possible.

ADDRESSES: Direct all comments to Les Smith, Federal Communications Commission, Room 1–A804, 445 12th Street, SW., Washington, DC 20554 or via the Internet to Leslie.Smith@fcc.gov or Kristy L. LaLonde, Office of Management and Budget (OMB), Room 10236 NEOB, Washington, DC 20503, (202) 395–3087 or via the Internet at *Kristy_L._LaLonde@omb.eop.gov.*

FOR FURTHER INFORMATION CONTACT: For additional information or copy of the information collection(s) contact Les Smith at (202) 418–0217 or via the Internet at *Leslie.Smith@fcc.gov.*

SUPPLEMENTARY INFORMATION:

OMB Control Number: 3060–0788.

Title: DTV Showings/Interference Agreements.

Form Number: FCC Form 301 and FCC Form 340.

Type of Review: Revision of a currently approved collection.

Respondents: Business or other for-profit entities; and Not-for-profit institutions.

Number of Respondents: 300.

Estimated Time per Response: 5 hours.

Frequency of Response: On occasion reporting requirement; and Third party disclosure.

Total Annual Burden: 1,500 hours.

Total Annual Cost: $2,400,000.

Privacy Act Impact Assessment: No impact(s).

Needs and Uses: Section III–D of the FCC Form 301 and Section VII of the FCC Form 340 begin with a ''Certification Checklist.'' This checklist contains a series of questions by which applicants may certify compliance with key processing requirements. The first certification requires conformance with the DTV Table of Allotments. The Commission allows flexibility for DTV facilities to be constructed at locations within five kilometers of the reference allotment sites without consideration of additional interference to analog or DTV service, provided the DTV service does not exceed the allotment reference height above average terrain or effective radiated power. In order for the Commission to process applications that cannot certify affirmatively, 47 CFR Section 73.623(c) requires applicants to submit a technical showing to establish that their proposed facilities will not result in additional interference to TV broadcast and DTV operations. Additionally, the Commission permits broadcasters to agree to proposed DTV facilities that do not conform to the initial allotment parameters, even though they might be affected by potential new interference. The Commission will consider granting applications on the basis of interference agreements if it finds that such grants will serve the public interest. These agreements must be signed by all parties to the agreement. In addition, the Commission needs the following information to enable such public interest determinations: A list of parties predicted to receive additional interference from the proposed facility, a showing as to why a grant based on the agreements would serve the public interest, and technical studies depicting the additional interference.

In 2001, the Commission removed from this collection all references to industry frequency coordination committees. These committees did not evolve. Respondents have been using consulting engineers and attorneys to prepare the technical showings and interference agreements.

OMB Control Number: 3060–0685.

Title: Annual Updating of Maximum Permitted Rates for Regulated Cable Services, FCC Form 1240.

Form Number: FCC 1240.

Type of Review: Revision of currently approved collection.

Respondents: Business or other for-profit entities; and State, local, or tribal government.

Number of Respondents: 3,000.

Estimated Time per Response: 10 hour (avg.).

Frequency of Response: Annual reporting requirement.

Total Annual Burden: 30,000 hours.

Total Annual Cost: $562,500.

Privacy Impact Assessment: No impact(s).

Needs and Uses: The FCC Form 1240 is filed with the local franchising authorities (''LFAs'') by cable operators seeking to adjust maximum permitted rates to reflect changes in external costs. The Commission authored the Form 1240 to enable local franchising authorities to adjudicate permitted rates for regulated cable rates, services, and equipment; for the addition and/or deletion of channels; and for allowance for pass through of external costs due to inflation.

Federal Communications Commission.

Marlene H. Dortch,

Secretary.

[FR Doc. 04–25286 Filed 11–12–04; 8:45 am]

BILLING CODE 6712–01–P

FEDERAL COMMUNICATIONS COMMISSION

[IB Docket No. 04–398; FCC 04–247]

The Effect of Foreign Mobile Termination Rates on U.S. Customers

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: This document is a summary of the *Notice of Inquiry* that was adopted by the Commission on October 14, 2004. The *Notice of Inquiry* seeks to develop a record on foreign mobile termination rates and inquires whether U.S. customers have adequate information and alternatives with regard to foreign mobile termination rates and surcharges, and whether such charges raise consumer concerns.

DATES: Comments are due January 14, 2005, and reply comments are due by February 14, 2005.

FOR FURTHER INFORMATION CONTACT: Peggy Reitzel or Francis Gutierrez, Policy Division, International Bureau, (202) 418–1460.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's *Notice of Inquiry* in IB Docket No. 04–398, FCC 04–247, which was adopted on October 14, 2004. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Reference Center (Room CY–A257), 445 12th Street, SW., Washington, DC 20554. The document may also be downloaded from the Commission's Web site at *http://hraunfoss.fcc.gov/edocs_public/attachmatch/FCC-04-247A1.pdf.* The complete text may also be purchased from the Commission's copy contractor, Best Copy and Printing, Inc., in person at 445 12th Street, SW., Room CY–B402, Washington, DC 20554, via telephone at (202) 488–5300, via facsimile at (202) 488–5563, or via e-mail at *FCC@BCPIWEB.COM.*

Summary of the Notice of Inquiry

On October 14, 2004, the Commission adopted a *Notice of Inquiry* on the Effect of Foreign Mobile Termination Rates on U.S. Customers. By this *Notice of Inquiry,* the Commission seeks to develop a record on foreign mobile termination rates that will enable the Commission to assess properly the effects of foreign mobile termination rates on U.S. customers and competition in the U.S.-international services market.

In the *Notice of Inquiry,* the Commission seeks comment on foreign mobile termination rate payment flows and the relevant regulatory regimes. The Commission seeks input, analyses, and comments on the concerns raised by parties in the *ISP Reform Order,* FCC 04–53, 69 FR 23151, April 28, 2004, and on actions taken by foreign national regulatory authorities to address mobile termination rates within their respective jurisdictions. In addition, the Commission asks for factual information and data on foreign mobile termination rates. Finally, the Commission seeks comment on the appropriate framework by which the Commission can analyze whether foreign mobile termination rates are unreasonably high.

The Commission encourages all interested parties to respond to the questions and requests set forth in the *Notice of Inquiry.*

Ordering Clauses

Pursuant to the authority contained in 47 U.S.C. Sections 151, 4(i), 201, 202, 203, 204, 205, 211, 218, 303(r), 403 this *Notice of Inquiry* is *adopted.*

Federal Communications Commission.

Marlene H. Dortch,

Secretary.

[FR Doc. 04–25287 Filed 11–12–04; 8:45 am]

BILLING CODE 6712–01–P

FEDERAL HOUSING FINANCE BOARD

Sunshine Act Meeting Notice; Announcing a Closed Meeting of the Board of Directors

TIME AND DATE: The meeting of the Board of Directors is scheduled to begin at 10 a.m. on Wednesday, November 17, 2004.

PLACE: Board Room, Second Floor, Federal Housing Finance Board, 1777 F Street, NW., Washington, DC 20006.

STATUS: The entire meeting will be closed to the public.

MATTER TO BE CONSIDERED AT THE MEETING:

Periodic Update of Examination Program Development and Supervisory Findings.

FOR FURTHER INFORMATION CONTACT: Shelia S. Willis, Paralegal Specialist, Office of General Counsel, by telephone at (202) 408–2876 or by electronic mail at *williss@fhfb.gov*.

Dated: November 10, 2004.

By the Federal Housing Finance Board.

Mark J. Tenhundfeld,

General Counsel.

[FR Doc. 04–25404 Filed 11–10–04; 12:41 pm]

BILLING CODE 6725–01–P

FEDERAL RESERVE SYSTEM

Change in Bank Control Notices; Acquisition of Shares of Bank or Bank Holding Companies

The notificants listed below have applied under the Change in Bank Control Act (12 U.S.C. 1817(j)) and § 225.41 of the Board's Regulation Y (12 CFR 225.41) to acquire a bank or bank holding company. The factors that are considered in acting on the notices are set forth in paragraph 7 of the Act (12 U.S.C. 1817(j)(7)).

The notices are available for immediate inspection at the Federal Reserve Bank indicated. The notices also will be available for inspection at the office of the Board of Governors. Interested persons may express their views in writing to the Reserve Bank indicated for that notice or to the offices of the Board of Governors. Comments must be received not later than November 29, 2004.

A. Federal Reserve Bank of Minneapolis (Jacqueline G. Nicholas, Community Affairs Officer) 90 Hennepin Avenue, Minneapolis, Minnesota 55480–0291:

1. Todd L. Johnson, Nancy S. Johnson, Hillary K. Johnson, and Matthew S. Johnson, all of Duluth, Minnesota; to acquire voting shares of NATCOM Bancshares, Inc., Superior, Wisconsin, and thereby indirectly acquire voting shares of National Bank of Commerce, Superior, Wisconsin.

2. Federal Reserve Bank of Kansas City (Donna J. Ward, Assistant Vice President) 925 Grand Avenue, Kansas City, Missouri 64198–0001:

1. Walter David Scott, Amy Scott, Sandra Parker, all of Omaha, Nebraska, and Karen Dixon, Leawood, Kansas; to acquire voting shares of DB Holding Company, Inc., Omaha, Nebraska, and thereby indirectly acquire voting shares of Omaha State Bank, Omaha, Nebraska.

Board of Governors of the Federal Reserve System, November 8, 2004.

Robert deV. Frierson,

Deputy Secretary of the Board.

[FR Doc. 04–25269 Filed 11–12–04; 8:45 am]

BILLING CODE 6210–01–S

FEDERAL RESERVE SYSTEM

Formations of, Acquisitions by, and Mergers of Bank Holding Companies

The companies listed in this notice have applied to the Board for approval, pursuant to the Bank Holding Company Act of 1956 (12 U.S.C. 1841 *et seq.*) (BHC Act), Regulation Y (12 CFR Part 225), and all other applicable statutes and regulations to become a bank holding company and/or to acquire the assets or the ownership of, control of, or the power to vote shares of a bank or bank holding company and all of the banks and nonbanking companies owned by the bank holding company, including the companies listed below.

The applications listed below, as well as other related filings required by the Board, are available for immediate inspection at the Federal Reserve Bank indicated. The application also will be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the standards enumerated in the BHC Act (12 U.S.C. 1842(c)). If the proposal also involves the acquisition of a nonbanking company, the review also includes whether the acquisition of the nonbanking company complies with the standards in section 4 of the BHC Act (12 U.S.C. 1843). Unless otherwise noted, nonbanking activities will be conducted throughout the United States. Additional information on all bank holding companies may be obtained from the National Information Center website at *www.ffiec.gov/nic/*.

Unless otherwise noted, comments regarding each of these applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than December 6, 2004.

A. Federal Reserve Bank of Atlanta (Sue Costello, Vice President) 1000 Peachtree Street, N.E., Atlanta, Georgia 30303:

1. CBS Financial Corporation, Smyrna, Georgia; to become a bank holding company by acquiring 100 percent of the voting shares of Community Bank of the South, Smyrna, Georgia.

B. Federal Reserve Bank of St. Louis (Randall C. Sumner, Vice President) 411 Locust Street, St. Louis, Missouri 63166–2034:

1. Centennial Bancshares, Inc., Little Rock, Arkansas; to become a bank holding company by acquiring 100 percent of the voting shares of Pine State Bancshares, Inc., Kingsland, Arkansas, and thereby indirectly acquire Pine State Bank, Kingsland, Arkansas.

Board of Governors of the Federal Reserve System, November 8, 2004.

Robert deV. Frierson,

Deputy Secretary of the Board.

[FR Doc. 04–25268 Filed 11–12–04; 8:45 am]

BILLING CODE 6210–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Coordinator for Health Information Technology; Development and Adoption of a National Health Information Network

AGENCY: Department of Health and Human Services.

ACTION: Request for information.

SUMMARY: Public comment is sought regarding considerations in implementing the President's call for widespread adoption of interoperable electronic health records (EHRs) within 10 years. On April 27, 2004, President Bush established the position of the National Health Information Technology Coordinator. On May 6, 2004, Secretary Tommy G. Thompson appointed David J. Brailer, MD, PhD to serve as National Coordinator for Health Information Technology. The Executive Order signed by the President required the National Coordinator to report within 90 days of operation on the development and implementation of a strategic plan. This Framework for Strategic Action entitled: ''The Decade of Health Information Technology: Delivering Consumer-centric and Information-rich Health Care'' (the Framework), was presented at the Health Information Technology Secretarial Summit II on July 21, 2004. The Framework is posted for reference at: *[http://www.hhs.gov/onchit/framework/]*. The Framework outlines an approach toward the nationwide implementation of interoperable health information technology in both the public and the private sectors.

In order to realize a new vision for health care through the use of information technology, the report called for a sustained set of strategic actions, embraced by the public and the private health sectors, which will be taken over many years. The Framework outlined four major goals: inform clinical practice with use of EHRs, interconnect clinicians so that they can exchange health information using advanced and secure electronic communication, personalize care with consumer-based health records and better information for consumers, and improve public health through advanced biosurveillance methods and streamlined collection of data for quality measurement and research.

This Request for Information (RFI) addresses the goal of interconnecting clinicians by seeking public comment and input regarding how widespread interoperability of health information technologies and health information exchange can be achieved. This RFI is intended to inform policy discussions about possible methods by which widespread interoperability and health information exchange could be deployed and operated on a sustainable basis.

DATES: Responses should be submitted to the Department of Health and Human Services (HHS), Office of the National Coordinator for Health Information Technology (ONCHIT), on or before 5 p.m. e.s.t. on January 18, 2005.

ADDRESSES: Electronic responses are preferred and should be addressed to: *NHINRFI@hhs.gov* in the Office of the National Coordinator for Health Information Technology, Department of Health and Human Services. Include NHIN RFI Responses in the subject line. Non-electronic responses will also be accepted. Please send to: Office of the National Coordinator Health Information Technology, Department of Health and Human Services, Attention: NHIN RFI Responses, Hubert H. Humphrey Building, Room 517D, 200 Independence Avenue, SW., Washington, DC 20201.

FOR FURTHER INFORMATION CONTACT: On December 6, 2004, there will be a technical assistance conference call to answer questions from potential responders. More details will be provided on how to participate in this call on the ONCHIT Web site *[http://www.hhs.gov/onchit/]*. Additionally, a public, online Frequently Asked Question (FAQ) page will be provided to answer questions throughout the response period on ONCHIT's Web site.

Please direct e-mail inquiries and responses to *NHINRFI@hhs.gov*. For additional information, contact Lee Jones or Lori Evans, in the Office of the National Coordinator for Health Information Technology at toll free (877) 474–3918.

Background: As the nation embarks on the widespread deployment of EHRs, a variety of concomitant challenges and barriers must be addressed. One of these is interoperability, or the ability to exchange patient health information among disparate clinicians and other authorized entities in real time and under stringent security, privacy and other protections. Interoperability is an essential factor in using health information technology to improve the

quality and efficiency of care in the United States. Interoperability is necessary for compiling the complete experience of a patient's care, for maintaining a patient's personal health records and for ensuring that complete health information is accessible to clinicians as the patient moves through various healthcare settings. Interoperability is needed for clinicians to make fact-based decisions so medical errors and redundant tests can be reduced. Interoperability is also critical to cost-effective and timely data collection for biosurveillance, quality measurement and clinical research. In short, interoperability is essential for realizing the key goals that are desired from health information technology.

With the exception of a few isolated regional projects, the United States does not currently have meaningful health information interoperability capabilities. Moreover, the broad set of actions and tasks that are needed to achieve interoperability are not well-defined. It is known that interoperability requires a set of common standards that specify how information can be communicated and in what format. On this, there has been considerable effort and progress achieved by private sector organizations such as Health Level 7 (HL7), and by the American National Standards Institute (ANSI), both of which are voluntary consensus standards setting organizations. Also, HHS and other Federal agencies have advanced the adoption of standards through the Consolidated Health Informatics (CHI) initiative, as well as the Public Health Information Network (PHIN) and National Electronic Disease Surveillance System (NEDSS) under the leadership of the Centers for Disease Control and Prevention (CDC). With HHS participation, HL7 has also created a functional model and standards for electronic health records.

However more remains to be done to achieve interoperability and to determine the process by which these tasks should be pursued in the public and private sectors. Clearly needed are interconnection tools such as mobile authentication, identification management, common web services architecture and security technologies. Also needed are precisely defined implementation regimens that are specified at the level of software code. There is also a need for common networking and communication tools to unify access and security. Aside from this, mechanisms for ensuring the sustainable operation of these components on a widespread and publicly available basis must be defined. There are potentially other components that may not be known at this time. The collective array of components that underlie nationwide interoperability is referred to as a National Health Information Network (NHIN) in the Framework.

The NHIN could be developed and operated in many ways. It could include state-of-the-art web technologies or more traditional clearinghouse architectures. It could be highly decentralized or somewhat centrally brokered. It could be a nationwide service, a collection of regional services or a set of tools that share common components. It could be overseen by public organizations, by private organizations, or by public-private consortia. Regardless of how it is developed, overseen or operated, there is a compelling public interest for a NHIN to exist.

Therefore, the National Coordinator for Health Information Technology is seeking comments on and ideas for how a NHIN can be deployed for widespread use. To begin this process, the National Coordinator is inviting responses about the questions in this RFI. We intend to explore the role of the federal government in facilitating deployment of a NHIN, how it could be coordinated with the Federal Health Architecture (FHA), and how it could be supported and coordinated by Regional Health Information Organizations (RHIOs). (For additional information on the FHA and the RHIOs, please refer to the report: ''The Decade of Health Information Technology: Delivering Consumer-centric and Information-rich Health Care,'' at: *[http://www.hhs.gov/onchit/framework/]*).

There are many perspectives that can be brought to bear on this important topic. Health information technology organizations, healthcare providers, industry associations and other stakeholders all have important insights that will inform future deliberation. In the interest of having the most compelling, complete and thorough responses possible, we encourage interested parties to collaborate and submit unified responses to this RFI wherever possible. Comments from the public at large are also invited.

Request for Information

General 1. The primary impetus for considering a NHIN is to achieve interoperability of health information technologies used in the mainstream delivery of health care in America. Please provide your working definition of a NHIN as completely as possible, particularly as it pertains to the information contained in or used by electronic health records. Please include key barriers to this interoperability that exist or are envisioned, and key enablers that exist or are envisioned. This description will allow reviewers of your submission to better interpret your responses to subsequent questions in this RFI regarding interoperability.

2. What type of model could be needed to have a NHIN that: Allows widely available access to information as it is produced and used across the health care continuum; enables interoperability and clinical health information exchange broadly across most/all HIT solutions; protects patients' individually identifiable health information; and allows vendors and other technology partners to be able to use the NHIN in the pursuit of their business objectives? Please include considerations such as roles of various private- and public-sector entities in your response.

3. What aspects of a NHIN could be national in scope (*i.e.*, centralized commonality or controlled at the national level), versus those that are local or regional in scope (*i.e.*, decentralized commonality or controlled at the regional level)? Please describe the roles of entities at those levels. (Note: ''national'' and ''regional'' are *not* meant to imply Federal or local governments in this context.)

Organizational and Business Framework

4. What type of framework could be needed to develop, set policies and standards for, operate, and adopt a NHIN? Please describe the kinds of entities and stakeholders that could compose the framework and address the following components:

a. How could a NHIN be developed? What could be key considerations in constructing a NHIN? What could be a feasible model for accomplishing its construction?

b. How could policies and standards be set for the development, use and operation of a NHIN?

c. How could the adoption and use of the NHIN be accelerated for the mainstream delivery of care?

d. How could the NHIN be operated? What are key considerations in operating a NHIN?

5. What kind of financial model could be required to build a NHIN? Please describe potential sources of initial funding, relative levels of contribution among sources and the implications of various funding models.

6. What kind of financial model could be required to operate and sustain a functioning NHIN? Please describe the

implications of various financing models.

7. What privacy and security considerations, including compliance with relevant rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), are implicated by the NHIN, and how could they be addressed?

8. How could the framework for a NHIN address public policy objectives for broad participation, responsiveness, open and non-proprietary interoperable infrastructure?

Management and Operational Considerations

9. How could private sector competition be appropriately addressed and/or encouraged in the construction and implementation of a NHIN?

10. How could the NHIN be established to maintain a health information infrastructure that:

a. Evolves appropriately from private investment;

b. Is non-proprietary and available in the public domain;

c. Achieves country-wide interoperability; and

d. Fosters market innovation.

11. How could a NHIN be established so that it will be utilized in the delivery of care by healthcare providers, regardless of their size and location, and also achieve enough national coverage to ensure that lower income rural and urban areas could be sufficiently served?

12. How could community and regional health information exchange projects be affected by the development and implementation of a NHIN? What issues might arise and how could they be addressed?

13. What effect could the implementation and broad adoption of a NHIN have on the health information technology market at large? Could the ensuing market opportunities be significant enough to merit the investment in a NHIN by the industry? To what entities could the benefits of these market opportunities accrue, and what implication (if any) does that have for the level of investment and/or role required from those beneficiaries in the establishment and perpetuation of a NHIN?

Standards and Policies To Achieve Interoperability

(Question 4b above asks how standards and policy setting for a NHIN could be considered and achieved. The questions below focus more specifically on standards and policy requirements.)

14. What kinds of entity or entities could be needed to develop and diffuse interoperability standards and policies? What could be the characteristics of these entities? Do they exist today?

15. How should the development and diffusion of technically sound, fully informed interoperability standards and policies be established and managed for a NHIN, initially and on an ongoing basis, that effectively address privacy and security issues and fully comply with HIPAA? How can these standards be protected from proprietary bias so that no vendors or organizations have undue influence or advantage? Examples of such standards and policies include: secure connectivity, mobile authentication, patient identification management and information exchange.

16. How could the efforts to develop and diffuse interoperability standards and policy relate to existing Standards Development Organizations (SDOs) to ensure maximum coordination and participation?

17. What type of management and business rules could be required to promote and produce widespread adoption of interoperability standards and the diffusion of such standards into practice?

18. What roles and relationships should the federal government take in relation to how interoperability standards and policies are developed, and what roles and relationships should it refrain from taking?

Financial and/or Regulatory Incentives and Legal Considerations

19. Are financial incentives required to drive the development of a marketplace for interoperable health information, so that relevant private industry companies will participate in the development of a broadly available, open and interoperable NHIN? If so, what types of incentives could gain the maximum benefit for the least investment? What restrictions or limitation should these incentives carry to ensure that the public interest is advanced?

20.What kind of incentives should be available to regional stakeholders (*e.g.*, health care providers, physicians, employers that purchase health insurance, payers) to use a health information exchange architecture based on a NHIN?

21. Are there statutory or regulatory requirements or prohibitions that might be perceived as barriers to the formation and operation of a NHIN, or to support it with critical functions?

22. How could proposed organizational mechanisms or approaches address statutory and regulatory requirements (*e.g.*, data privacy and security, antitrust constraints and tax issues)?

Other

23. Describe the major design principles/elements of a potential technical architecture for a NHIN. This description should be suitable for public discussion.

24. How could success be measured in achieving an interoperable health information infrastructure for the public sector, private sector and health care community or region?

Dated: November 9, 2004.

David J. Brailer,

National Coordinator, Office of the National Coordinator for Health Information Technology.

[FR Doc. 04–25382 Filed 11–10–04; 11:30 am]

BILLING CODE 4150–24–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration on Aging

Agency Information Collection Activities; Proposed Collection; Comment Request; Senior Medicare Patrol Program Outcome Measurement

AGENCY: Administration on Aging, HHS.

ACTION: Notice.

SUMMARY: The Administration on Aging (AoA) is announcing an opportunity for public comment on the proposed collection of certain information by the agency. Under the Paperwork Reduction Act of 1995 (the PRA), Federal agencies are required to publish notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension of an existing collection of information, and to allow 60 days for public comment in response to the notice. This notice solicits comments on the information collection requirements relating to Senior Medicare Patrol (SMP) program outcome measurement.

DATES: Submit written or electronic comments on the collection of information by January 14, 2005.

ADDRESSES: Submit electronic comments on the collection of information to: *Barbara.dieker@aoa.gov.* Submit written comments on the collection of information to Barbara Dieker, Administration on Aging, Washington, DC 20201 or by fax at (202) 357–3558.

FOR FURTHER INFORMATION CONTACT: Barbara Dieker at (202) 357–0139 or *Barbara.dieker@aoa.gov.*

SUPPLEMENTARY INFORMATION: Under the PRA (44 U.S.C. 3501–3520), Federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. ''Collection of information'' is defined in 44 U.S.C. 3502(3) and 5 CFR 1320.3(c) and includes agency request or requirements that members of the public submit reports, keep records, or provide information to a third party. Section 3506(c)(2)(A) of the PRA (44 U.S.C. 3506(c)(2)(A)) requires Federal agencies to provide a 60-day notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension of an existing collection of information, before submitting the collection to OMB for approval. To comply with this requirement, AoA is publishing notice of the proposed collection of information set forth in this document. With respect to the following collection of information, AoA invites comments on: (1) Whether the proposed collection of information is necessary for the proper performance of AoA's functions, including whether the information will have practical utility; (2) the accuracy of AoA's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques when appropriate, and other forms of information technology. AoA estimates the burden of this collection of information as follows:

Frequency: Annually.

Respondents: Medicare beneficiaries after SMP education/training on fraud prevention; administered by staff or senior volunteers in 57 SMP projects nationwide.

Estimated number of responses: 21,000.

Total Estimated Burden Hours: 2,300.

Josefina G. Carbonell,

Assistant Secretary for Aging.

[FR Doc. 04–25241 Filed 11–12–04; 8:45 am]

BILLING CODE 4154–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

[Document Identifier: CMS–R–185, CMS 10131, CMS–10054 and CMS–R–50]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Centers for Medicare and Medicaid Services.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Centers for Medicare and Medicaid Services (CMS) (formerly known as the Health Care Financing Administration (HCFA)), Department of Health and Human Services, is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

1. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Granting and Withdrawal of Deeming Authority to Private Nonprofit Accreditation Organizations and of State Exemption Under State Laboratory Programs and Supporting Regulations in 42 CFR 493.551–493.557; *Use:* The information required is necessary to determine whether a private accreditation organization's or State licensure program's standards and accreditation/licensure process is equal to or more stringent than those of CLIA. *Form Number:* CMS–R–185 (OMB#: 0938–0686); *Frequency:* Initial application and as needed; *Affected Public:* Not-for-profit institutions, Business or other for-profit and State, Local, or Tribal Government; *Number of Respondents:* 8; *Total Annual Responses:* 76; *Total Annual Hours:* 768.

2. *Type of Information Collection Request:* New Collection; *Title of Information Collection:* Evaluation of Medicare Disease Management Demonstrations; *Form No.:* CMS–10131 (OMB# 0938–NEW); *Use:* CMS contracted with Mathematic Policy Research, Inc. (MPR) for the evaluation of disease management programs. The purpose of the patient survey is to assess the impact of disease management and prescription drug benefits on patient health, functioning status, care satisfaction, health behaviors and knowledge of condition. Data from the physician survey will be used to assess physician satisfaction with disease management services, physician perceptions of the impact of disease management on patient outcomes, education and service use, and the impact of disease management programs on physician practices and office workload.; *Frequency:* On Occasion; *Affected Public:* Individuals or households, Business or other for-profit; *Number of Respondents:* 5000; *Total Annual Responses:* 2500; *Total Annual Hours:* 1625.

3. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Recognition of Payment for New Technology Services for Ambulatory Payment Classifications (APCs) under the Outpatient Prospective Payment System and Supporting Regulations in 42 CFR, 413.65 and 419.42; *Form No.:* CMS–10054 (OMB# 0938–0860); *Use:* Information is necessary to determine services eligible for payment in new technology ambulatory payment classifications (APCs) in the outpatient prospective payment system; *Frequency:* On Occasion; *Affected Public:* Business or other for-profit; *Number of Respondents:* 15; *Total Annual Responses:* 15; *Total Annual Hours:* 180.

4. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Medical Records Review under PPS and Supporting Regulations in 42 CFR, Sections 412.40–412.52; *Form No.:* CMS–R–50 (OMB# 0938–0359); *Use:* The Quality Improvement Organizations (QIOs) are authorized to conduct medical review activities under the Prospective Payment System (PPS) . In order to conduct these review activites, the agency depends upon hospitals to make available specific records regarding care provided to Medicare beneficiaries. The Clinical Data Abstraction Centers (CDACs) obtain copies of medical records from which they abstract data to analyze patterns of care and outcomes for heart failure/myocardial infarction, pneumonia, diabetes and surgical infection.; *Frequency:* Other: when records are reviewed; *Affected Public:*

Business or other for-profit, Not-for-profit institutions, Federal Government, and State, Local or Tribal Govt.; *Number of Respondents:* 6,100; *Total Annual Responses:* 397,500; *Total Annual Hours:* 11,925.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS' Web site address at *http://www.cms.hhs.gov/regulations/pra/*, or e-mail your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov*, or call the Reports Clearance Office on (410) 786–1326.

Written comments and recommendations for the proposed information collections must be mailed within 60 days of this notice directly to the CMS Paperwork Clearance Officer designated at the following address: CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development and Issuances, Attention: Melissa Musotto, Room C5–14–03, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: November 5, 2004.

John P. Burke, III,

Paperwork Reduction Act Team Leader, Office of Strategic Operations and Strategic Affairs, Division of Regulations Development and Issuances.

[FR Doc. 04–25250 Filed 11–12–04; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

SES Executive Review Board/ Performance Review Board

AGENCY: Indian Health Service.

ACTION: Notice.

SUMMARY: Notice is hereby given of the appointment of members of the Indian Health Service (IHS) Senior Executive Service (SES) Executive Review Board/ SES Performance Review Board.

FOR FURTHER INFORMATION CONTACT: Phyllis Eddy, Acting Director, Office of Management Services, 801 Thompson Avenue, Suite 120, Rockville, Maryland 20852, (301) 443–6290.

SUPPLEMENTARY INFORMATION: Section 4314(c) (1) through (5) of Title 5, U.S.C., requires each agency to establish, in accordance with regulations prescribed by the Office of Personnel Management, one or more SES performance review boards. The board reviews and evaluates the initial appraisal of a senior executive's performance by the supervisor and considers recommendations to the appointing authority regarding the performance of the senior executive.

The following have been designated as regular members of the Senior Executive Service (SES) Executive Review Board/SES Performance Review Board for IHS: Phyllis Eddy, Chair; Elaine Perry, Deputy Director, Office of the Administrator, Substance Abuse and Mental Health Services Administration; Robert G. McSwain, Acting Deputy Director, Management Operations; Gary Hartz, Acting Deputy Director, IHS; Chris Mandregan, Jr., Director, Alaska Area IHS; Doni Wilder, Director, Portland Area IHS; John Hubbard, Director, Navajo Area IHS.

Dated: November 5, 2004.

Charles W. Grim,

Assistant Surgeon General, Director.

[FR Doc. 04–25244 Filed 11–12–04; 8:45 am]

BILLING CODE 4160–16–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General

Program Exclusions: October 2004

AGENCY: Office of Inspector General, HHS.

ACTION: Notice of program exclusions.

During the month of October 2004, the HHS Office of Inspector General imposed exclusions in the cases set forth below. When an exclusions is imposed, no program payment is made to anyone for any items or services (other than an emergency item or service not provided in a hospital emergency room) furnished, ordered or prescribed by an excluded party under the Medicare, Medicaid, and all Federal Health Care programs. In addition, no program payment is made to any business or facility, *e.g.*, a hospital, that submits bills for payment for items or services provided by an excluded party. Program beneficiaries remain free to decide for themselves whether they will continue to use the services of an excluded party even though no program payments will be made for items and services provided by that excluded party. The exclusions have national effect and also apply to all Executive Branch procurement and non-procurement programs and activities.

Subject name	Address	Effective date
PROGRAM-RELATED CONVICTIONS		
ARMON, BOBBY	MILWAUKEE, WI	11/18/2004
ARNOLD, RODELL	TOLEDO, OH	11/18/2004
ARRUDA, CARMEN	ISSAQUAH, WA	11/18/2004
BAUMAN, DAVID	HOUSTON, TX	11/18/2004
BROWN, AUWANA	FRESNO, CA	11/18/2004
CABRERA, MARCO	MIAMI, FL	11/18/2004
CARTER, JERRY	DYERSBURG, TN	11/18/2004
CASIANO, ROSARIO	ROSEMEAD, CA	11/18/2004
CORBETT, KERMIS	ELGIN, SC	11/18/2004
CORTES, FRANCISCO	HIALEAH, FL	11/18/2004
DAY, APRIL	LOS ANGELES, CA	11/18/2004
DELEON, VANESSA	HAWTHORNE, CA	11/18/2004
ELBAGDADI, HAZEM	PETERSBURG, VA	11/18/2004
ENCINAS, BENJAMIN	TUCSON, AZ	11/18/2004
FATEMI, MOHAMMAD	DUNKIRK, MD	11/18/2004
FINDLEY, KATHERINE	LAKEWOOD, CO	11/18/2004
FORD, FRED	EGLIN AFB, FL	11/18/2004
FREITAS, JOHN	CARTNEGE, MO	11/18/2004
GONZALEZ, GIORDY	MIAMI, FL	11/18/2004
GONZALEZ, MILAGROS	MIAMI, FL	11/18/2004

Subject name	Address	Effective date
GROCE, TINA	GRANVIEW, OH	11/18/2004
HARRIS, THOMAS	POTEAU, OK	11/18/2004
HEDRINGTON, HERBERT	FRESNO, CA	11/18/2004
HOLTHAUS, CHARLES	NEW ORLEANS, LA	11/18/2004
JACOBS, ROZA	COLUMBUS, OH	11/18/2004
JULIUS, RYAN	YORK, PA	11/18/2004
KERSEY-THOMAS, CHRISTINE	N AUGUSTA, SC	11/18/2004
LEUTTERS, FLORENCE	HICKSVILLE, NY	11/18/2004
LOZANO, CARRIE	FRESNO, CA	11/18/2004
MALDONADO, MARIA	LOS ANGELES, CA	11/18/2004
NEIL, TAMMY	CARTHAGE, MO	11/18/2004
OSSEI, HARRY	DULUTH, MN	11/18/2004
OYENUSI, ADEBOWALE	MAPLEWOOD, NJ	11/18/2004
PARKER, MARILYN	MESA, AZ	11/18/2004
PARTON, BRENDA	LAKEWOOD, WA	11/18/2004
PATEL, DIPAKKUMAR	MIDLAND, TX	11/18/2004
PETRILLO, LOUIS	MIAMI, FL	11/18/2004
HILLIPS, KAWAII	MARKS, MS	11/18/2004
RECAIDO, BERT	CARSON, CA	11/18/2004
RECAIDO, EVELYN	CARSON, CA	11/18/2004
ROBISON, TROY	ORANGE PARK, FL	5/3/2004
SALINAS, CARLOS	DENVER, CO	11/18/2004
SCHULTZ, DENISE	GROVE CITY, OH	11/18/2004
SHELHAMMER, PAUL	PITTSBURGH, PA	11/18/2004
SMITH, RANDALL	OREGON CITY, OR	11/18/2004
STECKLER, SCOTT	ROCKVILLE, MD	11/18/2004
STRICKMAN, IRA	PENSACOLA, FL	11/18/2004
TITH, LAURA	MESA, AZ	8/9/2004
TUCKER, DAVID	BRONX, NY	11/18/2004
VELEZ, SAMUEL	BROOKLYN, NY	11/18/2004
WALBORN, TODD	BIRMINGHAM, AL	11/18/2004
WATERHOUSE, DEA	FAIRHAVEN, VT	11/18/2004
WATTS, WILLIAM	SEMINOLE, OK	11/18/2004
WEISS, BETH	COLLINGSWOOD, NJ	11/18/2004
WELCH, DARRYL	FOX LAKE, WI	11/18/2004
FELONY CONVICTION FOR HEALTH CARE FRAUD		
DORRIN, ROBIN	ST LOUIS, MO	11/18/2004
GUTIERREZ, JEREMY	HOUSTON, TX	11/18/2004
KREUTZER, DONALD	CLARKSVILLE, MO	11/18/2004
LAWTON, JANICE	WARREN, OH	11/18/2004
MORAN, KELLIE	W. MONROE, NY	11/18/2004
MURGATROYD, ROBERT	ATLANTA, GA	11/18/2004
SAVAGE, LORI	STRONG, ME	11/18/2004
STUBBS, PAMELA	RICHMOND, IN	11/18/2004
TORRES, TIA	PELLA, IA	11/18/2004
WINTERS, MARIANNE	TUMWATER, WA	11/18/2004
YEX, ANITA	BRUNSWICK HILLS, OH	11/18/2004
FELONY CONTROL SUBSTANCE CONVICTION		
ATKINSON, TAMMY	ANTHONY, FL	11/18/2004
BARTOLO, KATHRYN	SANFORD, MI	11/18/2004
BRILL, LAURA	DECATUR, GA	11/18/2004
ENNIS, LORI	SPARTA, MO	11/18/2004
HOSKINS, TAMMY	SPRINGFIELD, IL	11/18/2004
JUMPER, DONNA	BOONEVILLE, MS	11/18/2004
MARTIN, TRAVIS	INDEPENDENCE, WV	11/18/2004
OTINIANO, JOSHUA	ORLANDO, FL	11/18/2004
PATTERSON, BARBARA	WINSTON, GA	11/18/2004
ROBERSON, ELLICK	PHOENIX, AZ	5/3/2004
SIGNORINE, LOUIS	GILFORD, NH	11/18/2004
SUGGS, WINDY	LORIS, SC	11/18/2004
TALBERT, TONY	ORLANDO, FL	11/18/2004
VANDALL, TAMMY	BELTON, TX	11/18/2004
WILDE, LONA	PORT ST LUCIE, FL	11/18/2004
PATIENT ABUSE/NEGLECT CONVICTIONS		
BRYANT, THOMAS	HIBBING, MN	11/18/2004
FINKEL, BRIAN	FLORENCE, AZ	11/18/2004
FLORES, FELIX	MORENO VALLEY, CA	11/18/2004
FRAZIER, WILLIAM	PETAL, MS	11/18/2004

Subject name	Address	Effective date
GONDREZ, JACKIE	ST CLOUD, MN	11/18/2004
HARMON, WAYNE	NEW WATERFORD, OH	11/18/2004
HOFFART, JAMES	LONG BEACH, CA	11/18/2004
HOWARD, COLIN	SAN FRANCISCO, CA	11/18/2004
HOWARD, LILLIE	SHREVEPORT, LA	11/18/2004
JOHNSTON, WENDELL	SARDIS, MS	11/18/2004
LAMM, TAMARA	PANAMA CITY, FL	11/18/2004
MCCARTY-ROSARIO, DONNA	VALLEJO, CA	11/18/2004
PALKO, DEBORAH	SURGOINSVILLE, TN	11/18/2004
PLOURDE, STEVEN	EUREKA, CA	11/18/2004
SEARL, PENNY	ONEIDA, NY	11/18/2004
SHUKLA, PARAM	WAKEFIELD, MA	11/18/2004
SMITH, KEYONNA	FLINT, MI	11/18/2004
STANTON, JOSEPH	THORNTON, CO	11/18/2004
TAMBER, SATWINDER	COVINA, CA	11/18/2004
TARDAGUILA, GREGORY	TORRANCE, CA	11/18/2004
VAN OORT, CHRISTINE	MT PLEASANT, IA	11/18/2004
WHITEHEAD, LYNN	SMITHVILLE, TN	11/18/2004
WISEMAN, RUSSELL	MEMPHIS, TN	11/18/2004
ZAIDI, MOSHIN	HOFFMAN ESTATES, IL	11/18/2004
CONVICTION FOR HEALTH CARE FRAUD		
WHEELER, ROBERT	WATERLOO, IA	11/18/2004
LICENSE REVOCATION/SUSPENSION/SURRENDERED		
A HEALTH & STRESS FREE	AVENTURA, FL	11/18/2004
ABBOTT, KARA	CYPRESS, TX	11/18/2004
AIMONE, CONNIE	BENTON CITY, WA	11/18/2004
AL-GHRAOUI, FADI	FORT LAUDERDALE, FL	11/18/2004
ALLEN, TOBIE	COLUMBIA, TN	11/18/2004
AMENS, JOHN	TACOMA, WA	11/18/2004
ANAST, SUSAN	LAKE HAVASU, AZ	11/18/2004
ARMSTRONG, SHAWN	BONIFAY, FL	11/18/2004
BAKER, CYNDIE	ORANGE PARK, FL	11/18/2004
BAKER, JOHN	LARGO, FL	11/18/2004
BARBANELL, JOANNE	PRESCOTT, AZ	11/18/2004
BARNETT, BELINDA	ALMO, KY	11/18/2004
BEGALLIA, DEBI	TACOMA, WA	11/18/2004
BENDERS, CLARA	DORCHESTER, MA	11/18/2004
BLALOCK, KERRY	TOONE, TN	11/18/2004
BLENKLE, ELIZABETH	INDIAN ROCKS BEACH, FL	11/18/2004
BOESE, DEBORAH	CAPE CORAL, FL	11/18/2004
BRASWELL, KATHRYN	PORT CHARLOTTE, FL	11/18/2004
BRIDGES, CONNIE	COLVILLE, WA	11/18/2004
BUMGARDNER, CHRISTIE	BAXTER, KY	11/18/2004
BURKS, LAUREN	LOUISVILLE, KY	11/18/2004
CALDWELL, PATRICIA	LEHIGH ACRES, FL	11/18/2004
CAMPOSTRINI, KATHERINE	OROVILLE, CA	11/18/2004
CATALANELLO, MARK	MISSOULA, MT	11/18/2004
CHANDRA, PEGGY	MELBOURNE, FL	11/18/2004
CLAGHORN, PEGGY	WEST RICHLAND, WA	11/18/2004
COBB, KAREN	OCALA, FL	11/18/2004
COCHRANE, CATHERINE	DELAND, FL	11/18/2004
COMPTON, TERRI	MONTEVALLO, AL	11/18/2004
CONNER, FREDERICK	YAKIMA, WA	11/18/2004
COPLEY, CRYSTAL	LOUISVILLE, KY	11/18/2004
COTTENGAIN, TONY	LAKELAND, FL	11/18/2004
CURRY, DAVID	PARKVILLE, MD	11/18/2004
CWALINA, CHARLENE	ATHOL, MA	11/18/2004
DANIEL, JEAN	LEHIGH ACRES, FL	11/18/2004
DECKER, MARIA	STOCKTON, CA	11/18/2004
DECKER, RICHARD	JONESBOROUGH, TN	11/18/2004
DESTEFANO, LISA	WEST MIFFLIN, PA	11/18/2004
DICKINSON, HELEN	SARASOTA, FL	11/18/2004
DIONISIO, RENATO	LOS ANGELES, CA	11/18/2004
DORSEY, LARRY	AUBURN, CA	11/18/2004
DWYER, DAN	BOISE, ID	11/18/2004
EARLY, JAMES	NEW MILFORD, CT	11/18/2004
EDWARDS, CYNTHIA	JONESVILLE, VA	11/18/2004
ELMEER, GORDON	DERRY, NH	11/18/2004
ENNIS, ANNA-DALE	YULEE, FL	11/18/2004
ESGUERRA, CORNELIO	MESA, AZ	11/18/2004

Subject name	Address	Effective date
FARIN, ANNA	MIAMI BEACH, FL	11/18/2004
FINLEY, JANE	PADUCAH, KY	11/18/2004
FINNIE, AMANDA	MADISONVILLE, KY	11/18/2004
FOUGHTZ, ROBIN	ELK GROVE, CA	11/18/2004
FULGHUM, ROBERTA	BAILEY, NC	11/18/2004
GALLIEN, MAUDIE	NORTHPORT, AL	11/18/2004
GEORGE, GINGER	BIRMINGHAM, AL	11/18/2004
GERKIN, VICKI	MITCHELL, IN	11/18/2004
GERVAIS, TINA	OWENS CROSS RDS, AL	11/18/2004
GOLDSMITH, WILLIAM	LEXINGTON, KY	11/18/2004
GOULD, CAROL	NEW IPSWITCH, NH	11/18/2004
GREEN, AARON	SPOKANE, WA	11/18/2004
GUINN, LISA	SPRINGFIELD, IL	11/18/2004
HANSHEW, EVELYN	RENTON, WA	11/18/2004
HARKONEN, JOHN	LOUISVILLE, KY	11/18/2004
HARRIS, FITZ	MIAMI, FL	11/18/2004
HART-TOWN, RAGEN	SNOHOMISH, WA	11/18/2004
HERMOSURA, RICARDO	SUNNYVALE, CA	11/18/2004
HOGATE, MARY	MENDOTA, IL	11/18/2004
HOLDEN, JEFFREY	LATROBE, PA	11/18/2004
HOMME, JULIE	KENNEWICK, WA	11/18/2004
HORNSBY, DARIN	LOVELAND, OH	11/18/2004
JENSEN, MARGARET	KELOS, WA	11/18/2004
JOHNSON, HERBERT	MAYO, FL	11/18/2004
JOHNSON, JOANNE	CLEARWATER, FL	11/18/2004
JOHNSTON, TERRI	TYNER, KY	11/18/2004
JONES, AWANDA	WESTCHESTER, IL	11/18/2004
JONES, VICKI	HARRDOSBURG, KY	11/18/2004
JORDAN, LISA	SPRING HOPE, NC	11/18/2004
KARTY, JACQUELIN	WAURIKA, OK	11/18/2004
KENT, AMY	MIAMI, FL	11/18/2004
KIDDER, CHRISTINE	GLENDALE, CA	11/18/2004
KING, DORA	SEYMOUR, TN	11/18/2004
KING, LISA	CAIRO, NY	11/18/2004
KING, PRESTON	JENNINGS, FL	11/18/2004
KINNEY, JOSEPH THOMAS	ORLAND, FL	11/18/2004
KIPER, KEVIN	PAWLING, NY	11/18/2004
KNOX, DENISE	MCKEESPORT, PA	11/18/2004
KOTECKI, LISA	WATERFORD, CT	11/18/2004
KOTLER, JOSEPH	AVENTURA, FL	11/18/2004
KRUSE, OLGAELENA	BUSHNELL, FL	11/18/2004
LAMBERT, MARTHA	OSWEGO, NY	11/18/2004
LEMAK, MARILYN	DWIGHT, IL	11/18/2004
LEMINGS, SHELLEY	CLINTON, AR	11/18/2004
LEPAGE, LINDA	GLOUCESTER, MA	11/18/2004
LIDDLE, KIMBERLY	BOWLING GREEN, KY	11/18/2004
LITTERAL, AMY	ASHLAND, KY	11/18/2004
LOUQUE, CATHERINE	HUNTSVILLE, AL	11/18/2004
MAISEL, LINDA	RENO, NV	11/18/2004
MANZI, DEBORAH	NORTH HAVEN, CT	11/18/2004
MARLOW, JESSICA	JELLICO, TN	11/18/2004
MARLOW, KATHLEEN	WELLINGTON, FL	11/18/2004
MARSHALL, DONNA	NEWTON, MA	11/18/2004
MARTIN, BRANT	NORTH PORT, FL	11/18/2004
MARTINSON, DEBORAH	NEW MILFORD, CT	11/18/2004
MASON, JEFFREY	VENTURA, CA	11/18/2004
MATTE, KIMBERLY	HENDERSONVILLE, NC	11/18/2004
MCELRATH, MITCHALENA	WHITEVILLE, NC	11/18/2004
MEYER, MELISSA	SOMERSET, CA	11/18/2004
MIDGETTE, JENNIFER	ROANOKE RAPIDS, NC	11/18/2004
MIKHAIL, PETER	ELMONT, NY	11/18/2004
MILLS, ANNE	PITTSBURGH, PA	11/18/2004
MIMNAGH, JANICE	WINTER HAVEN, FL	11/18/2004
MISHRA, RAJENDRA	DOUGLASTON, NY	11/18/2004
MOODY, JACKI	LOUISVILLE, KY	11/18/2004
MOORE, KEVIN	SHASTA, CA	11/18/2004
MOORE, THOMAS	CORBIN, KY	11/18/2004
MOSER, DIANA	TAHLEQUAH, OK	11/18/2004
MOUL, MARIANNE	DOWNINGTOWN, PA	11/18/2004
MUELLER, SUSAN	PHOENIX, AZ	11/18/2004
MUNOZ, ESTELLA	CHANDLER, AZ	11/18/2004
NELSON, PATRICIA	GAINESVILLE, FL	11/18/2004
NESTER, SHANE	MESA, AZ	11/18/2004
NICHOLS, JOHN	TACOMA, WA	11/18/2004

Subject name	Address	Effective date
NUNN, AMY	NEW TAZEWELL, TN	11/18/2004
O'NEILL, LISA	WAKEFIELD, MA	11/18/2004
OLSEN, PAM	PHILADELPHIA, PA	11/18/2004
ORT, CHARLES	HACKETTSTOWN, NJ	11/18/2004
OSTROM, MARSHA	MILFORD, MA	11/18/2004
PACE, MIMI	BRADENTON, FL	11/18/2004
PADGETT, LISA	BONIFAY, FL	11/18/2004
PANICO, BARBARA	SYRACUSE, NY	11/18/2004
PANTALL, CARL	SUMMERFIELD, FL	11/18/2004
PASSER, ANNETTE	SCOTTSDALE, AZ	11/18/2004
PECK, CHRISTINE	HEMET, CA	11/18/2004
PELCZARSKI, JUDITH	HOLYOKE, MA	11/18/2004
PENDZICK, RICK	DANBURY, CT	11/18/2004
PEREZ, LUIS	CHULA VISTA, CA	11/18/2004
PETERSON, CHERYL	FARRAGUT, IA	11/18/2004
PETROCELLI, LORRAINE	BRISTOL, CT	11/18/2004
PHILLIPS, SHERRY	TUBA CITY, CA	11/18/2004
PITTMAN, SHANNON	WAYNESBORO, PA	11/18/2004
POLITIS, JOANNA	CHARLOTTE, NC	11/18/2004
RAM, RISHI	MODESTO, CA	11/18/2004
REDDING, JENIFER	CONESUS, NY	11/18/2004
REEVES, JENNIFER	TROUTMAN, NC	11/18/2004
RHODES, MICHELLE	BUTLER, PA	11/18/2004
RILEY, DONNA	NEW BEDFORD, MA	11/18/2004
RODERICK, PAULA	NORTON, MA	11/18/2004
RONEY, MICHELE	NORTH VERSAILLES, PA	11/18/2004
SANTANA, NANCY	MIAMI, FL	11/18/2004
SARMIENTO, BENJAMIN	VALLEJO, CA	11/18/2004
SAYRE, DEIDRE	LUCEDALE, MS	11/18/2004
SEBASTIAN-GUANDOLO, CYNTHIA	HOLLYWOOD, FL	11/18/2004
SELBERG, CAROL	YAKIMA, WA	11/18/2004
SHAMP, ANNMARIE	W PALM BEACH, FL	11/18/2004
SHEFFIELD, ALTON	PORT ORANGE, FL	11/18/2004
SIC-CUA, KAREN	BALTIMORE, MD	11/18/2004
SIMAY, DOUGLAS	LA JOLLA, CA	11/18/2004
SLOAN, ELLA	SHARPSBURG, KY	11/18/2004
SMITH, CHAD	ALTAMONTE SPRINGS, FL	11/18/2004
SPENCER, LASHAWNDA	COCOA, FL	11/18/2004
STAINBACK, PAMELA	OXFORD, NC	11/18/2004
STANDARD, TAMMY	SALISBURY, NC	11/18/2004
STECHER, KARL	GREENWOOD VILLAGE, CO	11/18/2004
STEEL, SAMUEL	ELPASO, TX	11/18/2004
STEINBERG, ANDREA	BROCKTON, MA	11/18/2004
STEPHENSON, JEFFREY	S POINT, OH	11/18/2004
STEPHENSON, SHARON	CLAYTON, NC	11/18/2004
STODDARD, TAMMY	REW, PA	11/18/2004
SUMMERS, PATSY	STEVENSON, AL	11/18/2004
TEBEAU, HOLLY	SAVANNAH, GA	11/18/2004
THIEL, GREGORY	HENDERSON, NV	11/18/2004
TRANELL, DENISE	HUNLOCK CREEK, PA	11/18/2004
TUCKER, ANGELA	NEW CITY, NY	11/18/2004
TUCKER, LISA	BROOKLET, GA	11/18/2004
TURNER, FRANK	WARRENTON, VA	11/18/2004
VANCE, DEBRAH	FAYETTEVILLE, NC	11/18/2004
VASQUEZ, ANGELA	FRESNO, CA	11/18/2004
VAUGHAN, DARA	SEDALIA, KY	11/18/2004
VERBECK, MELISSA	TAYLORSVILLE, KY	11/18/2004
VILLAFANE, KATHRYN	SNOW CAMP, NC	11/18/2004
WALSTON, DENNIS	LAS VEGAS, NV	11/18/2004
WESTLAKE, LAURIE	PORT ANGELES, WA	11/18/2004
WHITE, CHARLIETTE	LAKE CITY, FL	11/18/2004
WILLIAMS, JEROME	GRANADA HILLS, CA	11/18/2004
WOOD, JOSHUA	COLLEGE PLACE, WA	11/18/2004
WOOLSON, SUSAN	WORCESTER, MA	11/18/2004
YOST, DAVID	SPARKS, NV	11/18/2004
YOUNG, KIMBERLY	BOWLING GREEN, KY	11/18/2004
ZHAO, CHUN	EUREKA, CA	11/18/2004
FEDERAL/STATE EXCLUSION/SUSPENSION		
KUMAR, DAVID	UNION, NJ	11/18/2004
PARIVAN INVALID COACH SERVICES	EDISON, NJ	11/18/2004
PATEL, ASHOK	EDISON, NJ	11/18/2004
TULSANIA, NITAN	BASKING RIDGE, NJ	11/18/2004

Subject name	Address	Effective date
FRAUD/KICKBACKS/PROHIBITED ACTS/SETTLEMENT AGREEMENTS		
KUMAR, ANIL	MONMOUTH JUNCTION, NJ	9/21/2004
KUMAR, SAROJ	MONMOUTH JUNCTION, NJ	9/21/2004
OWNED/CONTROLLED BY CONVICTED ENTITIES		
BFK TRANSIT, INC	MILWAUKEE, WI	11/18/2004
EMMETT FOOT & ANKLE CLINIC	EMMETT, ID	11/18/2004
KAZEM S SADATI DDS, PA	MIAMI LAKES, FL	11/18/2004
MEDICAL SOUTH, INC	COLUMBUS, MS	11/18/2004
ONTARIO FOOT & ANKLE CLINIC	ONTARIO, OR	11/18/2004
PALM BEACH TOTAL HEALTH CARE, INC	BOYNTON BEACH, FL	11/18/2004
UNIVERSAL PLACEMENT, INC	LOS ANGELES, CA	11/18/2004
DEFAULT ON HEAL LOAN		
CONLEY, PAMELA	NEW ORLEANS, LA	9/14/2004
FARHAT, HASSAN	STATEN ISLAND, NY	11/18/2004
LAM, THE	SAN JOSE, CA	11/18/2004
SHEEHY, DANIEL	MIDDLETOWN, CA	11/18/2004

Dated: November 3, 2004.

Katherine B. Petrowski,

Director, Exclusions Staff, Office of Inspector General.

[FR Doc. 04–25251 Filed 11–12–04; 8:45 am]

BILLING CODE 4150–04–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Proposed Collection; Comment Request; Outcome Evaluation of the Fogarty International Center (FIC) AIDS International Training and Research Program (AITRP)

SUMMARY: In compliance with the requirement of Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, for opportunity for public comment on proposed data collection projects, the Fogarty International Center (FIC), the National Institutes of Health (NIH), will publish periodic summaries of proposed projects to be submitted to the Office of Management and Budget (OMB) for review and approval.

Proposed Collection: Title: Outcome Evaluation of the FIC AIDS International Training and Research Program (AITRP). *Type of Information Collection Request:* New. *Need and Use of Information Collection:* This study will assess the outputs, outcomes and impacts of the AIDS International Training and Research Program (AITRP). The findings will provide valuable information concerning: (1) The research capacity development, collaboration, public health, and public policy outputs, outcomes, and impacts of AITRP at the program level and country level; (2) management and policy implications for the AITRP program based on trainee responses. *Frequency of Response:* Once. *Affected Public:* none. *Type of Respondents:* Trainees involved in the AITRP program. There are no Capital Costs to report. There are no Operating or Maintenance Costs to report.

Type of respondents	Estimated number of respondents	Estimated number of responses per respondent	Average burden hours per response	Estimated total annual burden hours requested
Trainees	300	1	1	300
Total	300	300		

Type of respondents	Estimated number of respondents	Frequency of response	Average hourly wage rate	Respondent cost
Trainees	300	1	$5.00/hr	$1500
Total Cost				$1500

Request for Comments: Written comments and/or suggestions from the public and affected agencies are invited on one or more of the following points: (1) Whether the proposed collection of information is necessary for the proper performance of the function of the agency, including whether the information will have practical utility; (2) the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of

the methodology and assumptions used; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) ways to minimize the burden of the collection of information on those who are to respond, including the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology.

FOR FURTHER INFORMATION CONTACT: To request more information on the proposed project or to obtain a copy of the data collection plans and instruments, contact Dr. Linda Kupfer, Fogarty International Center, National Institutes of Health, 16 Center Drive, Building 16, Bethesda, MD 20892–6705 or call non-toll-free number 301–496–3288 or E-mail your request, including your address to: *Kupferl@mail.nih.gov*.

Comments Due Date: Comments regarding this information collection are best assured of having their full effect if received within 60-days of the date of this publication.

Dated: November 5, 2004.

Richard Miller,

Executive Officer, FIC, National Institutes of Health.

[FR Doc. 04–25281 Filed 11–12–04; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Government-Owned Inventions; Availability for Licensing

AGENCY: National Institutes of Health, Public Health Service, DHHS.

ACTION: Notice.

SUMMARY: The inventions listed below are owned by an agency of the U.S. Government and are available for licensing in the U.S. in accordance with 35 U.S.C. 207 to achieve expeditious commercialization of results of federally-funded research and development. Foreign patent applications are filed on selected inventions to extend market coverage for companies and may also be available for licensing.

ADDRESSES: Licensing information and copies of the U.S. patent applications listed below may be obtained by writing to the indicated licensing contact at the Office of Technology Transfer, National Institutes of Health, 6011 Executive Boulevard, Suite 325, Rockville, Maryland 20852–3804; telephone: 301/496–7057; fax: 301/402–0220. A signed Confidential Disclosure Agreement will be required to receive copies of the patent applications.

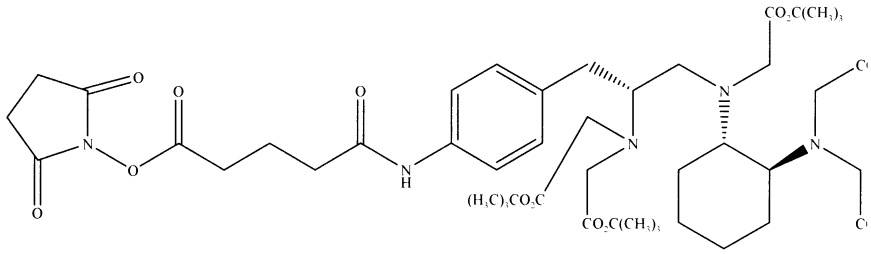
Metal Chelators and Target-Moiety Complexes for Imaging

Martin W. Brechbiel and Thomas Clifford (NCI).

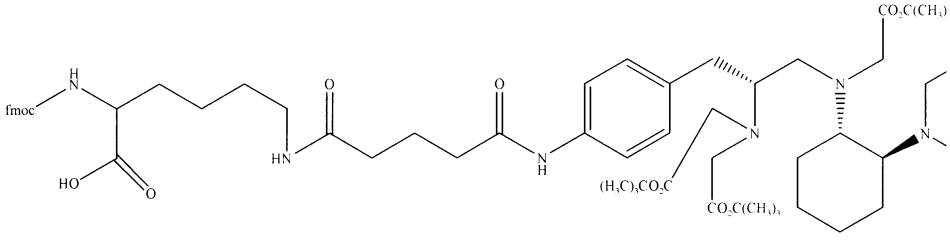
U.S. Provisional Application filed 23 Aug 2004 (DHHS Reference No. E–317–2004).

Licensing Contact: Michael Shmilovich; 301/435–5019; *shmilovm@mail.nih.gov*.

Available for licensing and commercial development are bifunctional metal chelators, metal chelator-targeting moiety complexes, metal chelator-targeting moiety-metal conjugates, kits, and methods of preparing them. These chelators are useful in diagnosing and/or treatment of cancer and thrombosis. The metal chelators may be used in conventional and solid-phase synthetic methods to form targeting moieties (*e.g.*, peptides, and Starburst polyamidoamine dendrimers (PAMAM), capable of conjugating diagnostic and/or therapeutic metals. The formulae for two such chelators is shown below:



I



II

Anti-HIV Peptide Secreting Bacteria: Therapeutics and Methods of Use

Dean Hamer (NCI).

U.S. Provisional Application No. 60/604,051 filed 25 Aug 2004 (DHHS Reference No. E–233–2004/0–US–01).

Licensing Contact: Michael Shmilovich; 301/435–5019; *shmilovm@mail.nih.gov*.

Available for licensing and commercial development are genetically

engineered commensal bacteria compositions that secrete HIV infectivity interfering peptides with the aid of co-expressed translocation mediators such as *HylB, HylD* or *tolC* gene products. The bacteria can be, for example, *Escherichia coli* and are preferably those that colonize the gastrointestinal or genitourinary tracts. The secreted anti-HIV peptide can be a functional inhibitory fragment from the C-terminus of HIV, SHIV or SIV, or an inhibitory peptide derived from the N-terminus receptor-binding domain of SIV gp41, HIV–1 gp41, or HIV–2 gp41. The secreted anti-HIV peptide can also be a peptide from the allosteric domain of gp120, an extracellular loop of CCR5, an anti-CD4 immunoglobulin, a mimetic of CD4, an alpha-defensin or theta-defensin, a CD38 fragment homologous to the V3 loop of gp120, polphemusin II (a CXCR4 antagonist), a RANTES peptide that binds to CCR5 or an HIV surface binding peptide such as cyanovirin.

Method of Assessing Ischemia in a Patient

Steven Warach, Lawrence Latour (NINDS).

U.S. Provisional Application No. 60/381,611 filed 17 Mar 2002 (DHHS Reference No. E–082–2002/0–US–01); PCT Application No. PCT/US03/15368 filed 16 May 2003 (DHHS Reference No. E–082–2002/0–PCT–02).

Licensing Contact: Michael Shmilovich; 301/435–5019; *shmilovm@mail.nih.gov.*

Hyperintense acute reperfusion marker (HARM) is well correlated with reperfusion and is a precursor to or concomitant with reperfusion injury. The inventors have developed a novel technique of assessing injuries associated with ischemia, stroke, or reperfusion injury in a patient by administering a contract agent to the patient, acquiring a fluid-attenuated inversion-recovery (FLAIR) image, and observing the presence or absence of HARM on the acquired image. The technique can also be used to determine the effectiveness of a therapeutic protocol for the treatment or prevention of reperfusion injury in a patient that has previously suffered an ischemic event.

This research has been described, in part, in Latour *et al.*, ''Early Blood-Brain Barrier Disruption in Human Focal Brain Ischemia,'' Ann. Neurol. 2004 56:568–477.

Dated: November 4, 2004.

Steven M. Ferguson,

Director, Division of Technology Development and Transfer, Office of Technology Transfer, National Institutes of Health.

[FR Doc. 04–25278 Filed 11–12–04; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Government-Owned Inventions; Availability for Licensing

AGENCY: National Institutes of Health, Public Health Service, DHHS.

ACTION: Notice.

SUMMARY: The inventions listed below are owned by an agency of the U.S. Government and are available for licensing in the U.S. in accordance with 35 U.S.C. 207 to achieve expeditious commercialization of results of federally-funded research and development. Foreign patent applications are filed on selected inventions to extend market coverage for companies and may also be available for licensing.

ADDRESSES: Licensing information and copies of the U.S. patent applications listed below may be obtained by writing to the indicated licensing contact at the Office of Technology Transfer, National Institutes of Health, 6011 Executive Boulevard, Suite 325, Rockville, Maryland 20852–3804; telephone: 301/496–7057; fax: 301/402–0220. A signed Confidential Disclosure Agreement will be required to receive copies of the patent applications.

Infectious Clone of Human Parvovirus B19 and Methods of Use

Ning Zhi *et al.* (NHLBI).

U.S. Patent Application No. 10/887,770 filed 09 Jul 2004 (DHHS Reference No.E–178–2004/0–US–01 and corresponding Canadian patent application (DHHS Reference No. E–178–2004/0–CA–02).

Licensing Contact: Susan Ano; 301/435–5515; *anos@mail.nih.gov.*

This technology described in this patent application relates the first reported infectious human parvovirus B19 clone, methods of cloning the parvovirus B19 genome as well as other viral genomes that have secondary DNA structures that are unstable in bacterial cells. The infectious clone and methods of producing the same would be useful in producing infectious virus, which can in turn be used, among other things, to identify and develop therapeutic agents for treatment and/or prevention of human parvovirus B19 infections. The infectious parvovirus B19 clone is also available for licensing. Additional information about this invention can be found in Virology 2004, 318(1), 142–152.

Immunogenic Compositions for Eradication of Latent HIV

Genoveffa Franchini *et al.* (NCI).

U.S. Provisional Application No. 60/536,467 filed 13 Jan 2004 (DHHS Reference No. E–072–2004/0–US–01); U.S. Provisional Application No. 60/536,976 filed 16 Jan 2004 (DHHS Reference No. E–072–2004/1–US–01).

Licensing Contact: Susan Ano; 301/435–5515; *anos@mail.nih.gov.*

HIV infects CD4+ cells and, after incorporation of the viral genome into the host genome, can either produce infectious virus or remain latent. HIV that is latent presents a challenge for complete removal of the virus in infected individuals and is becoming an increasingly important consideration in the identification of potential therapeutics or treatment regimens. This patent application describes immunogenic compositions based on inhibiting the function of $p28^{TEV}$ protein, the first protein expressed during HIV infection, for treatment of latent HIV infection. Specifically, these compositions include the $p28^{TEV}$ polypeptide, a polypeptide with significant sequence homology to $p28^{TEV}$, or immunogenic fragments of these polypeptides. Additional compositions include antibodies and other compounds that act to inhibit $p28^{TEV}$ activity. This technology can also be utilized to detect latent HIV in biological samples. These compositions and methods offer a potential solution for complete virus eradication in therapeutic treatment of HIV infected individuals.

Accelerated Vaccination Strategies To Provide Protection Against Viral Infections

Gary J. Nabel *et al.* (NIAID).

U.S. Provisional Application No. 60/491,933 filed 01 Aug 2003 (DHHS Reference No. E–317–2003/0–US–01); PCT Application filed on 01 Aug 2004 (DHHS Reference No. E–317–2003/0-PCT–02).

Licensing Contact: Susan Ano; 301/435–5515; *anos@mail.nih.gov.*

The technology described in this patent application relates to recombinant viruses for use as vaccines. These viruses contain a single or plurality of sequences encoding antigens from pathogenic viruses

heterologous to the recombinant virus. The antigenic sequences from pathogens such as influenza, RSV, measles, HPV, Epstein-Barr, Lassa, Polio, West Nile, Dengue, HIV–1 and 2, HTLV, herpes simplex virus, hepatitis viruses A, B, C, D, and E, Marburg, Ebola, and SARS are inserted into non-essential regions of either replication-competent or replication-defective adenovirus, adeno-associated virus (AAV), SV40 virus, herpes simplex virus, or vaccinia virus vectors that retain elements necessary for infectivity but are devoid of any pathogenic sequence elements. In these recombinant viruses, the antigenic sequences are operably linked to viral control elements. Thus, these recombinant viruses are capable of infecting a host and mounting an immune response specific to a given virus(es) without eliciting pathogenicity. In addition to the above, the technology also describes methods of accelerated pre-exposure or post-exposure vaccination comprising single-dose administration. The attractive features of this invention include the broad applicability of the recombinant viruses against a number of common pathogens and the potential of using them against other emergent infectious viruses; the ability of the vaccines to stimulate both cellular and humoral immune responses in humans and other hosts; and the ease of administration in single dose form via a number of routes. This technology is now available for licensing. Some fields of use may not be available.

Dated: November 9, 2004.

Steven M. Ferguson,

Director, Division of Technology Development and Transfer, Office of Technology Transfer, National Institutes of Health.

[FR Doc. 04–25279 Filed 11–12–04; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Cancer Institute; Notice of Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the meeting of the National Cancer Advisory Board.

The meeting will be open to the public as indicated below, with attendance limited to space available. Individuals who plan to attend and need special assistance, such as sign language interpretation or other reasonable accommodations, should notify the Contact Person listed below in advance of the meeting.

A portion of the meeting will be closed to the public in accordance with the provision set forth in section 552b(6), as amended. The discussion could disclose personal information concerning NCI Staff and/or its contractors, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Cancer Advisory Board.

Open: November 30, 2004, 8:30 a.m. to 5:30 p.m.

Agenda: Program reports and presentations; Business of the Board.

Place: Name Cancer Institute, 9000 Rockville Pike, Building 31, C Wing, 6th Floor, Conference Room 10, Bethesda, MD 20892.

Contact Person: Dr. Paulette S. Gray, Executive Secretary, National Cancer Institute, National Institutes of Health, 6116 Executive Boulevard, 8th Floor, Room 8001, Bethesda, MD 20892–8327, (301) 496–5147.

Name of Committee: National Cancer Advisory Board.

Open: December 1, 2004, 8:30 a.m. to 10:30 a.m.

Agenda: Program reports and presentations; Business of the Board.

Contact Person: Dr. Paulette S. Gray, Executive Secretary, National Cancer Institute, National Institutes of Health, 6116 Executive Boulevard, 8th Floor, Room 8001, Bethesda, MD 20892–8327, (301) 496–5147.

Name of Committee: National Cancer Advisory Board.

Closed: December 1, 2004, 10:30 a.m. to adjournment.

Agenda: Review intramural program site visit outcomes; Discussion of confidential personnel issues.

Contact Person: Dr. Paulette S. Gray, Executive Secretary, National Cancer Institute, National Institutes of Health, 6116 Executive Boulevard, 8th Floor, Room 8001, Bethesda, MD 20892–8327, (301) 496–5147.

Any interested person may file written comments with the committee by forwarding the statement to the Contact Person listed on this notice. The statement should include the name, address, telephone number and when applicable, the business or professional affiliation of the interested person.

Information is also available on the Institute's/Center's home page: *deainfo.nci.nih.gov/advisory/ncab.htm,* where an agenda and any additional information for the meeting will be posted when available.

(Catalogue of Federal Domestic Assistance Program Nos. 93.392, Cancer Construction; 93.393, Cancer Cause and Prevention Research; 93.394, Cancer Detection and Diagnosis Research; 93.395, Cancer Treatment Research; 93.396, Cancer Biology Research; 93.397, Cancer Centers Support; 93.398, Cancer Research Manpower; 93.399, Cancer Control, National Institutes of Health, HHS)

Dated: November 5, 2004.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 04–25271 Filed 11–12–04; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Diabetes and Digestive and Kidney Diseases; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute of Diabetes and Digestive and Kidney Diseases Special Emphasis Panel, Urinary Infection.

Date: December 7, 2004.

Time: 8 a.m. to 5 p.m.

Agenda: To reveiw and evaluate grant applications.

Place: Courtyard By Marriott, 2899 Jefferson Davis Highway, Arlington, VA 22202.

Contact Person: Maxine A. Lesniak, MPH, Scientific Review Administrator, Review Branch, DEA, NIDDK, National Institutes of Health, Room 756, 6707 Democracy Boulevard, Bethesda, MD 20892–5452, (301) 594–7792, *lesniakm@extra.niddk.nih.gov.*

Name of Committee: National Institute of Diabetes and Digestive and Kidney Diseases Special Emphasis Panel, Diabetes.

Date: December 13, 2004.

Time: 8 a.m. to 5 p.m.

Agenda: To reveiw and evaluate grant applications.

Place: Hyatt Regency—Crystal City, 2799 Jefferson Davis Highway, Arlington, VA 22202.

Contact Person: Maxine A. Lesniak, MPH, Scientific Review Administrator, Review Branch, DEA, NIDDK, National Institutes of Health, Room 756, 6707 Democracy Boulevard, Bethesda, MD 20892–5452, (301) 594–7792, *lesniakm@extra.niddk.nih.gov.*

Name of Committee: National Institute of Diabetes and Digestive and Kidney Diseases Special Emphasis Panel, Clinical Studies of Kidney Disease.

Date: December 16, 2004.

Time: 8 a.m. to 5 p.m.

Agenda: To reveiw and evaluate grant applications.

Place: Marriott Baltimore, Washington International Airport, 1743 West Nursery Road, Baltimore, MD 21240.

Contact Person: Dan E. Matsumoto, PhD, Scientific Review Administrator, Review Branch, DEA, NIDDK, Room 749, 6707 Democracy Boulevard, National Institutes of Health, Bethesda, MD 20892–5452, (301) 594–8894, *matsumotod@extra.niddk.nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.847, Diabetes, Endocrinology and Metabolic Research; 93.848, Digestive Diseases and Nutrition Research; 93.849, Kidney Diseases, Urology and Hematology Research, National Institutes of Health, HHS)

Dated: November 4, 2004.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 04–25270 Filed 11–12–04; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Child Health and Human Development; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth is sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute of Child Health and Human Development Special Emphasis Panel, Communication of People with Mental Retardation.

Date: December 6, 2004.

Time: 9 a.m. to 1 p.m.

Agenda: To review and evaluate grant applications.

Place: Embassy Suites at the Chevy Chase Pavilion, 4300 Military Road, NW., Washington, DC 20015.

Contact Person: Marita R. Hopmann, PhD, Scientific Review Administrator, Division of Scientific Review, National Institute of Child Health and Human Development, 6100 Building, Room 5B01, Bethesda, MD 20892, (301) 435–6911, *hopmannm@mail.nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.864, Population Research; 93.865, Research for Mothers and Children; 93.929, Center for Medical Rehabilitation Research; 93.209, Contraception and Infertility Loan Repayment Program, National Institutes of Health, HHS)

Dated: November 5, 2004.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 04–25272 Filed 11–12–04; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Child Health and Human Development; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute of Child Health and Human Development Special Emphasis Panel, Women's Reproductive Health Research Career Development Program.

Date: November 22, 2004.

Time: 9:30 a.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: Holiday Inn Select Bethesda, 8120 Wisconsin Avenue, Bethesda, MD 20814.

Contact Person: Gopal M. Bhatnagar, PhD, Scientific Review Administrator, National Institute of Child Health and Human Development, National Institutes of Health, 6100 Bldg Rm 5B01, Rockville, MD 20852, (301) 435–6889, *bhatnagg@mail.nih.gov.*

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

(Catalogue of Federal Domestic Assistance Program Nos. 93.864, Population Research; 93.865, Research for Mothers and Children; 93.929, Center for Medical Rehabilitation Research; 93.209, Contraception and Infertility Loan Repayment Program, National Institutes of Health, HHS)

Dated: November 5, 2004.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 04–25273 Filed 11–12–04; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Child Health and Human Development; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute of Child Health and Human Development Special Emphasis Panel, Genes, Aneuploidy and Mamalian Development.

Date: November 17, 2004.

Time: 9:30 a.m. to 3 p.m.

Agenda: To review and evaluate grant applications.

Place: Ramada Inn Rockville, 1775 Rockville Pike, Rockville, MD 20852.

Contact Person: Gopal M. Bhatnagar, PhD, Scientific Review Administrator, National Institutes of Child Health and Human Development, National Institutes of Health, 6100 Bldg Rm 5B01, Rockville, MD 20852, (301) 435–6889, *bhatnagg@mail.nih.gov.*

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

(Catalogue of Federal Domestic Assistance Program Nos. 93.864, Population Research; 93.865, Research for Mothers and Children; 93.929, Center for Medical Rehabilitation Research; 93.209, Contraception and Infertility Loan Repayment Program, National Institutes of Health, HHS)

Dated: November 5, 2004.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 04–25274 Filed 11–12–04; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Child Health and Human Development; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute of Child Health and Human Development Special Emphasis Panel Program Project: Changing Social Contexts & Family Formations.

Date: December 3, 2004.

Time: 8 a.m. to 1 p.m.

Agenda: To review and evaluate grant applications.

Place: Embassy Suites at the Chevy Chase Pavilion, 4300 Military Road, NW., Washington, DC 20015.

Contact Person: Carla T. Walls, PhD, Scientific Review Administrator, Division of Scientific Review, National Institute of Child Health, and Human Development, NIH, 6100 Executive Blvd., Room 5B01, Bethesda, MD 20892, (301) 435–6898, *wallsc@mail.nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.864, Population Research; 93.865, Research for Mothers and Children; 93.929, Center for Medical Rehabilitation Research; 93.209 Contraception and Infertility Loan Repayment Program, National Institutes of Health, HHS)

Dated: November 5, 2004.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 04–25275 Filed 11–12–04; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Child Health and Human Development; Notice of Meeting

Pursuant to section 10(a) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of a meeting of the National Advisory Board on Medical Rehabilitation Research.

The meeting will be open to the public, with attendance limited to space available. Individuals who plan to attend and need special assistance, such as sign language interpretation or other reasonable accommodations, should notify the Contact Person listed below in advance of the meeting.

Name of Committee: National Advisory Board on Medical Rehabilitation Research.

Date: December 2–3, 2004.

Time: December 2, 2004, 8:30 a.m. to 5:30 p.m.

Agenda: NICHD Director's Report presentation, Regional Research Networks, and an update on the Rehabilitation Medicine Scientist Training Program.

Place: Holiday Inn—Silver Spring, 8777 Georgia Avenue, Silver Spring, MD 20910.

Time: December 3, 2004, 8:30 am. to 12 p.m.

Agenda: Other business dealing with the NABMRR Board.

Place: Holiday Inn—Silver Spring, 8777 Georgia Avenue, Silver Spring, MD 20910.

Contact Person: Ralph M. Nitkin, PhD, Director, BSCD, National Center for Medical Rehabilitation Research, National Institute of Child Health and Human Development, NIH, 6100 Building, Room 2A03, Bethesda, MD 20892. (301) 402–4206.

Any interested person may file written comments with the committee by forwarding the statement to the Contact Person listed on this notice. The statement should include the name, address, telephone number and when applicable, the business or professional affiliation of the interested person.

Information is also available on the Institute's/Center's home page: *http://www.nichd.nih.gov/about/ncmrr.htm*, where an agenda and any additional information for the meeting will be posted when available.

(Catalogue of Federal Domestic Assistance Program Nos. 93.864, Population Research; 93.865, Research for Mothers and Children; 93.929, Center for Medical Rehabilitation Research; 93.209, Contraception and Infertility Loan Repayment Program, National Institutes of Health, HHS)

Dated: November 5, 2004.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 04–25276 Filed 11–12–04; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of General Medical Sciences; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute of General Medical Sciences Special Emphasis Panel, R13 Application Review.

Date: November 23, 2004.

Time: 8 a.m. to 11 a.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Natcher Building, 45 Center Drive, Bethesda, MD 20892.

Contact Person: Arthur L. Zachary, PhD, Office of Scientific Review, National Institutes of General Medical Sciences, National Institutes of Health, Natcher Building, Room 3AN–12, Bethesda, MD 20892. (301) 594–2886; *zacharya@nigms.nih.gov.*

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

(Catalogue of Federal Domestic Assistance Program Nos. 93.375, Minority Biomedical Research Support; 93.821, Cell Biology and Biophysics Research; 93.859, Pharmacology, Physiology, and Biological Chemistry Research; 93.862, Genetics and Developmental Biology Research; 93.88, Minority Access to Research Careers; 93.96, Special Minority Initiatives, National Institutes of Health, HHS.)

Dated: November 5, 2004.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 04–25277 Filed 11–12–04; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

National Toxicology Program (NTP) Board of Scientific Counselors Technical Reports Review Subcommittee Meeting; Review of Draft NTP Technical Reports

Pursuant to Pub. L. 92–463, notice is hereby given of the next meeting of the NTP Board of Scientific Counselors Technical Reports Review Subcommittee (''TRR Subcommittee'') on December 9–10, 2004, in the Rodbell Auditorium, Rall Building at the

National Institute of Environmental Health Sciences, 111 T.W. Alexander Drive, Research Triangle Park, NC 27709. The meeting will begin each day at 8:30 a.m. The meeting is open to the public with attendance limited only by the space available (see ''Attendance, Registration, and Remote Access'' below).

Agenda

The primary agenda topic is the peer review by the TRR Subcommittee of the findings and conclusions of seven draft NTP Technical Reports (TR) of rodent toxicology and carcinogenesis studies conducted by the NTP (*see* Preliminary Agenda below). There will also be a presentation on how the NTP handles contaminants in study materials and their impact on the interpretation of 2-year bioassays. In addition, at the request of the NTP Board of Scientific Counselors, the TRR Subcommittee will readdress the title of the Draft NTP Technical Report on Anthraquinone (see minutes from the NTP Board of Scientific Counselors meeting held June 29, 2004, available at *http://ntp-server.niehs.nih.gov/ntpweb/index.cfm?objectid=720164E3-BDB7-CEBA-F338FA2626639D56*). As an introduction to the reports on the studies of polychlorinated biphenyl (PCB), a short presentation will be given on the use of Toxic Equivalency Factors (TEFs). The TEF methodology was developed as a mathematical tool that ranks the dioxin-like activity of a compound relative to 2,3,7,8-tetrachlorodibenzo-p-dioxin (TCDD), the most potent dioxin. This methodology has been applied to the NTP studies reported in TR 531: Mixture of 3,3′,4,4′,5-Pentachlorobiphenyl (PCB 126) and 2,3′,4,4′,5-Pentachlorobiphenyl (PCB 118), TR 529: 2,2′,4,4′,5,5′-Hexachlorobiphenyl (PCB 153), and TR 530: Mixture of PCB 126 and PCB 153.

A copy of the agenda, TRR Subcommittee roster, and the draft NTP Technical Reports, as available, will be posted on the NTP Web site (*http://ntp-server.niehs.nih.gov/* under *Latest News*) and will be available upon request to the NTP Executive Secretary, Dr. Barbara S. Shane (PO Box 12233, 111 T.W. Alexander Dr., MD A3–01, Research Triangle Park, NC 27709, T: 919–541–4253; F: 919–541–0295; e-mail: *shane@niehs.nih.gov*). Following the meeting, summary minutes will be available on the TRR Subcommittee Web site (see *http://ntp-server.niehs.nih.gov/ntpweb/index.cfm?objectid=227FC084=EB0C–7E93–9DCD6F03104F0D22*) and in hard copy upon request to the NTP Executive Secretary.

Draft Reports Available for Public Review and Comment

Approximately four weeks prior to the meeting, the draft reports will be available for public review, through the NTP Web page (*http://ntp-server.niehs.nih.gov/* under *Latest News*). Printed copies of the Draft NTP Technical Reports can be obtained, as available, from Central Data Management (NIEHS, PO Box 12233, MD EC–03, Research Triangle Park, NC 27709, T: 919–541–3419, F: 919–541–3687, e-mail: *CDM@niehs.nih.gov*).

Attendance, Registration and Remote Access

The meeting is open to the public with attendance limited only by the space available. Individuals who plan to attend are strongly encouraged to register with the NTP Executive Secretary by December 2, 2004 to ensure easy access to the NIEHS campus (contact information above) or online on the NTP Web site (*http://ntp.niehs.nih.gov* under *Latest News*). Please note that a photo ID is required to access the NIEHS campus. Persons needing special assistance, such as sign language interpretation or other reasonable accommodation in order to attend are asked to notify the NTP Executive Secretary at least seven business days in advance of the meeting. The NTP is also making plans to videocast the TRR Subcommittee meeting through the Internet at *http://www.niehs.nih.gov/external/video.htm.* The NTP cannot guarantee the technical quality of the video casting and people wishing to use this option are encouraged to test their ability to access the video cast at the above Internet address under *Check your live video setup.*

Public Comment

Comments on any of the Draft NTP Technical Reports are welcome. Time will be provided at the meeting for oral public comment on the reports. Persons requesting time for an oral presentation on a particular report are asked to notify the NTP Executive Secretary (contact information given above) by December 2, 2004, and to provide their contact information (name, affiliation, mailing address, phone, fax, e-mail), and supporting organization (if any). Persons registering to make comments are asked to provide a written copy of their statement to the NTP Executive Secretary on or before December 2, 2004, to enable review by the TRR Subcommittee and NTP staff prior to the meeting. These statements can supplement or expand an oral presentation. Each speaker will be allotted at least 7 minutes and, if time permits, up 10 minutes for presentation of oral comments. Each organization is allowed one time slot per report being reviewed. Registration for making public comments will also be available on-site. If registering on-site to speak and reading comments from printed text, the speaker is asked to provide 25 copies of the statement for distribution to the Subcommittee and NTP staff, and to supplement the record.

Written comments without an oral presentation at the meeting are also welcome. Comments should include contact information for the submitter (name, affiliation, mailing address, phone, fax, and e-mail) and supporting organization (if any). Written comments should be received by the NTP Executive Secretary on or before December 2, 2004, to enable distribution to the Subcommittee and NTP staff for their review and consideration prior to the meeting. Written comments received in response to this notice will be posted on the NTP Web site (*http://ntp.niehs.nih.gov* under *Latest News*).

Request for Additional Information

The NTP would welcome receiving toxicology and carcinogenesis information from completed, ongoing or planned studies as well as current production data, human exposure information, and use patterns for any of the chemicals listed in this announcement. Please send this information to Central Data Management at the address given above and it will be forwarded to the appropriate NTP staff.

NTP Technical and Toxicity Report Series

The NTP conducts toxicology and carcinogenesis studies of agents of public health concern. Any scientist, organization, or member of the public may nominate a chemical for NTP testing. Details about the nomination process are available on the NTP Web site (*http://ntp.niehs.nih.gov* under *Nominations to the Testing Program*). The results of short-term rodent toxicology studies are published in the NTP Toxicity Report series. Longer-term studies, generally, rodent carcinogenicity studies, are published in the NTP Technical Report series. The NTP has a new technical report series for studies conducted in genetically modified models. PDF files of completed reports are available free-of-charge at the NTP Web site (*http://ntp-server.niehs.nih.gov/index.cfm?objectid=084801F0-F43F–7B74–0BE549908B5E5C1C*).

NTP Board of Scientific Counselors

The NTP Board of Scientific Counselors (''the Board'') is a technical advisory body composed of scientists from the public and private sectors who provide primary scientific oversight and peer review to the NTP. Specifically, the Board advises the NTP on matters of scientific program content, both present and future, and conducts periodic review of the program for the purpose of determining and advising on the scientific merit of its activities and overall scientific quality. The TRR Subcommittee of the Board provides scientific peer review of the findings and conclusions of NTP Technical Reports. The Report on Carcinogens Subcommittee of the Board provides scientific peer review of nominations to the Report on Carcinogens, a Congressionally mandated listing of agents *known* or *reasonably anticipated to be human carcinogens.*

The Board's members are selected from recognized authorities knowledgeable in fields, such as toxicology, pharmacology, pathology, biochemistry, epidemiology, risk assessment, carcinogenesis, mutagenesis, molecular biology, behavioral toxicology, neurotoxicology, immunotoxicology, reproductive toxicology or teratology, and biostatistics. The NTP strives for equitable geographic distribution and for minority and female representation on the Board.

Dated: November 5, 2004.

Samuel H. Wilson,

Deputy Director, National Institute of Environmental Health Sciences.

Preliminary Agenda

National Toxicology Program (NTP) Technical Reports (TR) Scheduled for Review by the NTP Board of Scientific Counselors Technical Reports Review Subcommittee

December 9–10, 2004

Rodbell Auditorium, National Institute of Environmental Health Sciences, 111 TW Alexander Drive, Research Triangle Park, NC.

1. Overview of Dioxin Toxic Equivalency Factors (TEFs).
2. TR 531: Mixture of 3,3′,4,4′,5-Pentachlorobiphenyl (PCB 126) and 2,3′,4,4′,5-Pentachlorobiphenyl (PCB 118) (CAS Nos. 57465–28–8 and 31508–00–6, respectively).
   - No longer used commercially; persistent polyhalogenated aromatic hydrocarbons present in the environment.
3. TR 529: 2,2′,4,4′,5,5′-Hexachlorobiphenyl (PCB 153) (CAS No. 35065–27–1).
   - No longer used commercially; persistent polyhalogenated aromatic hydrocarbon present in the environment.
4. TR 530: Mixture of PCB 126 and PCB 153 (CAS No: 57465–28–8 and 835065–27–1, respectively).
   - No longer used commercially; persistent polyhalogenated aromatic hydrocarbons present in the environment.
5. Discussion on Contaminants in NTP Study Materials: Impact on Interpretation of 2-year Bioassays.
   - Discussion of the Title of Draft NTP Technical Report on Anthraquinone (TR–494).
6. TR 517: Sodium Chlorate (CAS No. 7775–09–9).
   - Oxidizing agent, precursor in the synthesis of chlorine dioxide; found as byproduct in water disinfected with chlorine dioxide.
7. TR 532: Bromodichloromethane (CAS No. 75–27–4).
   - Water disinfectant by-product.
8. TR 522: 3′-Azido-3′-thymidine (AZT) (CAS No. 30516–87–1).
   - Chemotherapeutic agent for treatment of people with acquired immune deficiency syndrome (AIDS).
9. TR 533: Benzophenone (CAS No. 119–61–9).
   - Photoinitiator fragrance enhancer, ultraviolet curing agent, intermediate in the manufacture of agricultural chemicals.

[FR Doc. 04–25280 Filed 11–12–04; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

RIN 1660–ZA05

Privacy Act Systems of Records; Amendment to Existing Routine Uses

AGENCY: Federal Emergency Management Agency (FEMA), Emergency Preparedness and Response Directorate, Department of Homeland Security (DHS).

ACTION: Notice of amendment to routine uses.

SUMMARY: In compliance with the requirements of the Privacy Act of 1974, as amended, FEMA gives notice that it intends to rename its system of records notice for FEMA/REG–2, Disaster Recovery Assistance Files, to acknowledge in the nomenclature that it is now part of DHS, that it proposes to revise the existing routine uses for this system to allow information sharing with voluntary agencies actively working in the open disaster and that it proposes to add new routine uses to provide notice about routine management and oversight information sharing. In addition, to reduce the burden on the public applying for disaster assistance, FEMA has proposed to allow the registration process to be done by individuals electronically over the Internet and is therefore revising its system notice to account for electronic records.

EFFECTIVE DATE: The amended system of records will be effective December 15, 2004, unless comments are received that result in a contrary determination. The amended system of records will be applicable to major disaster or emergencies declared on or after August 13, 2004, unless comments are received that result in a contrary determination.

ADDRESSES: You may submit comments, identified by EPA DOCKET NUMBER DHS–2004–0014 and/or 1660–ZA05 by *one* of the following methods:

- EPA Federal Partner EDOCKET Web Site: *http://www.epa.gov/feddocket.* Follow instructions for submitting comments on the Web site. DHS has joined the Environmental Protection Electronic Docket System (Partner EDOCKET). DHS and its agencies (excluding the United States Coast Guard (USCG) and Transportation Security Administration (TSA)) will use the EPA Federal Partner EDOCKET system. The USCG and TSA [legacy Department of Transportation (DOT) agencies] will continue to use the DOT Docket Management System until full migration to the electronic rulemaking federal docket management system occurs in 2005.
- Federal e-Rulemaking Portal: *http://www.regulations.gov.* Follow the instructions for submitting comments.
- Fax: (202) 646–4536.
- Mail: Rules Docket Clerk, Federal Emergency Management Agency, Office of General Counsel, room 840, 500 C Street SW., Washington, DC 20472.

FOR FURTHER INFORMATION CONTACT: Rena Y. Kim, Privacy Act Officer, Room 840, 500 C Street, SW., Washington, DC 20472; (telephone) (202) 646–3949, or (e-mail) *Rena.Kim@dhs.gov.*

SUPPLEMENTARY INFORMATION: Prior to March 1, 2003, FEMA was an independent agency within the Federal Government. While operating as an independent agency, FEMA published notices concerning its systems of

records. The system at issue in this notice was last published on October 9, 2001. In compliance with the requirements of the Privacy Act of 1974, as amended, 5 U.S.C. 552a, FEMA gives notice that it intends to revise the routines uses and to add several new ones to its system of records entitled, FEMA/REG–2, Disaster Recovery Assistance Files. FEMA has amended the language in routine use (a) to allow information sharing with voluntary agencies actively working in the open disaster. FEMA also intends to add two new routine uses that allow for information sharing with other Federal and State agencies to enhance FEMA's ability to provide oversight and coordination of State activities and to ensure that the State performs and adheres to FEMA regulations and policy guidance. In addition, because FEMA became a part of DHS on March 1, 2003, FEMA is incorporating appropriate DHS routine uses as part of this system of records.

FEMA altered its system of records and provided a report as required by 5 U.S.C. 552a(r). This change is to amend the language of routine use (a). This amendment will not change the type or amount of information collected from individuals who apply for disaster assistance. Finally, this notice will make the public aware of routine management and oversight information sharing between FEMA and other Federal agencies, State and local governments, and contractors providing services in support of the Individual Assistance program. Routine uses (d), (e), (f), and (g) allow us to disclose information from this system of records to Federal, State, and local governments in the course of providing disaster assistance and in creating and implementing emergency evacuation plans. In addition, to reduce the burden on the public applying for disaster assistance, FEMA is now making the registration process available by an additional means—electronically via the Internet. In addition to filling out paper applications or calling in and applying over the telephone, individuals who wish to apply for disaster assistance can now also do so over the Internet.

Accordingly, FEMA amends the Disaster Recovery Assistance Files of the FEMA Privacy Act system of records to read as follows:

SYSTEM NAME:

Disaster Recovery Assistance Files.

SYSTEM LOCATION:

National Processing Service Centers (NPSC) located at FEMA MD–NPSC, 6505 Belcrest Road, Hyattsville, MD 20782; FEMA VA–NPSC, 19844 Blue Ridge Mountain Road, Bluemont, VA 20135; FEMA TX–NPSC, 3900 Karina Lane, Denton, TX 76208; and FEMA PR–NPSC, Carr 8860, KM 1.1 Bldg T–1429, Trujillo Alto, PR 00976.

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

Individuals who apply for disaster recovery assistance through three different mediums including: (a) Electronically via the Internet, (b) by calling FEMA's toll-free number, or (c) through the submission of a paper copy of FEMA Form 90–69 following Presidentially-declared major disasters or emergencies. Our proposed additional new method will allow applicants to apply for disaster recovery assistance over the Internet, and will reduce the paperwork burden on the public.

CATEGORIES OF RECORDS IN THE SYSTEM:

(a) Records of registration for assistance (Form 90–69, Disaster Assistance Registration/Application) include individual applicants' names, addresses, telephone numbers, social security numbers, insurance coverage information, household size and composition, degree of damage incurred, income information, programs to which FEMA refers applicants for assistance, flood zones, location and height of high water level, and preliminary determinations of eligibility for disaster assistance.

(b) Inspection reports (Form 90–56, Inspection Report) contain individuals' identifying information and results of surveys of damaged real and personal property and goods, which may include individuals' homes and personal items.

(c) Temporary housing assistance eligibility determinations (Forms 90–11 through 90–13, 90–16, 90–22, 90–24 through 90–28, 90–31, 90–33, 90–41, 90–48, 90–57, 90–68 through 90–70, 90–71, 90–75 through 90–78, 90–82, 90–86, 90–87, 90–94 through 90–97, 90–99, and 90–101). These refer to approval and disapproval of temporary housing assistance and include: general correspondence, complaints, appeals and resolutions, requests for disbursement of payments, inquiries from tenants and landlords, general administrative and fiscal information, payment schedules and forms, termination notices, information shared with the temporary housing program staff from other agencies to prevent the duplication of benefits, leases, contracts, specifications for repair of disaster damaged residences, reasons for eviction or denial of aid, sales information after tenant purchase of housing units, and the status of disposition of applications for housing.

(d) Eligibility decisions for disaster aid from other Federal and State agencies (for example, the disaster loan program administered by the Small Business Administration, and disaster aid decisions of the State-administered Individual and Family Grants (IFG) and its successor program, Other Needs Assistance (ONA)) as they relate to determinations of individuals' eligibility for disaster assistance programs.

(e) State files, independently kept by the State, which contains records of persons who request disaster aid, specifically for IFG and its successor program, ONA, and administrative files and reports required by FEMA. As to individuals, the State keeps the same type of information as described above under registration, inspection, and temporary housing assistance records. As to administrative files and reporting requirements, the State uses forms 76–27, 76–28, 76–30, 76–32, 76–34, 76–35, and 76–38. This collection of information is essential to the effective monitoring and management of the IFG and the ONA Program by FEMA's Regional Office staff who have the oversight responsibility of ensuring that the State perform and adhere to FEMA regulations and policy guidance.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121–5206 and Reorganization Plan No. 3 of 1978.

PURPOSE(S):

To register applicants needing disaster assistance, to inspect damaged homes, to verify information provided by each applicant, to make eligibility determinations regarding an applicant's request for assistance, and to identify and implement measures to reduce future disaster damage.

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND THE PURPOSES OF SUCH USES:

(a) FEMA may disclose applicant information to certain agencies as necessary and as described below to prevent a duplication of efforts or a duplication of benefits in determining eligibility for disaster assistance. FEMA shall only release as much information as is necessary to enable the recipient agency to determine eligibility for that agency's particular assistance program(s). The receiving agency is not permitted to alter or to further disclose our disclosed records to other disaster organizations. FEMA may make such disclosures under the following circumstances:

(1) To another Federal agency or State government agency charged with administering disaster relief programs to make available any additional Federal and State disaster assistance to individuals and households.

(2) When an applicant seeks assistance from a local government agency or a voluntary organization (as defined at 44 CFR 206.2(a)(27), as amended or superseded) charged under legislation or charter with administering disaster relief programs, and FEMA receives a written request from that local government or voluntary agency that includes the applicant's name, FEMA registration/application number and damaged dwelling address. The written request must explain the type of tangible assistance being offered and the type of verification required before the assistance can be provided.

(3) To voluntary organizations (as defined at 44 CFR 206.2(a)(27), as amended or superseded) that have an established disaster assistance program to address the disaster-related unmet needs of disaster victims, are actively involved in the recovery efforts of the disaster, and either have a national membership, in good standing, with the National Voluntary Organizations Active in Disaster (NVOAD), or are participating in the disaster's Long-Term Recovery Committee. When a voluntary agency satisfies all of the criteria listed in this sub-paragraph, FEMA may release lists of individuals' names, contact information, and their FEMA inspected loss amount to the volunteer agency for the sole purpose of providing additional disaster assistance. FEMA shall release this information only while the period for assistance for the current disaster is open.

(b) When an individual's eligibility, in whole or in part, for a DHS/FEMA disaster assistance program depends upon benefits already received or available from another source for the same purpose, FEMA may disclose information to relevant agencies, organizations, and institutions as necessary to determine what benefits are available from another source and to prevent the duplication of disaster assistance benefits (as described in section 312 of the Stafford Act).

(c) In response to a written request, FEMA may disclose information from this system of records to Federal, State, or local government agencies charged with the implementation of hazard mitigation measures and the enforcement of hazard-specific provisions of building codes, standards, and ordinances. FEMA may only disclose information for the following purposes:

(1) For hazard mitigation planning purposes to assist States and local communities in identifying high-risk areas and preparing mitigation plans that target those areas for hazard mitigation projects implemented under Federal, State or local hazard mitigation programs.

(2) For enforcement purposes, to enable State and local communities to ensure that owners repair or rebuild structures in conformance with applicable hazard-specific building codes, standards, and ordinances.

(d) Pursuant to the Debt Collection Improvement Act of 1996, 31 U.S.C. 3325(d) and 7701(c)(1), FEMA is required to collect and release to the United States Department of the Treasury the social security number of the person doing business with FEMA, including an applicant for a grant. Therefore, FEMA will release an applicant's social security number in connection with a request for payment to the U.S. Treasury in order to provide a disaster assistance payment to an applicant under the Individual Assistance program.

(e) FEMA may provide a list of applicants' names, amounts of assistance provided, and related information to a State in connection with billing that State for the applicable non-Federal cost share under the Individuals and Households Program.

(f) When an applicant is occupying a FEMA Temporary Housing unit, FEMA may release only the location of the FEMA Temporary Housing unit to local emergency managers for the sole purpose of preparing emergency evacuation plans. FEMA shall not release any information on an individual, such as their name, type or amount of disaster assistance received.

(g) *Routine Use—Investigations:* Where a record, either on its face or in conjunction with other information, indicates a violation or potential violation of law—criminal, civil or regulatory—the relevant records may be referred to an appropriate Federal, State, territorial, tribal, local, international, or foreign agency law enforcement authority or other appropriate agency charged with investigating or prosecuting such a violation or enforcing or implementing such law.

(h) *Routine Use—Requesting Information:* To a Federal, State, local, tribal, territorial, foreign, or international agency, if necessary to obtain information relevant to a DHS decision concerning the hiring or retention of an employee, the issuance of a security clearance, the reporting of an investigation of an employee, the letting of a contract, or the issuance of a license, grant or other benefit.

(i) *Routine Use—Requested Information:* To a Federal, State, local, tribal, territorial, foreign, or international agency, in response to its request, in connection with the hiring or retention of an employee, the issuance of a security clearance, the reporting of an investigation of an employee, the letting of a contract, or the issuance of a license, grant, or other benefit by the requesting agency, to the extent that the information is relevant and necessary to the requesting agency's decision on the matter.

(j) Routine Use—Congressional Inquiries: To a congressional office from the record of an individual in response to an inquiry from that congressional office made at the request of the individual to whom the record pertains.

(k) Routine Use—Private Relief Legislation: To OMB at any stage of the legislative coordination and clearance process set out in OMB Circular No. A–19.

(l) Routine Use—National Archives and Records Administration: To the National Archives and Records Administration or other Federal Government agencies pursuant to records management inspections being conducted under the authority of 44 U.S.C. sections 2904 and 2906.

(m) Routine Use—Audits and Oversight: To an agency, organization, or individual for the purposes of performing authorized audit or oversight operations.

(n) Routine Use—Contractors, et al.: To contractors, grantees, experts, consultants, students, and others performing or working on a contract, service, grant, cooperative agreement, or other assignment for the Federal Government, when necessary to accomplish an agency function related to this system of records.

(o) Routine Use—Debt Collection: To the Department of the Treasury, Justice, the United States Attorney's Office, or a consumer reporting agency for further collection action on any delinquent debt when circumstances warrant.

(p) Routine Use—Freedom of Information Act (FOIA) Discussions with Other Agencies Regarding DHS Documents and Vice Versa: To a Federal agency or entity that furnished the record or information for the purpose of permitting that agency or entity to make a decision regarding access to or correction of the record or information, or to a Federal agency or entity for purposes of providing guidance or advice regarding the handling of particular requests.

(q) Routine Use—Litigation: To the Department of Justice (DOJ) or other Federal agency conducting litigation or in proceedings before any court, adjudicative or administrative body, when: (1) DHS, or (2) any employee of DHS in his/her official capacity, or (3) any employee of DHS in his/her individual capacity where DOJ or DHS has agreed to represent the employee, or (4) the United States or any agency thereof, is a party to the litigation or has an interest in such litigation.

(r) Routine Use—Privacy Act Verification and Amendment: To a Federal, State, territorial, tribal, local, international, or foreign agency or entity for the purpose of consulting with that agency or entity (1) to assist in making a determination regarding access to or amendment of information, or (2) for the purpose of verifying the identity of an individual or the accuracy of information submitted by an individual who has requested access to or amendment of information.

(s) Routine Use—Privacy Act/FOIA Access and Amendment: To the submitter or subject of a record or information to assist DHS in making a determination as to access or amendment.

DISCLOSURE TO CONSUMER REPORTING AGENCIES:

Disclosure under 5 U.S.C. 552a(b)(12): FEMA may make disclosures from this system to consumer reporting agencies, as defined in the Fair Credit Reporting Act, 15 U.S.C. Section 1681a(f), or the Debt Collection Act of 1982, 31 U.S.C. Section 3711(e).

POLICIES AND PRACTICES FOR STORING, RETRIEVING, ACCESSING, RETAINING, AND DISPOSING OF RECORDS IN THE SYSTEM:

STORAGE:

Interactive database, computer discs, and paper records in file folders.

RETRIEVABILITY:

By an individual's name, address, social security number, and case file number.

SAFEGUARDS:

Only authorized individuals and FEMA employees have access to this information. Hardware and software computer security measures are used to control access to the data. Access to the data is based upon an individual's position in FEMA and/or their designated duties. Individuals are assigned specific ''rights'' or specific access (*e.g.*, read only, modify, delete, etc.). The access granted is based upon an individual's position responsibilities for ''official use'' only. FEMA employees are allowed access to the data as a function of their specific job assignments within their respective organizations. Each FEMA employee's access to the data is restricted to that needed to carry out their duties.

No individual applying for disaster assistance will have access to the entire database via the Internet. Applicants will have limited access to only their own information that they submitted via the Internet, and to the status of their own information regarding the processing of their own application (*e.g.* the status of required documentation, inspection status, or SBA status). Applicants are provided a Logon id, password, and Personal Identification Number (PIN) that connect only to the applicant's data. The password and PIN ensures that the login id belongs to the applicant. Computer security software ensures that the login id is mapped only to the applicant's data. Applicants will have access to only their own application information after FEMA assigns them a properly authenticated user id, password, and PIN. Applicants will be registered and authenticated in accordance with National Institute of Standards and Technology Level 2 Assurance guidelines.

RETENTION AND DISPOSAL:

Records covered by paragraphs (a) through (d) are covered by Records Schedule N1–311–86–1 4C10a and are destroyed after 6 years and 3 months. Records covered by paragraph (e) are covered by Records Schedules N1–311–86–1 4C7 and/or N1–311–86–1 4C10b and are destroyed 3 years after closeout.

SYSTEM MANAGER(S) AND ADDRESS:

Division Director, Recovery Division, FEMA, 500 C Street SW., Washington, DC 20472 and applicable Regional Directors, as listed in Appendix A(1).

NOTIFICATION PROCEDURE:

Requests for Privacy Act protected information generally are governed by DHS regulations found at 6 CFR Part 5 and FEMA's regulations at 44 CFR Part 6. They must be made in writing, and clearly marked as a ''Privacy Act Request'' on the envelope and letter. Inquiries should be addressed to FEMA—Records Management, National Processing Service Center, P.O. Box 10055 Hyattsville, MD 20782–7055. Include the full name of the individual, the appropriate personal identification, and the current address. The name of the requester, the nature of the record sought, and the verification of identity must be clearly indicated, as required by DHS regulation 6 CFR 5.21 and FEMA regulation at 44 CFR 6.30. Requests may also be sent to: Privacy Act Officer, DHS/FEMA Office of General Counsel (GL), room 840, 500 C Street, SW., Washington, DC 20472.

RECORD ACCESS PROCEDURES:

Same as the Notification Procedure above.

CONTESTING RECORD PROCEDURE:

Same as the Notification Procedure above. The letter should state clearly and concisely what information you are contesting, the reasons for contesting it, and the proposed amendment to the information that you seek pursuant to DHS Privacy Act regulations at 6 CFR Part 5 and FEMA regulations at 44 CFR Part 6.

RECORD SOURCE CATEGORIES:

Applicants for disaster recovery assistance, credit rating bureaus, financial institutions, insurance companies, and state, local and voluntary agencies providing disaster relief.

EXEMPTIONS CLAIMED FOR THE SYSTEM:

None.

Dated: November 9, 2004.

David A. Trissell,

General Counsel, Emergency Preparedness and Response, Department of Homeland Security.

Appendix A (1)

Addresses for FEMA Regional Offices

Region I—Regional Director, FEMA, 99 High Street, 6th Floor, Boston, MA 02110;

Region II—Regional Director, FEMA, 26 Federal Plaza, New York, NY 10278–0002;

Region III—Regional Director, FEMA, One Independence Mall, 615 Chestnut Street, Philadelphia, PA 19106–4404;

Region IV—Regional Director, FEMA, 3003 Chamblee-Tucker Road, Atlanta, GA 30341;

Region V—Regional Director, FEMA, 536 S. Clark Street, Chicago, IL 60605;

Region VI—Regional Director, FEMA, Federal Center, 800 North Loop 288 Denton, TX 76209;

Region VII—Regional Director, FEMA, 2323 Grand Boulevard, Kansas City, MO 64108–2670;

Region VIII—Regional Director, FEMA, Denver Federal Center, Building 710, Box 25267, Denver, CO 80225–0267;

Region IX—Regional Director, FEMA, 1112 Broadway St. Oakland, CA 94607;

Region X—Regional Director, FEMA, Federal Regional Center, 130 228th Street, SW., Bothell, WA 98021–9796;

[FR Doc. 04–25284 Filed 11–12–04; 8:45 am]

BILLING CODE 9110–10–P

DEPARTMENT OF HOMELAND SECURITY

Transportation Security Administration

[Docket No. TSA–2004–19160]

Notice of Final Order for Secure Flight Test Phase; Response to Public Comments on Proposed Order and Secure Flight Test Records

AGENCY: Transportation Security Administration (TSA), Department of Homeland Security (DHS).

ACTION: Notice.

SUMMARY: This notice responds to public comments received in response to three documents that the Transportation Security Administration (TSA) published in the **Federal Register** on September 24, 2004, related to testing of a new domestic passenger prescreening program known as Secure Flight. Secure Flight is an aviation passenger prescreening program that, once operational, would identify passengers known or reasonably suspected to be engaged in terrorist activity in order to allow action to be taken to prevent them from boarding a domestic flight or to ensure that appropriate additional security screening procedures are applied. Under the program, TSA would compare passenger reservation information for domestic flights, primarily in the form of passenger name records (PNRs), to information maintained by the Federal Government about individuals known or reasonably suspected to be engaged in terrorist activity.

In preparation for testing the feasibility of the Secure Flight program, on September 24, 2004, TSA issued a **Federal Register** notice establishing a system of records under the Privacy Act for purposes of the Secure Flight program during the test phase. TSA also published a notice in the **Federal Register** that the agency had submitted to the Office of Management and Budget (OMB) a request for approval to collect PNRs from aircraft operators to test the Secure Flight program. That notice included the text of a proposed order to certain aircraft operators directing them to provide a limited set of historical PNRs to TSA. OMB subsequently has approved the information collection through March 31, 2005, and assigned OMB control number 1652–0025. In addition, TSA published a Privacy Impact Assessment for the testing phase of the Secure Flight program.

This **Federal Register** notice that TSA publishes today addresses public comments received in response to the **Federal Register** notices published on September 24, 2004, and describes changes made to TSA's proposed order, which TSA now is issuing in final form.

FOR FURTHER INFORMATION CONTACT: Lisa Dean, Privacy Officer, Transportation Security Administration, 601 South 12th Street, Arlington, VA 22202–4220; telephone (571) 227–3947; facsimile (571) 227–2594; e-mail *lisa.dean@dhs.gov.*

SUPPLEMENTARY INFORMATION:

Background

On September 24, 2004, TSA published in the **Federal Register** three notices related to TSA's plan to issue a final order to aircraft operators in order to obtain PNRs for testing of a new domestic passenger prescreening program known as Secure Flight (69 FR 57342, 57345, and 57352). This **Federal Register** notice that TSA is publishing today responds to public comments received in response to the notices published on September 24, 2004, and provides public notice of the final order that TSA is issuing for purposes of testing the Secure Flight program.

Secure Flight Program

The Secure Flight program is an effort to move the existing passenger prescreening process into the Federal Government in order to make the process more effective, consistent, and efficient for the traveling public. By administering this screening process within the Federal Government, the Secure Flight program will allow for better protection of government watchlist information that currently is provided to aircraft operators.

Secure Flight will involve the comparison of information in PNRs from domestic flights to names in the Terrorist Screening Database (TSDB) maintained by the Terrorist Screening Center (TSC), including the expanded TSA No-Fly and Selectee Lists, in order to identify individuals known or reasonably suspected to be engaged in terrorist activity. TSA anticipates that it will also apply, within the Secure Flight system, a streamlined version of the existing passenger prescreening process, known as the Computer Assisted Passenger Prescreening System (CAPPS), which evaluates information in PNRs that passengers otherwise provide to aircraft operators in the normal course of business.

Simple comparisons of PNR information against records maintained in the TSDB will not permit TSA to identify information provided by passengers that is incorrect or inaccurate, potentially rendering the comparisons less effective. Therefore, on a very limited basis, in addition to testing TSA's ability to compare passenger information with data maintained by TSC, TSA will separately test the use of commercial data to determine if use of such data is effective in identifying passenger information that is incorrect or inaccurate and reducing the number of false positive matches of passenger information against TSDB records. This test will involve commercial data aggregators whose procedures will be governed by strict privacy and data security protections. TSA will not receive the commercially available data that would be used by commercial data aggregators. TSA will use this test of commercial data to determine whether such use: (1) Could identify when passengers' information is inaccurate or incorrect and/or assist with the resolution of false positive matches; (2) would result in inappropriate differences in treatment of any protected category of persons; and (3) could be governed by data security safeguards and privacy protections that are sufficiently robust to ensure that commercial entities or other unauthorized entities do not gain access to passengers' personal information and to ensure that the government does not gain inappropriate access to commercial information about individuals. TSA will defer any decision of whether commercial data will be used in its prescreening programs, such as Secure Flight, until a thorough assessment of test results is completed. If TSA decides to use commercial data for Secure Flight, it will not do so until the agency publishes a new System of Records Notice announcing how commercial data will be used and individuals' privacy will be protected.

TSA's efforts to develop and test the Secure Flight program are fully consistent with the recommendation in the final report of the National Commission on Terrorist Attacks Upon the United States (9/11 Commission), which states at page 392:

> ''[I]mproved use of ''no-fly'' and ''automatic selectee'' lists should not be delayed while the argument about a successor to CAPPS continues. This screening function should be performed by TSA and it should utilize the larger set of watch lists maintained by the Federal Government. Air carriers should be required to supply the information needed to test and implement this new system.''

The expansion of these watchlists to include information not previously included for security reasons will be possible as integration and consolidation of the information related to individuals known or suspected to be engaged in terrorist activity maintained

by TSC is completed and the U.S. Government assumes the responsibility for administering the watchlist comparisons. Secure Flight will automate the vast majority of watchlist comparisons, will allow TSA to apply more consistent procedures where automated resolution of potential matches is not possible, and will allow for more consistent response procedures at airports for those passengers identified as potential matches.

Secure Flight represents a significant step in securing domestic air travel and safeguarding terrorism-related national security information, namely, the watchlists. It will dramatically improve consistency and effectiveness of comparisons of passenger information with data now maintained by TSC and will reduce the long-term costs to air carriers and passengers associated with maintaining the present system, which is operated individually by each aircraft operator that flies in the United States.

Prior Federal Register Notices

In order to test the feasibility of the Secure Flight program, TSA must obtain a sample of passenger information for domestic flights. In preparation for obtaining this information for testing purposes, on September 24, 2004, TSA published three public notices in the **Federal Register**. First, TSA published a system of records notice in accordance with the Privacy Act of 1974 (5 U.S.C. 552a), including a list of the proposed routine uses of information in the system of records. (69 FR 57345). The system of records notice establishes a new system entitled ''Secure Flight Test Records'' (hereafter referred to as DHS/TSA 017), which will govern the collection, maintenance, use, and disclosure of PNRs and other information obtained by TSA for purposes of testing the Secure Flight program. TSA requested public comment on the routine uses for DHS/TSA 017 during a 30-day comment period ending on October 25, 2004.

Second, TSA published in the **Federal Register** a notice that TSA had submitted to the Office of Management and Budget in accordance with the Paperwork Reduction Act (PRA) of 1995 (44 U.S.C. 3501, *et seq.*) a request for emergency processing of OMB's review and approval for TSA to collect PNRs from aircraft operators to test the Secure Flight program (PRA notice). (69 FR 57342). That notice included the text of a proposed order to certain aircraft operators directing them to provide a limited set of historical PNRs to TSA that cover commercial scheduled domestic flights. Specifically, the proposed order covered PNRs with domestic flight segments flown during the month of June 2004 and excluded those PNRs with flight segments that occurred after June 30, 2004. The purpose of this limitation was to ensure that during the test phase, TSA does not obtain any information about future travel plans of passengers on domestic flights. The order also proposed to exclude PNR flight segments to or from the U.S. Although not required to do so, TSA requested public comment on the proposed order during a 30-day comment period ending on October 25, 2004. OMB subsequently has approved the information collection through March 31, 2005, and assigned OMB control number 1652–0025.

Third, TSA published in the **Federal Register** a Privacy Impact Assessment for the test phase of the Secure Flight program, which TSA prepared in accordance with the E-Government Act of 2002. (69 FR 57352).

TSA received approximately 500 public comments on the Privacy Act system of records notice for DHS/TSA 017. Identical versions of most of those comments also were sent to OMB in response to TSA's PRA notice. TSA has reviewed and considered the issues raised by the public comments submitted to TSA and OMB. This notice addresses those issues and describes changes made to TSA's proposed order to aircraft operators, which, after carefully considering the comments, TSA now is issuing in final form.

Public Comments

Public comments on the Secure Flight system of records notice and PRA notice generally focused on one or more of the following categories of issues: (1) The program's effect on individual privacy and civil liberties; (2) the routine uses established for the Secure Flight Test Records System (DHS/TSA 017); (3) passenger consent to the use of historical PNRs; (4) the absence of a redress process; (5) concerns with the use of commercial data; (6) the efficacy of the Secure Flight program; (7) TSA's compliance with the Privacy Act, the PRA, and other laws; and (8) possible conflicts of laws involving European Union (EU) data privacy requirements.

Effect on Individual Privacy and Civil Liberties

A large majority of the commenters viewed the use of PNRs to prescreen passengers against government watchlists as an invasion of privacy and an infringement on their civil liberties, including individuals' right to travel and exercise other Constitutional rights that might be related to travel, such as the freedom of assembly. The National Business Travel Association (NBTA), stated that TSA should balance the need to establish better security measures with policies and procedures that protect civil liberties and privacy. The NBTA also stated that TSA should not impose unnecessary costs on business travelers.

TSA is aware of, and sensitive to, the need to preserve Americans' freedoms while pursing better security. In implementing a new security measure that affects these interests, it is necessary to move deliberately and cautiously. It is for this very reason that TSA is testing the Secure Flight program before moving forward with an operational system.

The prescreening of passengers against Government watchlists is a security measure that has been in place for several years, performed by aircraft operators, using watchlists provided by the Federal Government. Because the airlines have varying systems by which they implement passenger prescreening, the effectiveness, efficiency, and consistency in response for airline passengers of the current system is limited. The Secure Flight program is an effort to move this prescreening process into the Federal Government in order to make the process more effective, consistent, and efficient for the traveling public. This effort is consistent with a specific aviation security recommendation of the 9/11 Commission.

The Secure Flight program will not impose an unconstitutional burden on an individual's right to travel or exercise other Constitutional rights. The Secure Flight program is a limited, reasonable security screening measure designed to further the Federal Government's compelling interest in protecting aviation security. Except in cases where a passenger may authorize TSA to retain information about him or her for purposes of redress, TSA has no long-term need to retain the information and is seeking approval from the National Archives and Records Administration (NARA) to destroy passenger information shortly after completion of the passenger's itinerary. Similarly, for purposes of the test phase of the program, TSA is seeking NARA approval to destroy PNRs used for the test after the test has been completed and the results have been evaluated. TSA's purpose in obtaining PNRs is to test the program, not to maintain information on individuals' travel.

TSA agrees with NBTA's comments regarding the need to have policies and procedures that protect passengers' civil liberties and privacy interests and to ensure the Secure Flight program is

effective. TSA is in the process of developing redress procedures that will accomplish these goals, as discussed further below.

The Electronic Privacy Information Center (EPIC) objected to TSA's statement in the System of Records notice that the records created and maintained in the course of the Secure Flight test phase should be exempt from a number of the provisions of the Privacy Act, such as the provision allowing individuals to obtain access to certain records containing information about them.

The Privacy Act specifically permits agencies to exempt from certain of its provisions investigatory materials compiled for law enforcement purposes, because allowing individuals access to law enforcement files could impair investigations, particularly those involving complex or continuing patterns of behavior. The intent of the exemption is to prevent access to law enforcement records if that access would alert subjects that their activities are being scrutinized and allow them to take countermeasures to escape detection and prosecution.

In the Secure Flight system of records notice section entitled ''Exemptions Claimed for the System'', TSA stated that for portions of the system it would invoke exemptions to the Privacy Act's requirements such as those that: (1) Permit individuals to obtain access to, and amend, information pertaining to them; and (2) require that information collected by the agency be relevant and necessary to the agency's statutory purpose. (69 FR 57348). TSA is in the process of preparing a notice of proposed rulemaking to implement these exemptions, which will include a detailed explanation of the basis for invoking the exemptions and will offer the public an opportunity to comment further.

At this point, it is unclear whether TSA will need to invoke these exemptions for the Secure Flight program in its operational stage. In order, however, to preserve its ability to protect classified and law enforcement investigatory information from public disclosure, TSA identified these exemptions in the system of records notice as exemptions it may invoke, if necessary. EPIC noted in its comment that certain information in the system of records, such as PNRs, may not be subject to the exemptions and therefore should be releasable to the affected individual under the Privacy Act. TSA agrees with this view. As stated in the system of records notice, TSA will give individuals access to records in the system pertaining to them to the greatest extent feasible, consistent with law enforcement and national security concerns. It should become clearer during the test phase whether the records in the system may be structured in such a way as to exclude any information that must be withheld from the public for the reasons discussed above.

With regard to the requirement that information collected by the agency be ''relevant and necessary,'' one of the objectives of the test phase is to confirm what information in a PNR is relevant and necessary to conduct an effective comparison of PNRs to information in the TSDB. The results of the test phase should enable TSA to determine more precisely what passenger information is relevant and necessary to the operation of the Secure Flight program and to limit its collection accordingly during the operational stage.

A number of commenters expressed concern that the Secure Flight program could easily be expanded in the future beyond the scope outlined for the test phase. A number of other commenters anticipated that TSA would use passenger data to monitor where individuals travel and with whom they travel or whether they engage in other activities that could come within the First Amendment protection of freedom of assembly. These commenters have misconstrued the purpose of Secure Flight and the requirements that TSA has proposed for this test.

TSA will neither use passenger information to monitor individuals' movements within the country nor share such information with other agencies or third parties. In fact, for the operational phase of Secure Flight, TSA intends to seek approval from NARA to destroy passenger information shortly after completion of the passenger's itinerary. This will preclude TSA from keeping any record of passenger movements around the country. TSA will not monitor the individuals with whom a particular passenger travels.

If testing of the program indicates that it is a feasible and effective security measure, TSA will initiate a public rulemaking process in which it will provide an appropriate proposal for the workings of the system, as well as the redress process. This process, in conjunction with future publication of a Privacy Act system of records notice for the operational stage of the program will limit TSA's activities under Secure Flight to those outlined in the notice and serve as the basis for the operation of the program. To the extent that there are any substantial changes to collection of use of information under the program, these will be subject to additional notice and opportunity for public comment. This transparency will serve to prevent so-called ''mission creep.''

One commenter asked whether Secure Flight would use race, color, gender, age, religion, national origin, political views, origin of a passenger's name, disability, or other personal characteristics as the basis for screening decisions. One commenter suggested that TSA would use gun ownership as a basis for screening decisions. Several commenters stated that TSA should use ethnicity or national origin as a screening factor.

With regard to the use of race, gender, national origin, or other factors listed above, Secure Flight will comply with the Constitution and other applicable law. TSA has adopted and complies with the ''Guidance Regarding Use of Race by Federal Law Enforcement Agencies'' issued by the United States Department of Justice in June 2003.

Routine Uses

TSA received several comments on TSA's possible disclosure of personal data obtained for testing the Secure Flight program. Under the Privacy Act, TSA is required to list routine uses of the information it will maintain in the system of records created for testing the Secure Flight program. A routine use is a disclosure of a record outside the Department of Homeland Security for a purpose that is compatible with the purpose for which the information was collected. In its system of records notice for DHS/TSA 017, TSA listed the following routine uses for Secure Flight Test Records:

(1) To the Federal Bureau of Investigation where TSA becomes aware of information that may be related to an individual identified in the Terrorist Screening Database as known or reasonably suspected to be or having been engaged in conduct constituting, in preparation for, in aid of, or related to terrorism;

(2) To contractors, grantees, experts, consultants, or other like persons when necessary to perform a function or service related to the Secure Flight program or the system of records for which they have been engaged. Such recipients are required to comply with the Privacy Act, 5 U.S.C. 552a, as amended;

(3) To the Department of Justice (DOJ) or other Federal agency in the review, settlement, defense, and prosecution of claims, complaints, and lawsuits involving matters over which TSA exercises jurisdiction or when conducting litigation or in proceedings before any court, adjudicative or

administrative body, when: (a) TSA; or (b) any employee of TSA in his/her official capacity; or (c) any employee of TSA in his/her individual capacity, where DOJ or TSA has agreed to represent the employee; or (d) the United States or any agency thereof, is a party to the litigation or has an interest in such litigation, and TSA determines that the records are both relevant and necessary to the litigation and the use of such records is compatible with the purpose for which TSA collected the records;

(4) To the National Archives and Records Administration (NARA) or other Federal agencies pursuant to records management inspections being conducted under the authority of 44 U.S.C. 2904 and 2906;

(5) To a Congressional office from the record of an individual in response to an inquiry from that congressional office made at the request of the individual; and

(6) To an agency, organization, or individual for the purposes of performing authorized audit or oversight operations.

Some commenters objected to the disclosure of information to other agencies whose missions are unrelated to counterterrorism or security and to foreign governments. TSA has established a very limited set of routine uses for the Secure Flight Test Records. Consistent with the commenters' view, TSA will disclose information to the FBI in connection with its counterterrorism function where TSA becomes aware of information that may be related to an individual identified in the TSDB as known or reasonably suspected to be or having been engaged in conduct constituting, in preparation for, in aid of, or related to terrorism. The other routine uses applicable to DHS/TSA 017 are necessary for the operation of the agency or the operation and oversight of the Secure Flight program. TSA will not provide any of the information related to the Secure Flight program to foreign governments.

One commenter expressed concern with TSA's plan to allow government contractors access to personal data and suggested that TSA ensure that strong contractual requirements are in place to deter weak data handling practices. TSA will put such contractual requirements in place.

One commenter stated that TSA should ensure that if Secure Flight is used to screen actual passengers, any underlying information about the passenger used to make screening decisions should not be provided to the airlines or screeners. TSA agrees with this comment. One of the main purposes of Secure Flight is to bring within the Federal Government the watchlist comparison results that currently are in the hands of airlines.

Passenger Consent

Many commenters objected to the government's collection of PNRs for testing purposes because they had not given consent to the collection. As discussed previously, aircraft operators currently use the information in PNRs to conduct passenger prescreening, including watchlists checks and the application of CAPPS. The existence of these prescreening measures has been public knowledge for many years. Therefore, when passengers provide information to aircraft operators in order to purchase air transportation, they have notice that their information will be used for prescreening purposes. In fact, the PNRs TSA will receive for testing Secure Flight already were already used for airline-implemented prescreening in June 2004. Therefore, TSA's collection of the PNRs is consistent with the purposes for which the information in those PNRs originally was collected, and passengers who traveled by air in June 2004 had notice of those purposes.

Redress Process

Commenters noted that TSA has not yet established detailed redress procedures to handle cases where passengers believe they have been unfairly or inaccurately singled out for additional scrutiny as a result of the comparison of their PNRs to information in the TSDB. NBTA stated that TSA should develop a redress process to address inaccuracies in the databases TSA uses to prescreen passengers, including special procedures for corporate travelers to allow them to continue to fly while any security issue is resolved.

TSA is in the process of developing a robust redress program and has begun hiring and is well into the process of developing redress procedures that will be refined during the Secure Flight test in November. For present purposes, however, TSA is only testing the Secure Flight concept. Because the data to be used concerns domestic flights that have already been completed during the month of June 2004 ''meaning that passengers were already screened ''and because the test results will not be used in an operational setting to conduct passenger screening, no passengers will need to avail themselves of the redress process during testing. With respect to special procedures for business travelers, TSA does not, at this point, believe that the Secure Flight program will cause delays that would warrant special treatment for any class of passengers. Information obtained through program testing, however, may be relevant to this issue, and TSA will consider it in developing the operational aspects of the Secure Flight program.

Use of Commercial Data

A number of commenters had questions and concerns regarding TSA's plan to test the use of commercial data to identify passenger information that is incorrect or inaccurate. Commenters expressed concern that TSA's access to commercial information would open the door to abuse of individuals' privacy rights and possible theft of their personal information.

As discussed in detail in the Privacy Impact Assessment for the Secure Flight Test Phase (69 FR 57352), TSA's testing of commercial data will be governed by stringent data security and privacy protections, including: contractual prohibitions on commercial entities' maintenance or use of PNR information for any purposes other than testing under TSA parameters; strict firewalls between the government and commercial data providers; real-time auditing procedures to determine when data has been accessed and by whom; and strict rules prohibiting the access or use of commercially held personal data by TSA. TSA will not have access to or store the commercially available data that would be used by commercial data aggregators.

One commenter questioned TSA's need for passengers' credit card information as part of Secure Flight and whether TSA would be using commercial data to check credit histories and other personal information unrelated to Secure Flight. Commenters also had questions about the types of commercial information that could lead TSA to apply enhanced screening or deny an individual access to an aircraft. One commenter suggested that TSA use only those sources of commercial data that are easily corrected by consumers so that if there are errors in commercially available data that lead to incorrect screening decisions by TSA, those errors can be resolved in a timely manner.

These are all are key issues that TSA will be attempting to resolve during the testing phase. Once TSA has information about the feasibility and efficacy of using commercial data, such as credit card numbers, to gauge the accuracy of passenger information and reduce false positive matches to information in the TSDB, the agency will be in a position to provide specific answers to the types of questions raised

by the commenters. TSA will not have access to individuals' credit histories, medical records, or other personal records.

A number of commenters expressed concern over access by data aggregators to passenger information during the testing. TSA will require the data aggregators with whom it works to abide by the requirements of the Privacy Act as well as to execute legally enforceable nondisclosure agreements prohibiting their use of information for any purpose other than for the testing of the effectiveness of the use of commercial data for Secure Flight. As a security mechanism, TSA has installed an auditing system as part of the platform on which the Secure Flight program will operate. The auditing mechanism will immediately detect any unauthorized access to the passenger data. Within TSA, individuals who are not conducting the test of the Secure Flight program will not have access to any passenger information. The real-time auditing mechanisms in place should prevent unauthorized access by individuals who are not part of the team conducting the test. TSA personnel with access to information for the testing phase will undergo specialized privacy training and will be required to hold appropriate security clearances and, therefore, will understand the sensitivity of the information to which they have access.

Under section 552(d) of the Department of Homeland Security Appropriations Act, 2005 (Pub. L. 108–334), TSA may not test the use of commercial data until the agency has developed measures to determine the impact of the use of commercial data on aviation security and the Government Accountability Office (GAO) has reported on TSA's evaluation measures. TSA currently is working with GAO to provide the information GAO needs to evaluate TSA's measures.

Efficacy of the Program

Commenters questioned the potential effectiveness of the Secure Flight program because, they claim, the information in the TSDB regarding individuals known or suspected of being engaged in terrorist activity is inaccurate. A number of commenters stated that TSA should instead focus its resources and effort on improved physical security measures such as improved checkpoint screening, increased numbers of Federal Air Marshals and Federal Flight Deck Officers, and improved screening of baggage and cargo. NBTA stated that TSA should stress test the Secure Flight system and develop operational safeguards and oversight policies for the program.

TSA agrees with those commenters who have stated that TSA should ensure that the Secure Flight program is effective before going forward with implementation and should have a quick and effective redress process to address situations in which passengers are mistakenly subjected to enhanced scrutiny or believe that they have wrongly been included on a watchlist.

With respect to the suggested choice between developing Secure Flight or directing TSA's resources towards other security measures, TSA approaches security as a layered process. TSA is committed to taking actions that will improve each layer of security and believes that such actions are not mutually exclusive.

The American Civil Liberties Union (ACLU) commented that the continued expansion of government watchlists creates a risk of false positive matches of passengers on watchlists. Therefore, the ACLU stated, effective management of the watchlists will become even more important. Again, TSA agrees that the Secure Flight program must be shown to be effective in achieving its stated goals before it is implemented. In order to determine whether the program can be effective, however, TSA must test the system and is doing so while respecting the privacy and civil liberties of individuals.

A number of commenters stated that Secure Flight would not be effective in identifying terrorists who may travel by air but are not currently known to the Federal Government and therefore are not included in the TSDB. Commenters also stated that even if an individual is included in the TSDB, Secure Flight will not detect that individual if he or she assumes the identity of a person not included in the TSDB, such as through identity theft.

TSA agrees that checking passenger names against information in the TSDB will not identify unknown terrorists or those using a stolen identity. Commercial data may be useful in identifying instances where a passenger may have presented inaccurate or incorrect information.

As discussed previously, however, Secure Flight will involve the use of a streamlined version of the existing CAPPS system that aircraft operators currently are using to prescreen passengers. That system evaluates information in PNRs that passengers otherwise provide to aircraft operators in the normal course of business. This element of Secure Flight will address the threat posed by an individual who may pose a threat but is not included in the TSDB or has assumed the identity of a person not included in the TSDB.

A number of commenters stated that TSA should make public the results of the Secure Flight test phase. TSA will make the results available to the extent consistent with national security and homeland security.

Compliance With the Privacy Act, PRA, and Other Laws

The EPIC stated that OMB should not approve the information collection until TSA provides more detailed information to the public about the Secure Flight program.

The Secure Flight program is at a very early stage of development. The purpose of the test phase is to determine the technical feasibility of a consolidated system by which TSA may compare information in PNRs to information in the TSDB. At this point, therefore, TSA has provided as much detail as it can about the planned workings of the Secure Flight program. Once the test is completed and the results are analyzed, if the test phase indicates that the program is technically feasible, TSA will then be able to engage in a public rulemaking process that will involve a more detailed proposal for the Secure Flight program. This subsequent rulemaking will provide members of the public further opportunity to comment on operational and policy issues raised by the program.

One commenter questioned whether TSA had a basis for receiving emergency processing from OMB of the information collection contained in the proposed order. TSA's request for emergency processing was based on the need to move forward with a new passenger prescreening system as quickly as possible, consistent with the 9/11 Commission's recently issued recommendation that TSA take over from aircraft operators the function of passenger prescreening using government watchlists.

The commenter also articulated a number of aspects of the Secure Flight program that he argued are contrary to the requirements of the Privacy Act or other laws. First, he argued that PNRs constitute information regarding an individual's exercise of the First Amendment right of assembly because travel is a form of assembly.

The Privacy Act imposes certain limits on an agency's authority to collect records describing an individual's exercise of First Amendment Rights. See 5 U.S.C. 552a(e)(7). TSA does not agree that PNRs contain information related to the exercise of First Amendment rights, including the right of assembly.

Second, the commenter argued that TSA's proposed order to aircraft operators to submit PNRs is inconsistent with the requirement that an agency collect information to the maximum extent practical directly from an individual when the information may result in an adverse determination about an individual's rights, benefits, or privileges. *See* 5 U.S.C. 552a(e)(2). The commenter stated that TSA has failed to show that it would be impractical for TSA staff to collect information about passengers from them directly at the airport prior to boarding.

Collecting information from passengers at the airport for purposes of the Secure Flight test would impose a tremendous burden on the flying public in the form of additional time required for security screening. It also would not allow TSA to obtain and test the information in a PNR format, which is the form in which TSA would receive the information during the operational phase of the program.

Third, the commenter, as well as others, stated that the proposed order is inconsistent with the Privacy Act because passengers whose information will be submitted to TSA under the order did not receive notice in accordance with section 552a(e)(3) of the Privacy Act, which requires a Federal agency to ''inform each individual whom it asks to supply information'' of: (1) The authority under which the request is made; (2) whether the disclosure of the information is mandatory or voluntary; (3) the principal purpose for which the information is intended to be used and the routine uses which may be made of the information; and (4) the effects on the individual if any, of not providing all or part of the information.

The notice requirement under 5 U.S.C. 552a(e)(3) does not apply to the collection of the PNRs described in the proposed order. OMB has interpreted the notice requirement in section 552a(e)(3) to be inapplicable to situations in which an agency collects information about an individual from a third party.

Fourth, the commenter argues that the system of records notice for Secure Flight fails to meet the requirement in 5 U.S.C. 552a(e)(4)(B) that it describe the categories of individuals on whom records are maintained in the system. The commenter notes that PNRs may contain the names of travel agents or other individuals who make, pay for, or process a passenger's travel but who are not passengers. The commenter also noted that the proposed order covered PNRs with itineraries that were entirely cancelled, thereby capturing individuals who had not flown.

It is our understanding that the inclusion in PNRs of names other than those of passengers is rare. In any case, for purposes of testing the Secure Flight concept, TSA will not retrieve information from PNRs using the names of travel agents or other non-passengers who may be included in a PNR, because the purpose of Secure Flight is to screen passengers. The purpose of listing ''Categories of individuals covered'' in the system of records notice is to provide notice to those individuals whose records are subject to the Privacy Act because the records are retrieved by their name or personal identifier. The purpose is not to provide notice to every individual whose name may be incidentally mentioned in a record retrieved by the name of another individual. In addition, TSA has revised the final order to exclude from its scope any PNRs with itineraries that have been cancelled in whole, thereby avoiding collection of PNRs for individuals who have not actually completed any part of the itinerary in the PNR. For these reasons, the provision in the system of records notice meets the requirements of the Privacy Act.

Fifth, the commenter argues that TSA has failed to meet certain requirements applicable to the promulgation of regulations under the Airline Deregulation Act, the Aviation and Transportation Security Act, and the Unfunded Mandates Reform Act of 1995, and the Regulatory Flexibility Act. Other commenters noted that TSA has not published a cost-benefit analysis for the Secure Flight program.

As discussed previously, TSA is obtaining historical PNRs for the test phase of Secure Flight through the issuance of an order, not through rulemaking. Therefore, the foregoing statutes, as well as other statutes and Executive Orders that apply to agency rulemaking, do not apply in this instance. If testing of the program indicates that it is a feasible and effective security measure, TSA will initiate a public rulemaking process in which it will again fully comply with all applicable statutory requirements.

Sixth, the commenter argued that TSA has no authority to establish a system of records for Secure Flight or order aircraft operators to provide PNRs to TSA.

TSA has ample authority to conduct the Secure Flight test. Under the Aviation and Transportation Security Act and authority delegated to the Assistant Secretary of Homeland Security (Transportation Security Administration) by the Secretary of Homeland Security, TSA is responsible for, among other things, the screening of passengers and property transported in air transportation and intrastate air transportation. Also under its delegated authority, TSA has broad authority under 49 U.S.C. 40113(a) to issue orders necessary to carry out its statutory duties, which expressly include providing for security screening, under 49 U.S.C. 44901(a). TSA also is authorized to undertake research and development activities necessary to enhance transportation security under 49 U.S.C. 114(f)(8) and create a successor system to the existing CAPPS under 49 U.S.C. 44903(j)(2). Under these authorities, TSA may order aircraft operators to provide PNRs to TSA to test the Secure Flight program. Implementation of the Secure Flight test also is in furtherance of Homeland Security Presidential Directive–6/HSPD–6 of September 23, 2003 (''Integration and Use of Screening Information to Protect Against Terrorism''), which, among other things, directs Federal agencies to conduct screening at all appropriate opportunities using consolidated terrorist information and intelligence about individuals known or appropriately suspected to be or have been engaged in conduct constituting, in preparation for, in aid of, or related to terrorism.

Potential Conflict With EU Laws

United Airlines and other commenters expressed concern that complying with the proposed order would expose U.S. airlines to liability for violating privacy laws of the Member States of the EU. United suggested that the U.S. government work closely with foreign governments to address any conflicts of laws that may arise. While TSA has clear statutory authority to require the submission of reservation information for use in prescreening passengers on domestic flight segments, TSA understands the sensitivity of aircraft operators to the possibility of conflicting legal obligations under U.S. law and the laws of EU Member States. Therefore, in the interest of implementing this test expeditiously, TSA has determined that for purposes of this test phase, aircraft operators may opt to exclude from PNRs submitted to TSA any PNR that includes a flight segment between the United States and the EU.

TSA and Department officials briefed European Commission (EC) representatives on October 25 to provide further details on Secure Flight testing, including the parameters of data to be

submitted for the test. TSA informed the EC that carriers may elect not to submit to TSA for use in testing any PNRs with a flight segment between the EU and the United States. The Department and EC representatives will continue regular discussions to keep the EU fully apprised of TSA's progress regarding Secure Flight, and to receive EU feedback on Secure Flight issues. TSA, in conjunction with DHS, will continue to consult with the EU prior to and during Secure Flight implementation.

Other Issues

United Airlines stated in its comment the concern that the Secure Flight program might result in unnecessary costs to airlines if they are required to establish new systems to transmit passenger information to TSA, rather than relying on existing systems, such as those that U.S. Customs and Border Protection has in place for receiving advance passenger information for international flights. In planning and developing the operational stage of the Secure Flight program, TSA will work to use existing communications links between the airlines and the Federal Government in order to avoid imposing duplicative requirements on the airlines to the greatest extent possible.

Final Order

The final order is largely unchanged from the proposed order, with the exception of the following provisions.

First, in order to simplify and clarify compliance with the order, TSA changed the scope of PNRs that aircraft operators are required to provide and the description of the category of aircraft operators covered by the order. The proposed order would have required the submission of any PNRs with a flight segment completed during June 2004, so long as all the flight segments in the PNR had been completed by the end of June 2004. Thus, the proposed order covered PNRs with flight segments completed many months before June 2004. The final order applies only to those PNRs with all flight segments (flights between two locations) completed in June 2004.

The proposed order applied to PNRs for any passenger on ''a scheduled flight within the United States, in operations subject to a full security program under 49 CFR 1544.101(a).'' This language was intended to cover any scheduled passenger or public charter operation conducted under a full security program. Because the proposed order did not specifically mention public charter operations and used the term ''scheduled flight,'' there was some confusion as to whether TSA intended to cover any public charter operations. The final order clarifies this point by stating the following: ''This order applies to aircraft operators that conduct scheduled passenger or public charter operations subject to a full security program under 49 CFR 1544.101(a).''

The proposed order directed aircraft operators to exclude from the PNRs submitted to TSA any flight segment to or from the United States. TSA now understands, however, that deleting information related to flight segments from PNRs is difficult and could inhibit aircraft operators from complying with the order in a timely manner. After reviewing this issue and considering the issues discussed above related to possible conflicts of law with EU Member States, TSA revised the order to allow aircraft operators to exclude entirely from its submission PNRs that include flight segments between the United States and the EU.

TSA has modified the proposed order in response to questions about how the order applied to aircraft operators that use passenger manifests rather than PNRs. The final order provides that if an aircraft operator does not use PNRs, the order applies to the reservation data in whatever form the aircraft operators receive or maintain for operation of a flight, such as a passenger manifest. The final order also clarifies that with respect to codesharing operations, if an aircraft operator does not maintain PNRs or other passenger reservation information for the flights that it operates, the aircraft operator may comply with the order by stipulating in writing to TSA that the entity maintaining such PNRs or other passenger reservation information has agreed to provide the information to TSA on behalf of the aircraft operator. For example, a regional aircraft operator that relies on other aircraft operators to maintain PNRs for the regional operator's flights must stipulate that the other aircraft operators will submit PNRs to TSA on the regional aircraft operator's behalf.

TSA also received questions about how to address situations where PNR history, which was excluded from the scope of the proposed order, includes completed flight segments, which were included in the scope of the proposed order. The final order clarifies that if the PNR history includes information on flight segments already flown, they must be included in the PNR submitted to TSA. In such cases, the aircraft operator may move information on flights flown out of the PNR history or include the entire PNR history in the information submitted to TSA, and TSA will extract the flown flight segments. The final order also clarifies that PNRs must include all data that would have been available to the aircraft operator prior to the completion of the itinerary (active fields), including any ''remarks'' sections, the reservation creation date, and CAPPS scores and codes.

Finally, the final order provides additional information about how the PNRs are to be submitted, including a requirement that they be password protected.

Based on the foregoing, TSA will issue the following final order to aircraft operators. The text of the final order is set forth below.

Issued in Arlington, Virginia, on November 10, 2004.

Lisa S. Dean,

Privacy Officer.

OMB Control Number 1652–0025
Expiration Date: March 31, 2005

Transportation Security Administration Order

Pursuant to the authority vested in me as Assistant Secretary of Homeland Security (Transportation Security Administration) (TSA) by delegation from the Secretary of Homeland Security, 49 U.S.C. 40113(a), and other authorities described below, I hereby direct each aircraft operator listed in Attachment A to this order to provide passenger name records (PNRs) to TSA in accordance with the terms of this order.

Background and Authority

1. The Secretary of Homeland Security has delegated to the Assistant Secretary of Homeland Security (TSA), subject to the Secretary's guidance and control, the authority vested in the Secretary by section 403(2) of the Homeland Security Act respecting TSA, including that related to civil aviation security under the Aviation and Transportation Security Act.

2. Under 49 U.S.C. 114(e)(1) and 44901(a), TSA is responsible for, among other things, providing for the screening of passengers traveling in air transportation and intrastate air transportation.

3. One component of passenger screening is the Computer-Assisted Passenger Prescreening System (CAPPS), an automated screening system developed by the Federal Aviation Administration (FAA) in cooperation with U.S. aircraft operators. U.S. aircraft operators implemented CAPPS in 1997.

4. CAPPS evaluates information in PNRs that passengers otherwise provide to aircraft operators in the normal course of business to determine whether a passenger will be selected for a higher level of security screening prior to boarding. A PNR is a record that contains detailed information about an individual's travel on a particular flight, including information provided by the individual when making the flight reservation. While the Federal Government established the CAPPS selection criteria, CAPPS is operated entirely by U.S. aircraft operators.

5. Passenger prescreening also involves the comparison of identifying information of airline passengers against lists of individuals known to pose or suspected of posing a threat to civil aviation or national security. Aircraft operators currently carry out this function, using lists provided by TSA. Because the lists are provided in an unclassified form, the amount of information they include is limited. For this reason, TSA will take over from aircraft operators the function of screening passengers against such lists and use a larger set of data maintained by the Federal Government for this purpose. This is consistent with the recommendation by the National Commission on Terrorist Attacks upon the United States (9/11 Commission) related to the use of expanded ''No-Fly'' and ''Automatic Selectee'' lists, and the 9/11 Commission recommendation that aircraft operators be required to supply the information needed to test and implement such a system.

6. In accordance with the authority in 49 U.S.C. 44903(j)(2), TSA is in the process of developing a successor system to CAPPS that will be operated entirely by TSA and will incorporate the screening of passengers against data maintained by the Terrorist Screening Center (TSC) about individuals known or reasonably suspected to be or have been engaged in conduct constituting, in preparation for, in aid of, or related to terrorism.

7. In order to test such a system, TSA must have access to information contained in the PNRs for domestic passenger flights. TSA also must have access to passenger information from aircraft operators that maintain the information in forms other than PNRs, such as passenger manifests.

8. TSA has broad authority under 49 U.S.C. 40113(a) to issue orders necessary to carry out its functions, including its responsibility to provide for the security screening of passengers under 49 U.S.C. 44901(a). TSA also has authority to identify and undertake research and development activities necessary to enhance transportation security under 49 U.S.C. 114(f)(8).

Findings

9. The security prescreening of passengers, as mandated by Congress, is vital to aviation security and national security.

10. After a lengthy review of the initial plans for a successor system to CAPPS, and consistent with the recommendation of the 9/11 Commission, the Department of Homeland Security is moving forward with a next generation system of domestic passenger prescreening that meets the following goals: (1) Identifying, in advance of flight, passengers known or suspected to be engaged in terrorist activity; (2) moving of passengers through airport screening more quickly and reducing the number of individuals unnecessarily selected for secondary screening; and (3) fully protecting passengers' privacy and civil liberties.

11. In the revised program, known as Secure Flight, TSA will compare information in airline PNRs or other passenger manifest formats for domestic flights to information in the Terrorist Screening Database (TSDB) maintained by TSC, including expanded TSA No-Fly and Selectee lists, in order to identify individuals known or reasonably suspected to be or having been engaged in conduct constituting, in preparation for, in aid of, or related to terrorism. The Secure Flight program also will test operation of a streamlined version of the existing CAPPS evaluation criteria. TSA will use the PNRs obtained under this order to test these aspects of the program.

12. TSA also will test whether comparing passenger information to other commercially available data can enhance TSA's ability to identify passenger information that is inaccurate or incorrect.

13. In order to develop and test such a system, TSA must obtain passenger information in PNRs, or other passenger manifest formats where PNRs are not used, from aircraft operators.

14. On September 24, 2004, TSA published in the **Federal Register** a proposed order requiring aircraft operators to provide PNRs for testing the Secure Flight program. After considering the public comments received and making modifications to the proposed order, where appropriate, TSA is issuing this final order to aircraft operators for purposes of obtaining PNRs to test the Secure Flight program.

Action Ordered

15. *Scope:*

a. *Aircraft Operators:*

This order applies to aircraft operators that conduct scheduled passenger or public charter operations subject to a full security program under 49 CFR 1544.101(a).

b. *Information:*

This order applies to PNRs containing itineraries for domestic flights operated under a full security program and for which all flight segments in the itinerary were flown between June 1, 2004 and June 30, 2004, (after 2400 hours 31 May 2004 and before 0001 hours 1 July 2004). This includes PNRs for non-revenue and space available passengers.

For purposes of this order, ''PNR'' means the electronic record maintained by the aircraft operator detailing information about an individual's travel on a particular flight and any other information contained in that record.

For purposes of this order, ''domestic flight'' means a flight between two locations in the United States (to include the U.S. Virgin Islands, Puerto Rico, Guam, Saipan, and American Samoa).

This order does not apply to PNRs reflecting itineraries that were cancelled in whole.

An aircraft operator may elect to exclude from the scope of the order any PNRs which include any flight segments between the EU and the United States.

If an aircraft operator does not use PNRs, the order applies to the reservation data in whatever form aircraft operators receive or maintain for operation of a flight, such as a passenger manifest.

c. *Information in PNRs:*

PNRs must include all data that would have been available to the aircraft operator in a displayed PNR prior to the completion of the itinerary (active fields), including any ''remarks'' sections, the reservation creation date, and CAPPS scores and codes.

PNRs may not include information related to changes in a PNR prior to completion of the flight itinerary (PNR history). If, however, the PNR history includes information on flight segments already flown, they must be included in the PNR. In such cases, the aircraft operator may move information on flights flown out of the PNR history or include the entire PNR history in the information submitted to TSA, and TSA will extract the flown flights segments (itinerary).

PNRs may be submitted in archive format.

16. *Submission of PNRs:*

The aircraft operator must submit to TSA all PNRs described in paragraph 15 so that the data is received by TSA no later than 5 p.m. EST on November 23, 2004.

Mail all information through overnight carrier to: Lisa Dean, Privacy Officer, Transportation Security Administration, 601 S. 12th Street, TSA–9, Room E7–305N, Arlington, VA 22202, Phone: (571) 227–3947.

17. *Codesharing Operations:*

If an aircraft operator does not maintain PNRs or other passenger reservation information for the flights that it operates, the aircraft operator may comply with this order by stipulating in writing to TSA that the entity maintaining such PNRs or other passenger reservation information has agreed to provide the information to TSA on behalf of the aircraft operator. For example, a regional aircraft operator that relies on other aircraft operators to maintain PNRs for the regional operator's flights must stipulate the other aircraft operators will submit PNRs to TSA on the regional aircraft operator's behalf.

Letters of stipulation, described above, must be signed and on company letterhead. They may be delivered in one of the following three ways:

U.S. Mail: TSA/ONRA, Attention: Airline Team, P.O. Box 597, Annapolis Junction, MD 20701.

FAX: (240) 568–3528.

E-mail (scanned copies): SecureFlight@DHS.gov.

18. The aircraft operator must provide to TSA information about the aircraft operator's PNR data schema and layout, such as a PNR format book and a data dictionary that includes all acronyms and codes not standard to the International Air Transport Association.

19. For purposes of the test, the aircraft operator must provide the PNRs to TSA on optical media in an unpacked or uncompressed form, in a structured data format or XML, if available. Information must be password-protected. The aircraft operator must supply TSA with the password via e-mail at *SecureFlight@DHS.gov.*

Attachment A—Aircraft Operators

1. Air Midwest Inc.
2. Air Wisconsin Airline Corp
3. AirTran Airways Inc.
4. Alaska Airlines Inc.
5. Allegiant Air
6. Aloha Airlines Inc.
7. America West Airlines Inc.
8. American Airlines Inc.
9. American Eagle
10. American Trans Air Inc.

11. Atlantic Southeast Airlines (ASA)
12. Big Sky Airlines
13. Boston and Maine Airways
14. Cape Air (Hyannis Air Service)
15. Caribbean Air
16. Casino Airlines
17. Casino Express TEM Enterprises
18. Champion Air (Grand Holdings)
19. Chautauqua Airlines
20. Chicago Express Airlines
21. Colgan Air
22. Comair, Inc.
23. Commutair (Champlain Ent.)
24. Continental Airlines Inc.
25. Continental Micronesia Inc.
26. Corporate Airlines
27. Delta Air Lines Inc.
28. Executive Airlines/American Eagle
29. Expressjet Airlines (Cont. Express)
30. Falcon Air Express
31. Freedom Air
32. Freedom Airlines
33. Frontier Airlines
34. Great Lakes Aviation Ltd.
35. Gulfstream International Airlines
36. Hawaii Island Air (Island Air)
37. Hawaiian Airlines
38. Horizon Air
39. Independence Air (Atlantic Coast Airline)
40. Jetblue Airways Corp.
41. Kenmore (start-up)
42. Mesa Airlines
43. Mesaba Aviation Inc.
44. Miami Air International
45. Midwest Airlines Inc.
46. North American Airlines
47. Northwest Airlines Inc.
48. Omni
49. Pace/Hooters
50. Pacific Island Aviation Inc.
51. Pacific Wings
52. Pan American Airways Corp.
53. Piedmont Airlines
54. Pinnacle Airlines (d/b/a Northwest Airlink)
55. Planet Air
56. Primaris Airlines, Inc. (Primaris)
57. PSA Airlines
58. Ryan International Airlines
59. Shuttle America
60. Sky King
61. Sky West Airlines
62. Skyway Airlines/Midwest Connect
63. Southeast Airlines
64. Southwest Airlines (U.S.A.)
65. Spirit Airlines
66. Sun Country Airlines Inc.
67. Trans States Airlines
68. Transmeridian Airlines
69. United Airlines Inc.
70. US Airways Inc.
71. USA3000
72. World Airways

[FR Doc. 04–25396 Filed 11–12–04; 8:45 am]

BILLING CODE 4910–62–P

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–4665–N–20]

Meeting of the Manufactured Housing Consensus Committee

AGENCY: Office of the Assistant Secretary for Housing—Federal Housing Commissioner, HUD.

ACTION: Notice of upcoming meeting.

SUMMARY: This advises the public of an upcoming meeting of the Manufactured Housing Consensus Committee (the Committee) and publishes the schedule and proposed agenda for the meeting. The meeting is open to the public and the site is accessible to individuals with disabilities.

DATES: The Committee will meet on November 30, 2004 and December 1, 2004, from 8 a.m. to 5 p.m., and on December 2, 2004, from 8 a.m. to 12 p.m.

ADDRESSES: The Committee will meet at the Marriott San Diego Hotel & Marina, 333 West Harbor Drive, San Diego, California 92101, telephone (619) 234–1500.

FOR FURTHER INFORMATION CONTACT: William W. Matchneer III, Administrator, Manufactured Housing Program, Office of Consumer and Regulatory Affairs, Department of Housing and Urban Development, 451 7th Street SW., Washington, DC 20410–8000, telephone (202) 708–6409 (this is not a toll-free number). Persons with hearing- or speech-impairments may access this number through TTY by calling the toll-free Federal Information Relay Service at (800) 877–8339.

SUPPLEMENTARY INFORMATION: Notice of this meeting is provided in accordance with section 10(a)(2) of the Federal Advisory Committee Act (5 U.S.C. App.2) and 41 CFR 102–3.150. The Manufactured Housing Consensus Committee was established under section 604(a)(3) of the National Manufactured Housing Construction and Safety Standards Act of 1974, as amended by the Manufacturer Housing Improvement Act of 2000, 42 U.S.C. 4503(a)(3). The Consensus Committee is charged with providing recommendations to the Secretary to adopt, revise, and interpret manufactured housing construction and safety standards and procedural and enforcement regulations, and with developing proposed model installation standards.

Tentative Agenda

A. Welcome and Introductions
B. Departmental Status Report
C. Subpart I
D. Construction and Safety Standards
E. Installation Standards
F. Accessibility—Universal Design—Visitability
G. Public Testimony
H. Reports and Actions on Committee Work
I. Adjourn

Dated: November 9, 2004.

John C. Weicher,

Assistant Secretary for Housing—Federal Housing Commissioner.

[FR Doc. 04–25389 Filed 11–10–04; 11:36 am]

BILLING CODE 4210–27–P

INTER-AMERICAN FOUNDATION

Sunshine Act Meeting

Agenda for Board of Directors' Meeting, November 30, 2004; 9:30 a.m.–1:30 p.m.

The meeting will be open except for the portion specified as a closed session as provided in 22 CFR 1004.4(f).

9:30 a.m.
Call to Order—Approval of the Minutes of the October 1, 2004 meeting
Executive Session (Closed session to discuss personnel issues, as provided in 22 CFR Part 1004.4(f)).
10:30 a.m.
President's Report
The IAF Strategic Plan
The IAF Corporate Outreach program
12 p.m.
Lunch
12:30 p.m.
Discussion on the Role of the Advisory Council
Relations with OMB and Congress
Other Business
1:30 p.m.
Adjournment

Carolyn Karr,

Senior Vice President and General Counsel.

[FR Doc. 04–25372 Filed 11–10–04; 10:47 am]

BILLING CODE 7025–01–M

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

Information Collection Renewal to be Submitted to the Office of Management and Budget (OMB) for Approval Under the Paperwork Reduction Act; OMB Control Number 1018–0103, Conservation Order for Control of Mid-Continent Light Geese, 50 CFR 21.60

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Notice; request for comments.

SUMMARY: The Fish and Wildlife Service (We) will submit the collection of information described below to OMB for approval under the provisions of the Paperwork Reduction Act of 1995.

DATES: You must submit comments on or before January 14, 2005.

ADDRESSES: Send your comments on this information collection requirement to Hope Grey, Service Information Collection Clearance Officer, Fish and Wildlife Service, MS 222–ARLSQ, 4401 North Fairfax Drive, Arlington, VA 22203 (mail); *Hope_Grey@fws.gov* (e-mail); or (703) 358–2269 (fax).

FOR FURTHER INFORMATION CONTACT: To request a copy of the information collection requirements or explanatory material, contact Hope Grey at the addresses above or by telephone at (703) 358–2482.

SUPPLEMENTARY INFORMATION: The Office of Management and Budget regulations at 5 CFR 1320, which implement provisions of the Paperwork Reduction Act of 1995 (Public Law 104–13), require that interested members of the public and affected agencies have an opportunity to comment on information collection and recordkeeping activities (*see* 5 CFR 1320.8(d)). We plan to submit a request to OMB to renew approval of the collection of information for the Conservation Order for Control of Mid-Continent Light Geese. The current OMB Control Number for this information collection is 1018–0103, which expires March 31, 2005. We are requesting a 3-year term of approval for this information collection activity. Federal agencies may not conduct or sponsor and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number.

The number of light geese (lesser snow and Ross' geese) in the mid-continent region has nearly quadrupled during the past several decades due to a decline in adult mortality and an increase in winter survival. Lesser snow and Ross' geese are referred to as light geese because of their light coloration as opposed to dark geese such as white-fronted or Canada Geese. Because of their feeding activity, light geese have become seriously injurious to their habitat as well as to habitat important to other migratory birds. This poses a serious threat to the short- and long-term health and status of some migratory bird populations. We believe that the number of light geese in the mid-continent region has exceeded long-term sustainable levels for their arctic and subarctic breeding habitats and that the populations must be reduced. 50 CFR 21 provides authority for the management of overabundant mid-continent light geese.

Light geese in the mid-continent region are separated into two different populations for management purposes. Lesser snow and Ross' geese that primarily migrate through North Dakota, South Dakota, Nebraska, Kansas, Iowa, and Missouri, and winter in Arkansas, Louisiana, Mississippi, and eastern, central, and southern Texas and other Gulf States are referred to as the mid-continent population of light geese. Lesser snow and Ross' geese that primarily migrate through Montana, Wyoming, and Colorado and winter in New Mexico, northwestern Texas, and Chihuahua, Mexico, are referred to as Western Central Flyway population of light geese.

States that participate in the light geese conservation order must inform and brief all participants on the requirements in 50 CFR 21.60 and conservation order conditions that apply to the implementation of light geese control measures. Participating States must collect information on the number of birds taken during control efforts, the methods by which they were taken, and the date on which they were taken. We use this information to administer the conservation order and, particularly, to monitor the effectiveness of control strategies and to protect migratory birds. Each participating State must submit an annual report by August 30 of each year summarizing the activities it conducted. We contacted some participating States to estimate the burden hours for this information collection.

Title of Collection: Conservation Order for Control of Mid-Continent Light Geese, 50 CFR 21.60.

OMB Control Number: 1018–0103.

Form Number: None.

Frequency of Collection: Annually.

Description of Respondents: States participating in the conservation order.

Total Annual Burden Hours: 1,776.

Total Annual Responses: 24.

We invite comments concerning this submission on (1) whether or not the collection of information is necessary for the proper performance of our migratory bird management functions, including whether or not the information will have practical utility; (2) the accuracy of our estimate of the burden of the collection of information; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) ways to minimize the burden of the collection of information on respondents. The information collections in this program are part of a system of record covered by the Privacy Act (5 U.S.C. 552(a)).

Our practice is to make comments, including names and home addresses of respondents, available for public review during regular business hours. Individual respondents may request that we withhold their home addresses from the record, which we will honor to the extent allowable by law. There may also be limited circumstances in which we would withhold a respondent's identity from the administrative record, as allowable by law. If you wish us to withhold your name and/or address, you must state this clearly at the beginning of your comment. We will not consider anonymous comments. We generally make all submissions from organizations or businesses and from individuals identifying themselves as representatives or officials of organizations or businesses available for public inspection in their entirety.

Dated: November 1, 2004.

Hope Grey,

Information Collection Clearance Officer, Fish and Wildlife Service.

[FR Doc. 04–25267 Filed 11–12–04; 8:45 am]

BILLING CODE 4310–55–P

DEPARTMENT OF THE INTERIOR

Bureau of Indian Affairs

Proposed Agency Information Collection Activities; Comment Request

AGENCY: Bureau of Indian Affairs, Interior.

ACTION: Notice.

SUMMARY: This notice announces that the Information Collection Request for Adult Education Annual Report Form OMB #1076–0120 requires renewal. The current Adult Education Annual Report Form OMB #1076–0120, with no appreciable changes, will be submitted after the comment period to the Office of Management and Budget (OMB) for review, as required by the Paperwork Reduction Act of 1995. The Bureau is soliciting public comments on the subject proposal.

DATES: Written comments must be submitted on or before January 14, 2005.

ADDRESSES: Comments are to be mailed to Edward Parisian, Director, Office of Indian Education Programs, Department of the Interior, Bureau of Indian Affairs, 1849 C St., NW., Mail Stop 3609–MIB, Washington, DC 20240, or hand delivered to room 3623 at the above address.

FOR FURTHER INFORMATION CONTACT: Garry Martin, Bureau of Indian Affairs, 202–208–3478.

SUPPLEMENTARY INFORMATION:

I. Abstract

The information collection is necessary to assess the need for adult education programs in accordance with 25 CFR part 46, subpart A, sections 46.20 Program Requirements and 46.30 Records and Reporting Requirements of the Adult Education Program.

II. Method of Collection

The Adult Education Program regulations under 25 CFR part 46, subpart 46, contain the program requirements which govern the program. Information collected from the contractors will be used for administrative planning, setting long- and short-term goals, and analyzing and monitoring the use of funds.

III. Data

Title of the Collection of Information: Bureau of Indian Affairs Adult Education Program Annual Report Form.

OMB Control Number: 1076–0120; Expiration Date: January 31, 2005.

Type of Review: Renewal of a currently-approved information collection.

Summary of the Collection of Information: The collection of information provides pertinent data concerning the adult education programs.

Description of the need for the information and proposed use of the information: Submission of this information is necessary to assess the need for adult education programs. The information is needed for the utilization and management of program resources to provide education opportunities for adult American Indians and Alaska Natives to complete high school requirements, and to gain new skills and knowledge for individual student self enhancement. The information collected with the annual report will be used by the Bureau or tribally controlled programs for fiscal accountability and appropriate direct services documentation. The results of the data are used for administrative planning.

Affected Entities: Tribal adult education contractors.

Estimated number of respondents: 70. Respondents are tribal adult education program administrators.

Proposed frequency of responses: Annually.

Burden: The estimate of total annual reporting and recordkeeping burden that will result from the collection of information: Reporting 4 hours per response x 70 respondents = 280 hours.

Estimated Annual Costs: $5,040.00 (4 hours × 70 × $18.00 = salary dollars). Cost for recordkeeping and auditing is part of their costs for administering this program under Tribal Priority Allocation activity of the tribal budget.

IV. Request for Comments

The Department of the Interior invites comments on:

(a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

(b) The accuracy of the agency's estimate of the burden (including the hours and cost) of the proposed collection of information, including the validity of the methodology and assumption used;

(c) Ways to enhance the quality, utility, and clarity of the information to be collected; and

(d) Ways to minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other collection techniques or other forms of information technology.

Burden means the total time, effort, or financial resources expended by persons to generate, maintain, retain, or disclose or provide information to or for a Federal agency. This includes the time needed to review instructions; to develop, acquire, install and utilize technology and systems for the purpose of collecting, validating, and verifying information, processing and maintaining information, and disclosing and providing information, to search data sources, to complete and review the collection of information; and to transmit or otherwise disclose the information.

It is our policy to make all comments available to the public for review at the location listed in the **ADDRESSES** section, Room 3623, during the hours of 8 a.m. to 4:30 p.m., e.s.t., Monday through Friday, except for legal holidays. If you wish to have your name and/or address withheld, you must state this prominently at the beginning of your comments. We will honor your request according to the requirements of the law. All comments from organizations or representatives will be available for review. We may withhold comments from review for other reasons.

Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval of this information collection; they also will become a matter of public record.

An agency may not conduct or sponsor, and a person is not required to respond to a collection of information, unless it displays a currently valid Office of Management and Budget control number.

Dated: November 5, 2004.

David W. Anderson,

Assistant Secretary—Indian Affairs.

[FR Doc. 04–25265 Filed 11–12–04; 8:45 am]

BILLING CODE 4310–6W–P

DEPARTMENT OF THE INTERIOR

Bureau of Indian Affairs

Proposed Agency Information Collection Activities; Comment Request

AGENCY: Bureau of Indian Affairs, Interior.

ACTION: Notice.

SUMMARY: The Bureau of Indian Affairs (BIA) is seeking comments in preparation for renewal of the Indian Child Welfare Annual Report form. The information collected will aid the BIA in fulfilling requirements of law. This renewal meets the requirements of the Paperwork Reduction Act of 1995.

DATES: Submit comments on or before January 14, 2005.

ADDRESSES: Written comments should be sent directly to Larry Blair, Bureau of Indian Affairs, Office of Tribal Services, Division of Human Services, 1951 Constitution Avenue, NW., Mail Stop 320–SIB, Washington, DC 20240.

FOR FURTHER INFORMATION CONTACT: Interested persons may obtain copies of the information collection requests without charge by contacting Mr. Larry Blair, (202) 513–7621, Facsimile number (202) 208–2648.

SUPPLEMENTARY INFORMATION:

I. Abstract

The information collection required by the use of this form is necessary to comply with Public Law 95–608, The Indian Child Welfare Act, and as codified in 25 CFR Part 23, Indian Child Welfare Act (ICWA). This information is collected through the use of a consolidated caseload form by tribal Indian Child Welfare Act program directors who are the providers of the ICWA services. The information is used to determine the extent of service needs in local Indian communities, assessment of the Indian Child Welfare Act program effectiveness, and to provide data for the annual program budget justification.

The responses to this request for information collection are voluntary and the aggregated report is not considered confidential. The public is not required to respond unless a currently valid OMB control number is displayed.

II. Request for Comments

The Bureau of Indian Affairs requests your comments on this collection concerning:

(a) The necessity of this information collection for the proper performance of the functions of the agency, including whether the information will have practical utility;

(b) the accuracy of the agency's estimate of the burden (hours and cost) of the collection of information, including the validity of the methodology and assumptions used;

(c) ways we could enhance the quality, utility and clarity of the information to be collected; and

(d) ways we could minimize the burden of the collection of the information on the respondents, such as through the use of automated collection techniques or other forms of information technology.

Please note that an agency may not sponsor or request, and an individual need not respond to, a collection of information unless it has a valid OMB Control Number.

All comments received will be available for public review 2 weeks after publication in the **Federal Register**. If you wish to have your name and address withheld from review, please make that known at the start of your comments.

It is our policy to make all comments available to the public for review at the location listed in the **ADDRESSES** section, room 355–E, during the hours of 7 a.m. to 4 p.m., e.s.t., Monday through Friday except for legal holidays. All comments from organizations or representatives will be available for review. We may withhold comments from review for other reasons.

III. Data

Title: Department of the Interior, Bureau of Indian Affairs, Indian Child Welfare Act Annual Report, 25 CFR Part 23.4.

OMB Control Number: 1076–0131.

Type of review: Renewal.

Brief Description of collection: Indian tribes are required to collect selected data on Indian child welfare cases and submit them to the Bureau for consolidation. This data is useful on a local level, to the tribes and tribal organizations that collect it, for case management purposes and on a nationwide basis for planning and budget purposes.

Respondents: Indian tribes or tribal entities who are operating programs for Indian tribes.

Number of Respondents: 536.

Estimated Time per Response: 30 minutes.

Frequency of Response: Quarterly.

Estimated Annual Burden to Respondents: 1072 hours.

Dated: November 5, 2004.

David W. Anderson,

Assistant Secretary—Indian Affairs.

[FR Doc. 04–25266 Filed 11–12–04; 8:45 am]

BILLING CODE 4310–4J–P

DEPARTMENT OF THE INTERIOR

Minerals Management Service

Environmental Documents Prepared for Proposed Oil and Gas Operations on the Gulf of Mexico Outer Continental Shelf (OCS)

AGENCY: Minerals Management Service, Interior.

ACTION: Notice of the Availability of Environmental Documents. Prepared for OCS Mineral Proposals on the Gulf of Mexico OCS.

SUMMARY: Minerals Management Service (MMS), in accordance with Federal Regulations that implement the National Environmental Policy Act (NEPA), announces the availability of NEPA-related Site-Specific Environmental Assessments (SEA) and Findings of No Significant Impact (FONSI), prepared by MMS for the following oil and gas activities proposed on the Gulf of Mexico OCS.

FOR FURTHER INFORMATION CONTACT: Public Information Unit, Information Services Section at the number below. Minerals Management Service, Gulf of Mexico OCS Region, Attention: Public Information Office (MS 5034), 1201 Elmwood Park Boulevard, Room 114, New Orleans, Louisiana 70123–2394, or by calling 1–800–200–GULF.

SUPPLEMENTARY INFORMATION: MMS prepares SEAs and FONSIs for proposals that relate to exploration for and the development/production of oil and gas resources on the Gulf of Mexico OCS. These SEAs examine the potential environmental effects of activities described in the proposals and present MMS conclusions regarding the significance of those effects. Environmental Assessments are used as a basis for determining whether or not approval of the proposals constitutes major Federal actions that significantly affect the quality of the human environment in the sense of NEPA Section 102(2)(C). A FONSI is prepared in those instances where MMS finds that approval will not result in significant effects on the quality of the human environment. The FONSI briefly presents the basis for that finding and includes a summary or copy of the SEA.

This notice constitutes the public notice of availability of environmental documents required under the NEPA Regulations.

This listing includes all proposals for which the Gulf of Mexico OCS Region prepared a FONSI in the period subsequent to publication of the preceding notice.

Activity/Operator	Location	Date
Maritech Resources, Inc., Structure Removal SEA ES/SR 04–088.	West Delta, Block 17, Lease OCS–G 05668, located 10 miles from the nearest Louisiana shoreline.	7/1/2004
Newfield Exploration Company, Structure Removal SEA ES/SR 04–094.	East Cameron, Block 38, Lease OCS–G 02562, located 8 miles from the nearest Louisiana shoreline.	7/2/2004
Newfield Exploration Company, Structure Removal SEA ES/SR 04–090, 04–091, 04–092, 04–093.	West Cameron, Block 146, Lease OCS–G 01996, located 25 miles from the nearest Louisiana shoreline.	7/2/2004
Seneca Resources Corporation, Structure Removal SEA ES/SR 04–098.	Eugene Island, Block 98, Lease OCS–G 17965, located 20 miles from the nearest Louisiana shoreline.	7/7/2004
Newfield Exploration Company, Structure Removal SEA ES/SR 04–095.	Vermilion (South Addition), Block 308, Lease OCS–G 11892, located 78 miles from the nearest Louisiana shoreline.	7/7/2004
SPN Resources, LLC, Structure Removal SEA ES/SR 04–097.	South Marsh Island, Block 97, Lease OCS–G 21619, located 64 miles from the nearest Louisiana shoreline.	7/9/2004
Newfield Exploration Company, Structure Removal SEA ES/SR 04–096.	South Timbalier, Block 194, Lease OCS–G 05610, located 37 miles from the nearest Louisiana shoreline.	7/9/2004

Activity/Operator	Location	Date
El Paso Production, Structure Removal SEA ES/SR 04–099.	West Cameron (South), Block 526, Lease OCS–G 15100, located 90 miles from the nearest Louisiana shoreline.	7/13/2004
El Paso Production Oil & Gas Company, Structure Removal SEA ES/SR 04–100.	West Cameron (South Addition), Block 523, Lease OCS–G 19725, located 92 miles from the nearest Texas shoreline.	7/14/2004
Chevron USA, Inc., Structure Removal SEA ES/SR 04–101.	South Timbalier, Block 130, Lease OCS 00456, located 29 miles south of the Louisiana shoreline.	7/20/2004
El Paso Production GOM, Inc., Structure Removal SEA ES/SR 04–102, 04–103.	Grand Isle, Blocks 30 & 31, Leases OCS–G 23599 (RUE) & 18065, located 11 to 12 miles from the nearest Louisiana shoreline.	7/21/2004
El Paso Production Company, Structure Removal SEA ES/SR 04–104, 04–105.	Eugene Island, Block 52, Lease OCS–G 03148, located 10 miles from the nearest Louisiana shoreline.	7/23/2004
ATP Oil & Gas Corporation, Structure Removal SEA ES/SR 04–115.	Vermilion, Block 63, Lease OCS–G 15167, located 18 miles from the nearest Louisiana shoreline.	7/27/2004
Murphy Exploration & Production Company, Structure Removal SEA ES/SR 04–106, 04–107, 04–108, 04–109, 04–110, 04–011, 04–112.	South Pelto, Block 12, Lease OCS 00072, located 6 miles from the nearest Louisiana shoreline.	7/28/2004
Murphy Exploration & Production Company, Structure Removal SEA ES/SR 04–113.	South Pelto, Block 19, Lease OCS 00073, located 10 miles from the nearest Louisiana shoreline.	7/28/2004
Murphy Exploration & Production Company, Initial Exploration Plan SEA N–8098.	LLoyd Ridge, Blocks 1 & 2, Leases OCS–G 10486 & 10487, located 105 miles from the nearest Louisiana shoreline.	8/4/2004
Fugro GeoServices, Inc., Geological & Geophysical Exploration Plan for Apache Corporation, SEA L04–49.	Located in the central Gulf of Mexico	8/4/2004
Energy Partners, Ltd., Structure Removal SEA ES/SR 04–114.	West Cameron, Block 149, Lease OCS 00253, located 22 miles from the nearest Louisiana shoreline.	8/6/2004
SPN Resources, LLC, Structure Removal SEA ES/SR 04–119.	Eugene Island, Block 100, Lease OCS 00796, located 17 miles from the nearest Louisiana shoreline.	8/10/2004
Dunhill Resources, Inc., Structure Removal SEA ES/SR 04–120.	High Island, Block 139, Lease OCS–G 03235, located 20 miles from the nearest Louisiana shoreline.	8/10/2004
Fugro GeoServices, Inc., Geological & Geophysical Exploration Plan for GulfTerra Energy Partners, LP, SEA L04–51.	Located in the central Gulf of Mexico	8/11/2004
C & C Technologies, Inc., Geological & Geophysical Exploration Plan for BP America, Inc. SEA L04–54.	Located in the central Gulf of Mexico	8/12/2004
SPN Resources, LLC, Structure Removal SEA ES/SR 04–118.	Eugene Island, Block 100, Lease OCS 00796, located 18 miles from the nearest Louisiana shoreline.	8/17/2004
SPN Resources, LLC, Structure Removal SEA ES/SR 89–059A.	Eugene Island, Block 100, Lease OCS 00796, located 18 miles from the nearest Louisiana shoreline.	8/17/2004
Multiwave Geophysical Company, Geological & Geophysical Exploration Plan SEA L04–50.	Located in the Mississippi Canyon area of the central Gulf of Mexico	8/17/2004
BP America, Inc., Geological & Geophysical Exploration Plan SEA L04–55.	Located in the central Gulf of Mexico	8/17/2004
Energy Partners, LTD, Structure Removal SEA ES/SR 04–121.	West Delta, Block 94, OCS 00839, located 25 miles from the nearest Louisiana shoreline.	8/18/2004
Multiwave Geophysical Company, Geological & Geophysical Exploration Plan for Shell E & P, SEA L04–53.	Located in Mississippi Canyon of the central Gulf of Mexico south of the nearest Alabama shoreline.	8/20/2004
Noble Energy, Inc., Structure Removal SEA ES/SR 04–124.	High Island (East South), Block A281, Lease OCS–G 03377, located 85 miles from the nearest Louisiana shoreline.	8/26/2004
Forest Oil Corporation, Structure Removal SEA ES/SR 04–122, 04–123.	West Cameron & High Island, Blocks 228 & 132, ROW G 8607 & OCS–G 18937, located 42 miles south of the nearest Cameron Parish, Louisiana shoreline; 51 miles southeast of the Sabine Pass, Texas shoreline; and 28 miles south of the Jefferson County, Texas shoreline.	8/30/2004
Veritas DGC Corporation, Geological & Geophysical Exploration Plan SEA L04–58.	Located in the central Gulf of Mexico east of Galveston, Texas	9/1/2004
The Louisiana Land & Exploration Company, Structure Removal SEA ES/SR 04–089.	Eugene Island (South Addition), Block 384, Lease OCS–G 03159, located 78 miles from the nearest Louisiana shoreline.	9/8/2004
Chevron U.S.A., Inc., Structure Removal SEA ES/SR 04–126, 04–127, 04–128, 95–48A, 04–129, 04–130, 04–131.	Ship Shoal & West Cameron, Blocks 108 & 48, Leases OCS 00814 & OCS–G 01351, located 19 miles southwest from the nearest Terrebonne Parish, Louisiana shoreline, and 4 miles south from the nearest Cameron Parish, Louisiana shoreline, respectively.	9/13/2004
Calpine Natural Gas, LP, Structure Removal SEA ES/SR 04–125.	East Cameron, Block 89, Lease OCS–G 00935, located 22 miles from the nearest Louisiana shoreline.	9/21/2004
SPN Resources, LLC, Structure Removal SEA ES/SR 04–132.	Mobile, Block 830, Lease OCS–G 06845, located 4 miles from the nearest Alabama shoreline.	9/21/2004
Hunt Petroleum (AEC), Inc., Structure Removal SEA ES/SR 04–133.	Vermilion, Block 248, Lease OCS–G 15195, located 65 miles from the nearest Louisiana shoreline.	9/21/2004

Activity/Operator	Location	Date
Vintage Petroleum, Inc., Structure Removal SEA ES/SR 04–137.	Main Pass, Block 125, Lease OCS–G 04913, located 20 miles from the nearest Louisiana shoreline.	9/23/2004
Maritech Resources, Inc., Structure Removal SEA ES/SR 04–136.	East Cameron, Block 38, Lease OCS–G 02562, located 8 miles from the nearest Louisiana shoreline.	9/28/2004
Maritech Resources, Inc., Structure Removal SEA ES/SR 04–135.	Eugene Island, Block 28, Lease OCS–G 05478, located 12 miles from the nearest Louisiana shoreline.	9/28/2004
ATP Oil & Gas Corporation, Structure Removal SEA ES/SR 04–134.	High Island (East South), Block A354, Lease OCS–G 17212, located 110 miles from the nearest Texas shoreline.	9/28/2004
Veritas DGC, Inc., Geological & Geophysical Exploration Plan SEA L04–62.	Located in the central Gulf of Mexico south of Fourchon, Louisiana	9/30/2004

Persons interested in reviewing environmental documents for the proposals listed above or obtaining information about SEAs and FONSIs prepared for activities on the Gulf of Mexico OCS are encouraged to contact MMS at the address or telephone listed in the **FOR FURTHER INFORMATION CONTACT** section.

Dated: October 7, 2004.

Chris C. Oynes,

Regional Director, Gulf of Mexico OCS Region.

[FR Doc. 04–25242 Filed 11–12–04; 8:45 am]

BILLING CODE 4310–MR–P

DEPARTMENT OF INTERIOR

Office of Surface Mining Reclamation and Enforcement

Notice of Proposed Information Collection

AGENCY: Office of Surface Mining Reclamation and Enforcement.

ACTION: Notice and request for comments.

SUMMARY: In compliance with the Paperwork Reduction Act of 1995, the Office of Surface Mining Reclamation and Enforcement (OSM) is announcing that the information collection request for its Technical Evaluation customer surveys has been forwarded to the Office of Management and Budget (OMB) for review and comment. The information collection request describes the nature of the information collection and the expected burden and cost. The OMB control number for this collection of information is 1029–0114 and is on the forms along with the expiration date.

DATES: OMB has up to 60 days to approve or disapprove the information collections but may respond after 30 days. Therefore, public comments should be submitted to OMB by December 15, 2004, in order to be assured of consideration.

FOR FURTHER INFORMATION CONTACT: To request a copy of the information collection request, explanatory information and related form, contact John A. Trelease at (202) 208–2783, or electronically to *jtreleas@osmre.gov.*

SUPPLEMENTARY INFORMATION: The Office of Management and Budget (OMB) regulations at 5 CFR part 1320, which implement provisions of the Paperwork Reduction Act of 1995 (Pub. L. 104–13), require that interested members of the public and affected agencies have an opportunity to comment on information collection and recordkeeping activities (*see* 5 CFR 1320.8(d)). OSM has submitted a request to OMB to renew its approval of the collection of information contained in a series of technical evaluation customer surveys. OSM is requesting a 3-year term of approval for the information collection activity.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this collection of information is 1029–0114.

As required under 5 CFR 1320.8(d), a **Federal Register** notice soliciting comments on this collection of information was published on June 24, 2204 (69 FR 35391). No comments were received. This notice provides the public with an additional 30 days in which to comment on the following information collection activity:

Title: Technical Evaluations Series.

OMB Control Number: 1029–0114.

Summary: The series of surveys are needed to ensure that technical assistance activities, technology transfer activities and technical forums are useful for those who participate or receive the assistance. Specifically, representatives from State and tribal regulatory and reclamation authorities, representatives of industry, environmental or citizen groups, or the public, are the recipients of the assistance or participants in these forums. These surveys will be the primary means through which OSM evaluates its performance in meeting the performance goals outlined in its annual plans developed pursuant to the Government Performance and Results Act.

Bureau Form Number: None.

Frequency of Collection: Once.

Description of Respondents: 26 State and tribal governments, industry organizations and individuals who request information or assistance.

Total Annual Responses: 300.

Total Annual Burden Hours: 25.

Send comments on the need for the collection of information for the performance of the functions of the agency; the accuracy of the agency's burden estimates; ways to enhance the quality, utility and clarity of the information collection; and ways to minimize the information collection burden on respondents, such as use of automated means of collection of the information, to the following address. Please refer to the appropriate OMB control number in all correspondence.

ADDRESSES: Please send comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, Attention: Department of Interior Desk Officer, electronically to *OIRA_DOCKET@omb.eop.gov,* or via facsmile at (202) 395–6566. Also, please send a copy of your comments to John A. Trelease, Office of Surface Mining Reclamation and Enforcement, 1951 Constitution Ave, NW., Room 210–SIB, Washington, DC 20240, or electronically to *jtreleas@osmre.gov.*

Dated: September 7, 2004.

Sarah E. Donnelly,

Acting Chief, Division of Regulatory Support.

[FR Doc. 04–25319 Filed 11–12–04; 8:45 am]

BILLING CODE 4310–05–M

INTERNATIONAL TRADE COMMISSION

[Investigation No. 731–TA–1070 (Final)]

Certain Tissue Paper Products and Crepe Paper Products From China

AGENCY: United States International Trade Commission.

ACTION: Revised schedule for the subject investigation.

EFFECTIVE DATE: November 5, 2004.

FOR FURTHER INFORMATION CONTACT: Fred Forstall ((202) 205–3443), Office of Industries, U.S. International Trade Commission, 500 E Street SW., Washington, DC 20436. Hearing-impaired persons can obtain information on this matter by contacting the Commission's TDD terminal on (202) 205–1810. Persons with mobility impairments who will need special assistance in gaining access to the Commission should contact the Office of the Secretary at (202) 205–2000. General information concerning the Commission may also be obtained by accessing its internet server (*http://www.usitc.gov*). The public record for this investigation may be viewed on the Commission's electronic docket (EDIS) at *http://edis.usitc.gov.*

SUPPLEMENTARY INFORMATION: On October 4, 2004, the Commission issued a schedule for the conduct of the final phase of the subject investigation (69 FR 60423, October 8, 2004). Subsequently, counsel on behalf of petitioners in this investigation [1] requested that the Commission extend the deadline for filing posthearing briefs on issues related to tissue paper (also applicable to the deadline for the submission of a written statement of information on issues related to tissue paper by any person who has not entered an appearance as a party to the investigation) by one week or more (letter from Collier Shannon Scott, PLLC to Marilyn R. Abbott, Secretary, October 21, 2004). Upon consideration of the reasons stated for the request, including an overlapping deadline with a related filing on crepe paper from China, the Commission is revising its schedule to extend the deadline for filing posthearing briefs and written statements by non-parties on issues related to tissue paper from January 5, 2005, to January 12, 2005.

For further information concerning this investigation see the Commission's notice cited above and the Commission's Rules of Practice and Procedure, part 201, subparts A through E (19 CFR part 201), and part 207, subparts A and C (19 CFR part 207).

Authority: This investigation is being conducted under authority of title VII of the Tariff Act of 1930; this notice is published pursuant to section 207.21 of the Commission's rules.

[1] Petitioners are Seaman Paper Company of Massachusetts, Inc.; American Crepe Corp.; Eagle Tissue LLC; Flower City Tissue Mills Co.; Garlock Printing & Converting, Inc.; Paper Service Ltd.; Putney Paper Co., Ltd.; and the Paper, Allied-Industrial, Chemical and Energy Workers International Union AFL–CIO, CLC.

By order of the Commission.

Issued: November 8, 2004.

Marilyn R. Abbott,

Secretary to the Commission.

[FR Doc. 04–25255 Filed 11–12–04; 8:45 am]

BILLING CODE 7020–02–P

DEPARTMENT OF JUSTICE

Antitrust Division

United States v. Cingular Wireless Corporation, SBC Communications Inc., BellSouth Corporation, and AT&T Wireless Services, Inc.; Competitive Impact Statement, Proposed Final Judgment, Complaint, Preservation of Assets Stipulation and Order

Notice is hereby given pursuant to the Antitrust Procedures and Penalties Act, 15 U.S.C. 16(b)–(h), that a Complaint, proposed Final Judgment, Preservation of Assets Stipulation and Order, and Competitive Impact Statement have been filed with the U.S. District Court for the District of Columbia in *United States* v. *Cingular Wireless Corps.*, Civil Case No. 1:04CV01850 (RBW). On October 25, 2004, the United States, along with the Attorneys General from the states of Connecticut and Texas, filed a complaint alleging that the proposed acquisition of AT&T Wireless Services, Inc. (''AT&T Wireless'') by Cingular Wireless Corp. (''Cingular''), which is jointly owned by BellSouth Corporation (''BellSouth'') and SBC Communications, Inc. (''SBC''), would violate Section 7 of the Clayton Act, 15 U.S.C. 18, by substantially lessening competition in the provision of mobile wireless telecommunications services and mobile wireless broadband services. The proposed Final Judgment, filed at the same time as the Complaint and Preservation of Assets Stipulation and Order, requires Cingular to divest assets in eleven states—Connecticut, Georgia, Kansas, Kentucky, Louisiana, Massachusetts, Missouri, Michigan, Oklahoma, Tennessee, and Texas—in order to proceed with Cingular Wireless's $41 billion cash acquisition of AT&T Wireless. A Competitive Impact Statement filed by the United States on October 29, 2004 describes the Complaint, the proposed Final Judgment, the industry, and the remedies available to private litigants who may have been injured by the alleged violation.

Copies of the Complaint, proposed Final Judgment, Preservation of Assets Stipulation and Order, the Competitive Impact Statement, and all further papers filed with the Court in connection with the Complaint will be available for inspection at the Antitrust Documents Group, Antitrust Division, Liberty Place Building, Room 215, 325 7th Street, NW., Washington, DC 20530 (202–514–2481), and at the Office of the Clerk of the U.S. District Court for the District of Columbia. Copies of these materials may be obtained from the Antitrust Division upon request and payment of the copying fee set by Department of Justice regulations.

Interested persons may submit comments in writing regarding the proposed consent decree to the United States. Such comments must be received by the Antitrust Division within sixty (60) days and will be filed with the Court by the United States. Comments should be addressed to Nancy Goodman, Chief, Telecommunications & Media Enforcement Section, Antitrust Division, U.S. Department of Justice, 1401 H Street, NW., Suite 8000, Washington, DC 20530 (202–514–5621). At the conclusion of the sixty (60) day comment period. The U.S. District Court for the District of Columbia may enter the proposed consent decree upon finding that it serves the public interest.

J. Robert Kramer II,

Director of Operations, Antitrust Division.

In the United States District Court for the District of Columbia

United State of America, State of Connecticut and State of Texas, Plaintiffs, v. Cingular Wireless Corporation, SBC Communications Inc., Bellsouth Corporation and AT&T Wireless Services, Inc., Defendants; Competitive Impact Statement

Civil No. 1:04CV01850 (RBW).
Filed: October 29, 2004.

Plaintiff United States of America (''United States''), pursuant to Section 2(b) of the Antitrust Procedures and Penalties Act (''APPA'' or ''Tunney Act''), 15 U.S.C. § 16(b)–(h), files this Competitive Impact Statement relating to the proposed Final Judgment submitted for entry in this civil antitrust proceeding.

I. Nature and Purpose of the Proceeding

Defendants Cingular Wireless Corporation (''Cingular''), SBC Communications Inc. (''SBC''), BellSouth Corporation (''BellSouth''), and AT&T Wireless Services, Inc. (''AT&T Wireless Services'') entered into an Agreement and Plan of Merger dated February 17, 2004, pursuant to which Cingular will acquire AT&T Wireless. Plaintiff United States and the states of Connecticut and Texas (''plaintiff states'') filed a civil antitrust Complaint on October 25, 2004, seeking to enjoin the proposed acquisition. The

Compliant alleges that the likely effect of this acquisition would be to lessen competition substantially for mobile wireless telecommunications services and mobile wireless broadband services (collectively, ''Mobile wireless services'') in violation of Section 7 of the Clayton Act, 15 U.S.C. 18. This loss of competition would result in consumers facing higher prices, lower quality or quantity of mobile wireless services, or delayed launch of new mobile wireless services.

At the same time the Complaint was filed, plaintiff United States also filed a Preservation of Assets Stipulation and Order and proposed Final Judgment, which are designed to eliminate the anticompetitive effects of the acquisition. Under the proposed Final Judgment, which is explained more fully below, defendants are required to divest (1) AT&T Wireless's mobile wireless services business and related assets in five markets (''Wireless Business Divesture Assets''); (2) Cingular's or AT&T Wireless's minority interests in other mobile wireless services providers in five markets (''Minority Interests''); and (3) 10 MHz of contiguous PCS wireless spectrum in three markets (''Spectrum Divesture Assets''). Under the terms of the Preservation of Assets Stipulation and Order, defendants will take certain steps to ensure (a) that these assets are preserved and that the Wireless Business Divestiture Assets are operated as competitively independent, economically viable and ongoing businesses; (b) that they will remain independent and uninfluenced by defendants or the consummation of the transaction; and (c) that competition is maintained during the pendency of the ordered divestiture.

Plaintiffs and defendants have stipulated that the proposed Final Judgment may be entered after compliance with the APPA. Entry of the proposed Final Judgment would terminate this action, except that the Court would retain jurisdiction to construe, modify, or enforce the provisions of the proposed Final Judgment and to punish violations thereof. Plaintiffs and defendants have also stipulation that defendants will comply with the terms of the Preservation of Assets Stipulation and Order and the proposed Final Judgment from the date of signing of the Preservation of Assets Stipulation and Order, pending entry of the proposed Final Judgment by the Court and the required divestitures. Should the Court decline to enter the proposed Final Judgment, defendants have also committed to continue to abide by its requirements and those of the Preservation of Assets Stipulation and Order until the expiration of time for appeal.

II. Description of the Events Giving Rise to the Alleged Violation

A. The Defendants and the Proposed Transaction

Cingular, with headquarters in Atlanta, Georgia, is a company organized and existing under the laws of the State of Delaware. Cingular was formed in 2000 by SBC and BellSouth, who own equity interests in it of 60 and 40 percent, respectively. SBC and BellSouth evenly share management control of Cingular. Cingular is the second-largest provider of mobile wireless voice and data services in the United States by number of subscribers; it serves more than 24 million customers. Cingular provides mobile wireless services in areas throughout the United States and is one of only six providers with a national presence. In 2003, Cingular earned revenues of approximately $15.5 billion.

SBC, with headquarters in San Antonio, Texas, is a corporation organized and existing under the laws of the state of Delaware. SBC is one of several regional Bell operating companies (''RBOCs'') formed in 1984 as a result of the breakup of AT&T Corporation's local telephone business. SBC's wireline telecommunications businesses serve 54.7 million access lines in 13 states: Arkansas, California, Connecticut, Illinois, Indiana, Kansas, Michigan, Missouri, Nevada, Ohio, Oklahoma, Texas, and Wisconsin. In 2003, SBC earned approximately $40.8 billion in revenues.

BellSouth, an RBOC with headquarters in Atlanta, Georgia, is a corporation organized and existing under the laws of the state of Georgia. BellSouth's wireline telecommunications businesses serve 23.7 million access lines in nine states: Alabama, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, and Tennessee. Its total operating revenues for 2003 were approximately $22.6 billion.

AT&T Wireless, with headquarters in Redmond, Washington, is a corporation organized and existing under the laws of the state of Delaware. Spun off from AT&T Corporation in 2001, it had more than 22 million subscribers as of August 2004 and earned revenues of approximately $16.6 billion in 2003. AT&T Wireless is the third-largest U.S. mobile wireless services provider by number of subscribers, and, like Cingular, it provides mobile wireless services in areas throughout the United States and has a national presence.

Pursuant to an Agreement and Plan of Merger dated February 17, 2004, Cingular will pay AT&T Wireless shareholders $15 in cash per common share and thereby plans to acquire AT&T Wireless for approximately $41 billion. If this transaction is consummated, Cingular and AT&T Wireless combined would have more than 46 million subscribers, with over $32 billion in revenues, making it the largest mobile wireless services provider in the United States, with operations in 49 states covering 97 of the top 100 marketing areas.

The proposed transaction, as initially agreed to by defendants, would lessen competition substantially for mobile wireless telecommunications service in 10 markets and for mobile wireless broadband services in three markets. This acquisition is the subject of the Complaint and proposed Final Judgment filed by plaintiffs.

B. Mobile Wireless Services Industry

Mobile wireless services allow customers to make and receive telephone calls and use data services using radio transmissions without being confined to a small area during the call or data session, and without the need for unobstructed line-of-sight to the radio tower. This mobility is highly prized by customers, as demonstrated by the more than 160 million people in the United States who own mobile wireless telephones. In 2003, revenues for the sale of mobile wireless services in the United States were nearly $90 billion. To provide these services, mobile wireless services providers must acquire adequate and appropriate spectrum, deploy an extensive network of switches, radio transmitters, and receivers, and interconnect this network with those of local and long-distance wireline telecommunications providers and other mobile wireless services providers.

The first wireless voice systems were based on analog technology, now referred to as first-generation or ''1G'' technology. These analog systems were launched after the FCC issued the first licenses for mobile wireless telephone service: two cellular licenses (A-block and B-block) in each geographic area in the early to mid-1980s. The licenses are in the 800 MHz range of the radio spectrum, each license consists of 25 MHz of spectrum, and they are issued for each Metropolitan Statistical Area (''MSA'') and Rural Service Area (''RSA'') (collectively, ''Cellular Marketing Areas'' or ''CMAs''), with a total of 734 CMAs covering the entire

United States. In 1982, one of the licenses was issued to the incumbent local exchange carrier in the market, and the other was issued by lottery to someone other than the incumbent. Cellular licensees must support analog service until February 2008.

In 1995, the FCC allocated and subsequently issued licenses for additional spectrum for the provision of Personal Communications Services (''PCS''), a category of services that includes mobile wireless telephone services comparable to those offered by cellular licensees. These licenses are in the 1.8 GHz range of the radio spectrum and are divided into six blocks. A, B, and C, which consist of 30 MHz each; and D, E, and F, which consist of 10 MHz each. Geographically, the A and B-block 30 MHz licenses are issued by Major Trading Areas (''MTAs''), and C, D, E, and F-block licenses are issued by Basic Trading Areas (''BTAs''), several of which comprise each MTA. MTAs and BTAs do not generally correspond to MSAs and RSAs. With the introduction of the PCS license, both cellular and PCS licensees began offering digital services, thereby increasing capacity, shrinking handsets, and extending battery life. Unlike the cellular licensees, PCS licensees are not required to provide support for analog or any other technology standard. In 1996, one provider, a specialized mobile radio (''SMR'' or ''dispatch'') spectrum licensee, began to use its SMR spectrum of offer mobile wireless telephone services comparable to those offered by other mobile wireless services providers, in conjunction with its dispatch, or ''push-to-talk,'' service.

Today, more than 90 percent of all mobile wireless services customers have digital service, and nearly all mobile wireless voice service has migrated to second-generation or ''2G'' digital technologies: TDMA (time division multiple access), GSM (Global Standard for Mobile, a type of TDMA standard used by all carriers in Europe), and CDMA (code division multiple access). Mobile wireless services providers have chosen to build their networks on these incompatible technologies and most have chosen CDMA or GSM, with TDMA having been orphaned by equipment vendors. (The SMR providers use a fourth incompatible technological standard better suited to the spectrum they own, and, as SMR licensees, they have no obligation to support a specific technology standard.) Even more advanced technologies (''2.5G'') have begun to be deployed for voice and data (e.g., IxRIT (a/k/a CDMA 2000), GPRS (General Packet Radio Service), and EDGE (Enhanced Data for GSM Evolution)). The data transmission speeds of these technologies vary. For example, 1xRTT provides average user speeds of 70 kilobits per second (''kbps''), and GPRS and EDGE provide average user speeds of 20 to 40 kbps and 80 to 110 kbps, respectively.

Currently, the U.S. mobile wireless services industry is taking the next evolutionary step in wireless technology to third-generation or ''3G'' technologies (e.g., for GSM, UMTS (Universal Mobile Telecommunications System) and for CDMA, Ev–DO/DV (Evolution Data Only/Date Voice)) that provide for more capacity and higher data throughout. All of the national mobile wireless services providers and some of the regional providers are considering how and where they will deploy 3G services across their networks. Some providers have already deployed this service in some areas of the country.

C. The Competitive Effects of the Transaction on Mobile Wireless Telecommunications Services and Mobile Wireless Broadband Services

Cingular's proposed acquisition of AT&T Wireless will substantially lessen competition in mobile wireless telecommunications services and mobile wireless broadband services in the relevant geographic areas. Mobile wireless telecommunications services include both voice and data services provided over a radio network and allow customers to maintain their telephone calls or data sessions without wires, such as when traveling. Mobile wireless broadband services offer data speeds four to six times faster than the 2G and 2.5G data offerings currently provided by the mobile wireless services providers. Mobile wireless broadband services, which are now being launched using various 3G technologies, offer average data speeds of 200 to 300 kbps, peaking at 2 megabits per second or higher. These speeds rival wireline broadband services at peak speeds. At average speeds, they are comparable to low-end wireline high-speed data offerings and can support bandwidth-intensive services including video conferencing, video streaming, downloading of music and video files, and voice over Internet protocol (''VoIP'') calling, none of which can be used reliably at slower speeds. Fixed wireless services and other wireless services that have a limited range (e.g., Wi-Fi) do not offer a viable alternative to either mobile wireless telecommunications services or mobile wireless broadband services primarily because customers using these services cannot maintain a call or data session while moving from one location to another.

Most customers use mobile wireless services in close proximity to their workplaces and homes. Thus, customers purchasing mobile wireless telecommunications services and mobile wireless broadband services choose among mobile wireless services providers that offer services where they are located and travel on a regular basis: home, work, other areas they commonly visit, and areas in between. The number and identity of mobile wireless services providers varies from geographic area to geographic area, along with the quality of their services and the breadth of their geographic coverage, all of which are significant factors in customers' purchasing decisions. Mobile wireless services providers can and do offer different promotions, discounts, calling plans, and equipment subsidies in different geographic areas, effectively varying the actual price for customers by geographic area.

The relevant geographic markets for mobile wireless services are, therefore, local in nature and are generally centered around a metropolitan area or a population center and its environs. The FCC has licensed a limited number of mobile wireless services providers in these and other geographical areas based upon the availability of radio spectrum. These FCC spectrum licensing areas often represent the core of the business and social sphere where customers face the same competitive choices for mobile wireless services. Although not all FCC spectrum licensing areas are relevant geographic areas for the purpose of analyzing the antitrust impact of this transaction, the FCC spectrum licensing areas that encompass the 13 geographic areas of concern in this transaction are where consumers in these communities principally use their mobile wireless services. As described in the Complaint, the relevant geographic markets where the transactions will substantially lessen competition for mobile wireless telecommunications services are represented by the following FCC spectrum licensing areas: Oklahoma City, Oklahoma (CMA 045), Topeka, Kansas (CMA 179), Pittsfield, Massachusetts (CMA 213), Athens, Georgia (CMA 234), St. Joseph, Missouri (CMA 275), Connecticut RSA–1 (CMA 357), Kentucky RSA–1 (CMA 443), Oklahoma RSA–3 (CMA 598), Texas RSA–11 (CMA 662), and Shreveport, Louisiana (BTA 419). The relevant geographic markets where the transaction will substantially lessen competition for mobile wireless broadband services are represented by the following FCC spectrum licensing

areas: Dallas-Fort Worth, Texas (CMA 009), Detroit, Michigan (BTA 112), and Knoxville, Tennessee (BTA 232).

The 10 geographic markets of concern for mobile wireless telecommunications services were identified by a fact-specific, market-by-market analysis that included consideration of, but was not limited to, the following factors: the number of mobile wireless services providers and their competitive strengths and weaknesses, Cingular's and AT&T Wireless's market shares along with those of the other providers, whether additional spectrum is or is likely soon to be available, whether any providers are limited by insufficient spectrum or other factors in their ability to add new customers or launch additional services, the population of a market as it affects the need for spectrum to serve the population, the concentration of the market, and the breadth and depth of coverage by different providers in each market.

Cingular and AT&T Wireless both own all or part of businesses that offer mobile wireless telecommunications services in the 10 relevant geographic areas. In five of these areas (Athens, Georgia; Topeka, Kansas; Pittsfield, Massachusetts; St. Joseph, Missouri; and Shreveport, Louisiana), Cingular or AT&T Wireless also owns minority equity interests in another mobile wireless telecommunications services provider that would be a significant competitor to the merged firm for these services. The minority equity interests range from approximately 9 to 24 percent. Based upon these significant minority equity interests and the specific facts of the relationships, it was appropriate to attribute the shares and assets of the mobile wireless services businesses partially owned by Cingular or AT&T Wireless in these markets to either Cingular or AT&T Wireless, thus increasing the percentage of customers served by the merged firm.

The individual market shares of Cingular's and AT&T Wireless's mobile wireless telecommunications services businesses in the 10 relevant geographic markets as measures in terms of subscribers range from 9 to more than 71 percent, and their combined market shares range from 61 to nearly 90 percent. In each relevant geographic market, Cingular or AT&T Wireless has the largest market share, and, in all but one, the other is the second-largest mobile wireless telecommunications services provider. In all but one of the relevant geographic markets, Cingular and AT&T Wireless are the original cellular licensees and, as a result, have the network infrastructures with the greatest depth and breadth of coverage. Cingular and AT&T Wireless are likely closer substitutes for each other than the other mobile wireless telecommunications services providers in the relevant geographic markets. Additionally in these markets, there will be insufficient remaining competitors post-merger with the ability to compete effectively to defeat a small, but significant price increase by the merged firm.

The relevant geographic markets for mobile wireless telecommunications services are highly concentrated. As measured by the Herfindahl-Hirschman index (''HHI''), which is commonly employed in merger analysis and is defined and explained in Appendix A to the Compliant, concentration in these markets ranges from approximately 2600 to more than 5300, which is well above the 1800 threshold at which the Department considers a market to be highly concentrated. After Cingular's proposed acquisition of AT&T Wireless is consummated, the HHIs in the relevant geographic markets will range from approximately 4400 to more than 8000, with increases in the HHI as a result of the merger ranging from approximately 1100 to more than 3500.

Competition between Cingular and AT&T Wireless in the relevant geographic markets has resulted in lower prices and higher quality in mobile wireless telecommunications services than would otherwise have existed in these geographic markets. If Cingular's proposed acquisition of AT&T Wireless is consummated, the relevant geographic markets for mobile wireless telecommunications services will become substantially more concentrated, and the competition between Cingular and AT&T Wireless in mobile wireless telecommunications services will be eliminated in these markets. As a result, the loss of competition between Cingular and AT&T Wireless increases the likelihood of unilateral actions by the merged firm in the relevant geographic markets to increase prices, diminish the quality or quantity of services provided, refrain from or delay making investments in network improvements, and refrain from or delay launching new services.

In the relevant geographic markets for mobile wireless broadband services, Cingular and AT&T Wireless have either launched or are likely soon to launch mobile wireless broadband services. Each has the spectrum necessary to offer mobile wireless broadband services and has business plans to offer these services in these markets. Not all mobile wireless services providers have sufficient spectrum to launch mobile wireless broadband services in these markets, nor do they all have business plans to do so in the near future. In the relevant geographic markets, the current number of mobile wireless services providers that are likely to launch mobile wireless broadband services in the foreseeable future is limited. Because mobile wireless broadband services are nascent, however, HHIs are uninformative.

The competition between Cingular and AT&T Wireless has motivated their efforts to develop and launch mobile wireless broadband services in the relevant geographic markets. If Cingular's proposed acquisition of AT&T Wireless is consummated, the relevant geographic markets will lose one of only a few existing and likely mobile wireless broadband services providers. As a result, the loss of competition between Cingular and AT&T Wireless increases the likelihood of unilateral actions by the merged firm in these relevant geographic markets to increase prices, diminish the quality or quantity of services provided, and refrain from or delay the launch of mobile wireless broadband services.

Entry by a new mobile wireless services provider in the relevant geographic markets would be difficult, time-consuming, and expensive, requiring the acquisition of spectrum licenses and the build-out of a network. Therefore, new entry in response to a small but significant price increase for mobile wireless telecommunications services or mobile wireless broadband services by the merged firm in the relevant geographic markets would not be timely, likely, or sufficient to thwart the competitive harm that would result from Cingular's proposed acquisition of AT&T Wireless.

For these reasons, plaintiffs concluded that Cingular's proposed acquisition of AT&T Wireless will likely substantially lessen competition, in violation of Section 7 of the Clayton Act, in the provision of mobile wireless telecommunications services and mobile wireless broadband services in the relevant geographic markets.

III. Explanation of the Proposed Final Judgment

The divestiture requirements of the proposed Final Judgment will eliminate the anticompetitive effects of the acquisition in mobile wireless telecommunications services and mobile wireless broadband services in the 13 geographic markets of concern. The proposed Final Judgment requires defendants, within 120 days after the filing of the Complaint, or five days after notice of the entry of the Final Judgment by the Court, whichever is later, to

divest the Wireless Business Divestiture Assets, the Minority Interests, and Spectrum Divestiture Assets (collectively, ''Divestiture Assets''). The Wireless Business Divestiture Assets are essentially AT&T Wireless's entire mobile wireless business in the five markets where Cingular and AT&T Wireless both currently own and control providers of mobile wireless telecommunications services. These assets must be divested in such a way as to satisfy plaintiff United States in its sole discretion upon consultation with any relevant plaintiff state that they will be operated by the purchaser as a viable, ongoing business that can compete effectively in the relevant market. Defendants must take all reasonable steps necessary to accomplish the divestitures quickly and shall cooperate with prospective purchasers.

With respect to the Wireless Business Divestiture Assets, in some markets the merged firm may retain some of AT&T Wireless's wireless spectrum (Connecticut RSA–1, Kentucky RSA–1, and Texas RSA–11). The spectrum that must be divested is adequate to support the operation and expansion of the mobile wireless services business being divested, and allowing the merged firm to retain some of AT&T Wireless's spectrum may benefit consumers by allowing the merged firm to provide improved or new services.

In the five markets where either Cingular or AT&T Wireless owns a minority interest in another mobile wireless services provider, the proposed Final Judgment requires defendants to divest these Minority Interests. The proposed Final Judgment allows defendants to retain the Minority Interests in the Missouri, Kansas, and Louisiana areas with the approval of plaintiff United States in its sole discretion if they demonstrate that the retained minority interest will become irrevocably and entirely passive so long as the merged firm owns the interest and will not significantly diminish competition. The size of the minority interests and market concentrations in the Georgia and Massachusetts markets created concerns that allowing the merged firm to continue to hold even a passive interest would diminish competition, and defendants are required to divest fully their interests in those markets.

The Spectrum Divestiture Assets consist of 10 MHz of contiguous PCS spectrum in three markets and must be divested in such a way as to remedy the competitive harm from the transaction in the relevant mobile wireless broadband services markets. The availability of this spectrum will make it more likely that another mobile wireless services provider could offer high-speed data services in these areas. In Knoxville, Tennessee, the merged firm can alternatively restructure its relationship with another spectrum licensee in the market so that the merged firm no longer has an effective controlling interest in the licensee and that the licensee's spectrum will be used by it in a manner that resolves the competitive concerns identified in the Complaint, which is effectively the same as if the merged firm were to divest the required amount of spectrum.

A. Timing of Divestitures

In antitrust cases involving mergers or joint ventures in which plaintiff United States seeks a divestiture remedy, it requires completion of the divestitures within the shortest time period reasonable under the circumstances. The proposed Final Judgment in this case requires, in Section IV.A, divestiture of the Divestiture Assets, within 120 days after the filing of the Complaint, or five days after notice of the entry of the Final Judgment by the Court, whichever is later. Plaintiff United States in its sole discretion upon consultation with any relevant plaintiff state may extend the date for divestiture of the Divestiture Assets by up to 60 days. Because the FCC's approval is required for the transfer of the wireless licenses to a purchaser, Section IV.A provides that if applications for transfer of a wireless license have been filed with the FCC, but the FCC has not acted dispositively before the end of the required divestiture period, the period for divestiture of those assets shall be extended until five days after the FCC has acted. This extension is to be applied only to the individual Divestiture Assets affected by the delay in approval of the license transfer and does not entitle defendants to delay the divestiture of any other Divestiture Assets for which license transfer approval has been granted.

The divestiture timing provisions of the proposed Final Judgment will ensure that the divestitures are carried out in a timely manner, and at the same time will permit defendants an adequate opportunity to accomplish the divestitures through a fair and orderly process. Even if all Divestiture Assets have not been divested upon consummation of the transaction, there should be no adverse impact on competition given the limited duration of the period of common ownership and the detailed requirements of the Preservation of Assets Stipulation and Order.

B. Use of a Management Trustee

The Preservation of Assets Stipulation and Order, entered by the Court on October 26, 2004, ensures, prior to divestiture, that the Divestiture Assets are maintained and the Wireless Business Divestiture Assets remain an ongoing business concern and that the other Divestiture Assets remain economically viable. The Divestiture Assets will remain preserved, independent and uninfluenced by defendants, so that competition is maintained during the pendency of the ordered divestiture.

The Preservation of Assets Stipulation and Order appoints a management trustee selected by plaintiff United States upon consultation with plaintiff states to oversee the Divestiture Assets in the relevant geographic markets. The appointment of a management trustee in this unique situation is required because the Divestiture Assets are not independent facilities that can be held separate and operated as standalone units by the merged firm. Rather, the Wireless Business Divestiture Assets are an integral part of a nationwide network, and to maintain their competitive viability and economic value, they should remain part of that network during the divestiture period. To ensure that these assets are preserved and supported by defendants during this period, yet run independently, a management trustee is necessary to oversee the continuing relationship between defendants and these assets. The management trustee will have the power to operate the Wireless Business Divestiture Assets in the ordinary course of business, so that they will remain preserved, independent, and uninfluenced by defendants, and an ongoing and economically viable competitor to defendants and to other mobile wireless services providers. The management trustee will preserve the confidentiality of competitively sensitive marketing, pricing, and sales information; insure defendants' compliance with the Preservation of Assets Stipulation and Order and the proposed Final Judgment; and maximize the value of the Divestiture Assets so as to permit expeditious divestiture in a manner consistent with the proposed Final Judgment.

The Preservation of Assets Stipulation and Order provides that defendants will pay all costs and expenses of the management trustee, including the cost of consultants, accountants, attorneys, and other representatives and assistants hired by the management trustee as are reasonably necessary to carry out his or her duties and responsibilities. After his

or her appointment becomes effective, the management trustee will file monthly reports with plaintiffs setting forth the efforts to accomplish the goals of the Preservation of Assets Stipulation and Order and the proposed Final Judgment and the extent to which defendants are fulfilling their responsibilities. Finally, the management trustee may become the divestiture trustee, pursuant to the provisions of Section V of the proposed Final Judgment.

C. Use of a Divestiture Trustee

In the event that defendants do not accomplish the divestiture within the periods prescribed in the proposed Final Judgment, the Final Judgment provides that the Court will appoint a trustee selected by plaintiff United States upon consultation with any relevant plaintiff state to effect the divestitures. As part of this divestiture, defendants must relinquish any direct or indirect financial ownership interests and any direct or indirect role in management or participation in control. Pursuant to Section V of the proposed Final Judgment, the divestiture trustee will own and control the systems until they are sold to a final purchaser, subject to safeguards to prevent defendants from influencing their operation.

Section V details the requirements for the establishment of the divestiture trust, the selection and compensation of the divestiture trustee, the responsibilities of the divestiture trustee in connection with the divestiture and operation of the Divestiture Assets, and the termination of the divestiture trust. The divestiture trustee will have the obligation and the sole responsibility, under Section V.D, for the divestiture of any transferred Divestiture Assets. The divestiture trustee has the authority to accomplish divestitures at the earliest possible time and ''at the best price then obtainable upon a reasonable effort by the trustee.'' In addition, to insure that the divestiture trustee can promptly locate and divest to an acceptable purchaser, plaintiff United States, in its sole discretion upon consultation with any relevant plaintiff state, may require defendants to include additional assets, or allow defendants to substitute substantially similar assets, which substantially relate to the Wireless Business Divestiture Assets to be divested by the divestiture trustee.

The divestiture trustee will not only have responsibility for sale of the Divestiture Assets, but will also be the authorized holder of the wireless licenses, with full responsibility for the operations, marketing, and sales of the wireless businesses to be divested, and will not be subject to any control or direction by defendants. Defendants will no longer have any role in the ownership, operation, or management of the Divestiture Assets following consummation of the transaction, as provided by Section V, other than the right to receive the proceeds of the sale, and certain obligations to provide support to the Divestiture Assets, and cooperate with the divestiture trustee in order to complete the divestiture, as indicated in Section VI.L and in the Preservation of Assets Stipulation and Order.

The proposed Final Judgment provides that defendants will pay all costs and expenses of the divestiture trustee. The divestiture trustee's commission will be structured, under Section V.G of the proposed Final Judgment, so as to provide an incentive for the divestiture trustee based on the price obtained and the speed with which the divestitures are accomplished. After his or her appointment becomes effective, the divestiture trustee will file monthly reports with the Court and plaintiffs setting forth his or her efforts to accomplish the divestitures. Section V.J requires the divestiture trustee to divest the Divestiture Assets to an acceptable purchaser or purchasers no later than six months after the assets are transferred to the divestiture trustee. At the end of six months, if all divestitures have not been accomplished, the trustee, plaintiff United States, and any relevant plaintiff state will make recommendations to the Court, which shall enter such orders as appropriate in order to carry out the purpose of the trust, including extending the trust or term of the trustee's appointment.

The divestiture provisions of the proposed Final Judgment will eliminate the anticompetitive effects of the transaction in the provision of mobile wireless telecommunications services and mobile wireless broadband services. The divestitures of the Wireless Business Divestiture Assets and the Minority Interests will preserve competition in mobile wireless telecommunications services by maintaining an independent and economically viable competitor in the relevant geographic markets. The divestiture of the Spectrum Divestiture Assets will preserve competition in mobile wireless broadband services by making assets available to establish a new, independent, and economically viable competitor.

IV. Remedies Available to Potential Private Litigants

Section 4 of the Clayton Act, 15 U.S.C. 15, provides that any person who has been injured as a result of conduct prohibited by the antitrust laws may bring suit in federal court to recover three times the damages the person has suffered, as well as costs and reasonable attorneys' fees. Entry of the proposed Final Judgment will neither impair nor assist the bringing of any private antitrust damage action. Under the provisions of Section 5(a) of the Clayton Act, 15 U.S.C. 16(a), the proposed Final Judgment has no prima facie effect in any subsequent private lawsuit that may be brought against defendants.

V. Procedures Available for Modification of the Proposed Final Judgment

Plaintiffs and defendants have stipulated that the proposed Final Judgment may be entered by a Court after compliance with the provisions of the APPA, provided that plaintiffs have not withdrawn their consent. The APPA conditions entry upon the Court's determination that the proposed Final Judgment is in the public interest.

The APPA provides a period of at least sixty (60) days preceding the effective date of the proposed Final Judgment within which any person may submit to plaintiff United States written comments regarding the proposed Final Judgment. Any person who wishes to comment should do so within sixty (60) days of the date of publication of this Competitive Impact Statement in the **Federal Register**. All comments received during this period will be considered by the Department of Justice, which remains free to withdraw its consent to the proposed Final Judgment at any time prior to the Court's entry of judgment. The comments and the response of plaintiff United States will be filed with the Court and published in the **Federal Register**.

Written comments should be submitted to: Nancy M. Goodman, Chief, Telecommunications and Media Enforcement Section, Antitrust Division, U.S. Department of Justice, 1401 H Street, NW., Suite 8000, Washington, DC 20530. The proposed Final Judgment provides that the Court retains jurisdiction over this action, and the parties may apply to the Court for any order necessary or appropriate for the modification, interpretation, or enforcement of the Final Judgment.

VI. Alternatives to the Proposed Final Judgment

Plaintiff United States considered, as an alternative to the proposed Final

Judgment, a full trail on the merits against defendants. Plaintiff United States could have continued the litigation and sought preliminary and permanent injunctions against Cingular's acquisition of AT&T Wireless. Plaintiff United States is satisfied, however, that the divestiture of assets and other relief described in the proposed Final Judgment will preserve competition for the provision of mobile wireless telecommunications services and mobile wireless broadband services in the relevant markets identified in the Complaint.

VII. Standard of Review Under the APPA for the Proposed Final Judgment

The APPA requires that proposed consent judgments in antitrust cases brought by the United States be subject to a sixty-day comment period, after which the Court shall determine whether entry of the proposed Final Judgment ''is in the public interest.'' 15 U.S.C. 16(e)(1). In making that determination, the Court shall consider:

(A) The competitive impact of such judgment, including termination of alleged violations, provisions for enforcement and modification, duration or relief sought, anticipated effects of alternative remedies actually considered, whether its terms are ambiguous, any other competitive considerations bearing upon the adequacy of such judgment that the court deems necessary to a determination of whether the consent judgment is in the public interest; and

(B) The impact of entry of such judgment upon competition in the relevant market or markets, upon the public generally and individuals alleging specific injury from the violations set forth in the complaint including consideration of the public benefit, if any, to be derived from a determination of the issues at trial.

15 U.S.C. 16(e)(1)(A) & (B). As the United States Court of Appeals for the District of Columbia Circuit has held, the APPA permits a court to consider, among other things, the relationship between the remedy secured and the specific allegations set forth in the government's compliant, whether the consent judgment is sufficiently clear, whether enforcement mechanisms are sufficient, and whether the consent judgment may positively harm third parties. *See United States* v. *Microsoft Corp.,* 56 F.3d 1448, 1458–62 (D.C. Cir. 1995).

''Nothing in this section shall be construed to require the court to conduct an evidentiary hearing or to require the court to permit anyone to intervene.'' 15 U.S.C. 16(e)(2). Thus, in conducting this inquiry, ''[t]he court is nowhere compelled to go to trial or to engage in extended proceedings which might have the effect of vitiating the benefits of prompt and less costly settlement through the consent decree process.'' 119 Cong. Rec. 24,598 (1973) (statement of Senator Tunney).[1] Rather:

[a]bsent a showing of corrupt failure of the government to discharge its duty, the Court, in making its public interest finding, should * * * carefully consider the explanations of the government in the competitive impact statement and its responses to comments in order to determine whether those explanations are reasonable under the circumstances.

United States v. *Mid-America Dairymen, Inc.*, 1977–1 Trade Cas. (CCH) ¶61,508, at 71,980 (W.D. Mo. 1977).

Accordingly, with respect to the adequacy of the relief secured by the proposed Final Judgment, a court may not ''engage in an unrestricted evaluation of what relief would best serve the public.'' *United States* v. *BNS Inc.*, 858 F.2d 456, 462 (9th Cir. 1988) (citing *United States* v. *Bechtel Corp.*, 648 F.2d 660, 666 (9th Cir. 1981)); *see also Microsoft*, 56 F.3d at 1460–62. Courts have held that:

[t]he balancing of competing social and political interest affected by a proposed antitrust consent decree must be left, in the first instance, to the discretion of the Attorney General. The court's role in protecting the public interest is one of insuring that the government has not breached its duty to the public in consenting to the decree. The court is required to determine not whether a particular decree is the one that will best serve society, but whether the settlement is ''*within the reaches of the public interest.*'' More elaborate requirements might undermine the effectiveness of antitrust enforcement by consent decree.

Bechtel, 648 F.2d at 666 (emphasis added) (citations omitted).[2]

The proposed Final Judgment, therefore, should not be reviewed under a standard of whether it is certain to eliminate every anticompetitive effect of a particular practice or whether it mandates certainty of free competition in the future. Court approval of a final judgment requires a standard more flexible and less strict than the standard required for a finding of liability. ''[A] proposed decree must be approved even if it falls short of the remedy the court would impose on its own, as long as it falls within the range of acceptability or is 'within the reaches of public interest.' '' *United States* v. *AT&T Corp.*, 552 F. Supp. 131, 151 (D.D.C. 1982) (citations omitted) (quoting *Gillette*, 406 F. Supp. at 716), *aff'd sub nom. Maryland* v. *United States*, 460 U.S. 1001 (1983); *see also United States* v. *Alcan Aluminum Ltd.*, 605 F. supp. 619, 622 (W.D. Ky. 1985) (approving the consent judgment even though the court would have imposed a greater remedy).

Moreover, the Court's role under the APPA is limited to reviewing the remedy in relationship to the violations that the United States has alleged in its Complaint, and does not authorize the Court to ''construct [its] own hypothetical case and then evaluate the decree against that case.'' *Microsoft*, 56 F.3d at 1459. Because the ''court's authority to review the decree depends entirely on the government's exercising its prosecutorial discretion by bringing a case in the first place,'' it follows that ''the court is only authorized to review the decree itself,'' and not to ''effectively redraft the complaint'' to inquire into other matters that the United States did not pursue. *Id.* at 1459–60.

VIII. Determinative Documents

There are no determinative materials or documents within the meaning of the APPA that were considered by plaintiff United States in formulating the proposed Final Judgment.

Dated: October 29, 2004.

Respectfully submitted,

/s/

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[1] *See United States* v. *Gillette Co.*, 406 F. Supp. 713, 716 (D. Mass. 1975) (recognizing it was not the court's duty to settle; rather, the court must only answer ''whether the settlement achieved [was] within the reaches of the public interest''). A ''public interest'' determination can be made properly on the basis of the Competitive Impact Statement and Response to Comments field by the Department of Justice pursuant to the APPA. Although the APPA authorizes the use of additional procedures, 15 U.S.C. 16(f), those procedures are discretionary. A court need not invoke any of them unless it believes that the comments have raised significant issues and that further proceedings would aid the court in resolving those issues. *See* H.R. Rep. No. 93–1463, 93d Cong., 2d Sess. 8–9 (1974), *reprinted* in 1974 U.S.C.C.A.N. 6535, 6538–39.

[2] *Cf. BNS*, 858 F.2d at 464 (holding that the court's ''ultimate authority under the [APPA] is limited to approving or disapproving the consent decree''); *Gillette*, 406 F. Supp. at 716 (noting that, in this way, the court is constrained to ''look at the overall picture not hypercritically, nor with a microscope, but with an artist's reducing glass''); *see generally Microsoft*, 56 F.3d at 1461 (discussing whether ''the remedies [obtained in the decree are] so inconsonant with the allegations charged as to fall outside of the 'reaches of the public interest' '').

Certificate of Service

I hereby certify that copies of the Competitive Impact Statement have been mailed, by U.S. mail, postage prepaid, to the attorneys listed below, the *29th* day of October 2004.

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/s/

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In the United States District Court for the District of Columbia

United States of America, State of Connecticut and State of Texas, Plaintiffs, v. Cingular Wireless Corporation, SBC Communications Inc., BellSouth Corporation and AT&T Wireless Services, Inc., Defendants; Final Judgment

Civil No.: 1:04CV01850 (RBW)
Filed: November 3, 2004

Whereas, plaintiffs, United States of America, and the states of Connecticut and Texas (''plaintiff states''), filed their Complaint on October 25, 2004, plaintiffs and defendants, Cingular Wireless Corporation, SBC Communications Inc., BellSouth Corporation and AT&T Wireless Services, Inc. (''AT&T Wireless''), by their respective attorneys, have consented to the entry of this Final Judgment without trial or adjudication of any issue of fact or law, and without this Final Judgment constituting any evidence against or admission by any party regarding any issue of fact or law;

And Whereas, defendants agree to be bound by the provisions of this Final Judgment pending its approval by the Court;

And Whereas, the essence of this Final Judgment is the prompt and certain divestiture of certain rights or assets by the defendants to assure that competition is not substantially lessened;

And Whereas, plaintiffs require defendants to make certain divestitures for the purpose of remedying the loss of competition alleged in the Complaint;

And Whereas, defendants have represented to plaintiffs that the divestitures required below can and will be made and that defendants will later raise no claim of hardship or difficulty as grounds for asking the Court to modify any of the divestiture provisions contained below;

Now Therefore, before any testimony is taken, without trial or adjudication of any issue of fact or law, and upon consent of the parties, it is *ordered, adjudged and decreed:*

I. Jurisdiction

This Court has jurisdiction over the subject matter of and each of the parties to this action. The Complaint states a claim upon which relief may be granted against defendants under Section 7 of the Clayton Act, 15 U.S.C. 18.

II. Definitions

As used in this Final Judgment:

A. ''Acquirer'' or ''Acquirers'' means the entity or entities to whom defendants divest the Divestiture Assets.

B. ''AT&T Wireless'' means defendant AT&T Wireless Services, Inc., a Delaware corporation with headquarters in Redmond, Washington, its successors and assigns, and its subsidiaries, divisions, groups, affiliates, partnerships and joint ventures, and their directors, officers, managers, agents, and employees.

C. ''BellSouth'' means defendant BellSouth Corporation, a Georgia corporation with headquarters in Atlanta, Georgia, its successors and assigns, and its subsidiaries, divisions, groups, affiliates, partnerships and joint ventures, and their directors, officers, managers, agents, and employees.

D. ''Cingular'' means defendant Cingular Wireless Corporation, a Delaware corporation with headquarters in Atlanta, Georgia, and Cingular Wireless LLC, a Delaware limited liability company formed as a joint venture between SBC and BellSouth, with headquarters in Atlanta, Georgia, their successors and assigns, and their subsidiaries, divisions, groups, affiliates, partnerships and joint ventures, and their directors, officers, managers, agents, and employees.

E. ''Divestiture Assets'' means Wireless Business Divestiture Assets, Spectrum License Divestiture Assets, and Minority Interests, including any direct or indirect financial ownership or leasehold interests and any direct or indirect role in management or participation in control therein.

F. ''Minority Interests'' means the equity interests owned by any defendant in the following entities that are the licensees or operators of mobile wireless services businesses in the specified Metropolitan Statistical Areas (''MSAs'') and Rural Statistical Areas (''RSAs'') (collectively, Cellular Marketing Areas (''CMAs'')) used to define cellular license areas by the Federal Communications Commission (''FCC''):

(1) Alltel Communications of North Louisiana Cellular Limited Partnership, covering the Shreveport, Louisiana MSA (CMA 100), Monroe, Louisiana MSA (CMA 219), Louisiana RSA–1 (CMA 454), Louisiana RSA–2 (CMA 455) and Louisnana RSA–3 (CMA 456);

(2) Athens Cellular Inc., covering the Athens, Georgia MSA (CMA 234);

(3) CellTelCo, covering the St. Joseph, Missouri MSA (CMA 275);

(4) Pittsfield Cellular Telephone Co., covering the Pittsfield, Massachusetts MSA (CMA 213); and

(5) Topeka Cellular Telephone Co., Inc., covering the Topeka, Kansas MSA (CMA 179).

As an alternative to the divestiture of the Alltel Communications of North Louisiana Cellular Limited Partnership, CellTelCo, and Topeka Cellular Telephone Co., Inc. Minority Interests as required by Section IV of this Final Judgment, defendants may request, at least 20 days prior to consummation of the Transaction, approval from plaintiff United States to retain such interests. Plaintiff United States in its sole discretion may approve this request if it is demonstrated that the retained minority interest will become irrevocably and entirely passive, so long as defendants own the minority interests, and will not significantly diminish competition.

G. ''Multi-line Business Customer'' means a corporate or business customer that contracts with AT&T Wireless for mobile wireless services to provide multiple telephones to its employees or members whose services are provided pursuant to a contract with a corporate or business customer.

H. ''SBC'' means defendant SBC Communications Inc., a Delaware corporation with headquarters in San

Antonio, Texas, its successors and assigns, and its subsidiaries, divisions, groups, affiliates, partnerships and joint ventures, and their directors, officers, managers, agents, and employees.

I. ''Skagit'' means Skagit Wireless LLC, an Oregon corporation with headquarters in Portland, Oregon, its successors and assigns, and its subsidiaries, divisions, groups, affiliates, partnerships and joint ventures, and their directors, officers, managers, agents, and employees.

J. ''Spectrum License Divestiture Assets'' means a license for 10 MHz of contiguous PCS spectrum in the specified MSAs and Basic Trading Areas (''BTAs'') used to define cellular and PCS license areas by the FCC:

(1) The Dallas-Fort Worth, Texas MSA (CMA 009);

(2) The Detroit, Michigan BTA (BTA 112), provided that the license to be transferred does not have to include any PCS spectrum in Monroe and Sanilac counties; and

(3) The Knoxville, Tennessee BTA (BTA 232), provided that as an alternative to the divestiture of a license for 10 MHz of contiguous PCS spectrum as required by Section IV of this Final Judgment, defendants, with the approval of plaintiff United States in its sole discretion, can restructure AT&T Wireless's existing relationship with Skagit such that (i) defendants have no equity or leasehold interest in, hold no debt of, and have no managerial or operational interest in Skagit's PCS license in the Knoxville Tennessee BTA, and (ii) Skagit's PCS license in the Knoxville Tennessee BTA is contractually committed to be used in a manner that resolve the competitive concerns alleged by plaintiffs in the Complaint.

K. ''Transaction'' means the Agreement and Plan of Merger By and Among AT&T Wireless Services, Inc., Cingular Wireless Corporation, Cingular Wireless LLC, Links I Corporation, SBC Communications Inc., and BellSouth Corporation, dated February 17, 2004.

L. ''Wireless Business Divestiture Assets'' means, for each mobile wireless business to be divested under this Final Judgment, all types of assets, tangible and intangible, used by defendants in the operation of the mobile wireless businesses to be divested (including the provision of long distance telecommunications services for wireless calls). ''Wireless Business Divestiture Assets'' shall be construed broadly to accomplish the complete divestitures of the entire business of AT&T Wireless in each of the following MSA and RSA license areas as required by this Final Judgment and to ensure that the divested mobile wireless businesses remain viable, ongoing businesses:

(a) Oklahoma City, Oklahoma MSA (CMA 045);

(b) Connecticut RSA–1 (CMA 357), provided that defendants may retain 10 MHz of AT&T Wireless's PCS spectrum, provided that 10 MHz of contiguous PCS spectrum throughout the RSA is divested to an Acquirer;

(c) Kentucky RSA–1 (CMA 443), provided that defendants may retain 15 MHz of AT&T Wireless's PCS spectrum in Fulton county and 10 MHz of AT&T Wireless's PCS spectrum in the other counties contained within the RSA, provided that 30 MHz of contiguous PCS spectrum in Fulton county and 20 MHz of contiguous PCS spectrum in the other counties contained in the RSA is divested to an Acquirer;

(d) Oklahoma RSA–3 (CMA 598); and

(e) Texas RSA–11 (CMA 662), provided that defendants may retain 25 MHz of AT&T Wireless's PCS spectrum in Sabine county, and 20 MHz of AT&T Wireless's PCS spectrum in Angelina, Nacogdoches, and San Augustine counties, provided that 10 MHz of contiguous PCS spectrum throughout the RSA is divested to an Acquirer.

Wireless Business Divestiture Assets shall include, without limitation, all types of real and personal property, monies and financial instruments, equipment, inventory, office furniture, fixed assets and furnishings, supplies and materials, contracts, agreements, leases, commitments, spectrum licenses issued by the FCC and all other licenses, permits and authorizations, operational support systems, cell sites, network infrastructure, switches, customer support and billing systems, interfaces with other service providers, business and customer records and information, customer contracts, customer lists, credit records, accounts, and historic and current business plans which relate primarily to the wireless business being divested, as well as any patents, licenses, sub-licenses, trade secrets, know-how, drawings, blueprints, designs, technical and quality specifications and protocols, quality assurance and control procedures, manuals and other technical information defendants supply to their own employees, customers, suppliers, agents, or licensees, and trademarks, trade names and service marks or other intellectual property, including all intellectual property rights under third-party licenses that are capable of being transferred to an Acquirer either in their entirety, for assets described in (1) below, or through a license obtained through or from the divesting defendant, for assets described in (2) below; provided that defendants shall only be required to divest Multi-line business Customer contracts, if 50 percent or more of the Multi-line Business Customer's subscribers reside or work within any of the five (5) license areas described herein, and further, any subscribers who obtain mobile wireless services through any such contract retained by defendants and who are located within the five (5) geographic areas identified above, shall be given the option to terminate their relationship with defendants, without financial cost, within one year of the closing of the Transaction. Defendants shall provide written notice to these subscribers within 45 days after the closing of the Transaction.

These divestitures of the Wireless Business Divestiture Assets shall be accomplished by:

(1) Transferring to the Acquirers the complete ownership and/or other rights to the assets (other than those assets used substantially in the operations of AT&T Wireless's overall wireless business which must be retained to continue the existing operations of the wireless properties that defendants are not required to divest, and that either are not capable of being divided between the divested wireless businesses and those not divested, or are assets that the defendants and the Acquirer(s) agree, subject to approval of plaintiff United States upon consultation with any relevant plaintiff state, shall not be divided); and

(2) Granting to the Acquirer(s) an option to obtain a non-exclusive, transferable license from defendants for a reasonable period, subject to approval of plaintiff United States upon consultation with any relevant plaintiff state, at the election of an Acquirer to use any of AT&T Wireless's retained assets under paragraph (1) above, used in the operation of the wireless business being divested, so as to enable the Acquirer to continue to operate the divested wireless business without impairment. Defendants shall identify in a schedule submitted to plaintiffs and filed with the Court, as expeditiously as possible following the filing of the Complaint and in any event prior to any divestitures and before the approval by the Court of this Final Judgment, any intellectual property rights under third-party licenses that are used by the wireless businesses being divested but that defendants could not transfer to an Acquirer entirely or by license without third-party consent, and the specific reasons why such consent is necessary and how such consent would be obtained for each asset.

III. Applicability

A. This Final Judgment applies to defendants Cingular, SBC, BellSouth and AT&T Wireless, as defined above, and all other persons in active concert or participation with any of them who receive actual notice of this Final Judgment by personal service or otherwise.

B. Defendants shall require, as a condition of the sale or other disposition of all or substantially all of their assets or of lesser business units that include the Divestiture Assets, that the purchaser agrees to be bound by the provisions of this Final Judgment, provided that defendants need not obtain such an agreement from the Acquirer(s).

IV. Divestitures

A. Defendants are ordered and directed, within 120 days after consummation of the Transaction, or five (5) days after notice of entry of this Final Judgment, whichever is later, to divest the Divestiture Assets to an Acquirer or Acquirers acceptable to plaintiff United States in its sole discretion upon consultation with any relevant plaintiff state, and, if applicable, to a Divestiture Trustee designated pursuant to Section V of this Final Judgment. Plaintiff United States, in its sole discretion upon consultation with any relevant plaintiff state, may agree to one or more extensions of this time period not to exceed 60 days in total, and shall notify the Court in such circumstances. With respect to divestiture of the Divestiture Assets by defendants or the Divestiture Trustee, if applications have been filed with the FCC within the period permitted for divestiture seeking approval to assign or transfer licenses to the Acquirer(s) of the Divestiture Assets, but an order or other dispositive action by the FCC on such applications has not been issued before the end of the period permitted for divestiture, the period shall be extended with respect to divestiture of those Divestiture Assets for which FCC approval has not been issued until five (5) days after such approval is received. Defendants agree to use their best efforts to accomplish the divestitures set forth in this Final Judgment and to seek all necessary regulatory approvals as expeditiously as possible. This Final Judgment does not limit the FCC's exercise of its regulatory powers and process with respect to the Divestiture Assets. Authorization by the FCC to conduct the divestiture of a Divestiture Asset in a particular manner will not modify any of the requirements of this decree.

B. In accomplishing the divestitures ordered by this Final Judgment, defendants shall promptly make known, if they have not already done so, by usual and customary means, the availability of the Divestiture Assets. Defendants shall inform any person making inquiry regarding a possible purchase of the Divestiture Assets that they are being divested pursuant to this Final Judgment and provide that person with a copy of this Final Judgment. Defendants shall offer to furnish to all prospective Acquirers, subject to customary confidentiality assurances, all information and documents relating to the Divestiture Assets customarily provided in a due diligence process except such information or documents subject to the attorney-client or work productive privileges. Defendants shall make available such information to plaintiffs at the same time that such information is made available to any other person.

C. Defendants shall provide to the Acquirer(s) and plaintiffs information relating to the personnel involved in the operation, development, and sale of the Wireless Business Divestiture Assets to enable the Acquirer(s) to make offers of employment. Defendants will not interfere with any negotiations by the Acquirer(s) to employ any defendant employee whose primary responsibility is the operation, development, and sale of the Wireless Business Divestiture Assets.

D. Defendants shall permit prospective Acquirers of the Divestiture Assets to have reasonable access to personnel and to make inspections of the Divestiture Assets; access to any and all environmental, zoning, and other permit documents and information; and access to any and all financial, operational, and other documents and information customarily provided as part of a due diligence process.

E. Defendants shall warrant to all Acquirer(s) that (1) each asset of the Wireless Business Divestiture Assets will be operational on the date of sale, and (2) every wireless spectrum license is in full force and effect on the date of sale.

F. Defendants shall not take any action that will impede in any way the permitting, licensing, operation, or divestiture of the Divestiture Assets.

G. Defendants shall warrant to the Acquirer(s) of the Divestiture Assets that there are no material defects in the environmental, zoning, licensing or other permits pertaining to the operation of each assets, and that following the sale of the Divestiture Assets, defendants will not undertake, directly or indirectly, any challenges to the environmental, zoning, licensing or other permits relating to the operation of the Divestiture Assets.

H. Unless plaintiff United States otherwise consents in writing, upon consultation with any relevant plaintiff state, the divestitures pursuant to Section IV, or by a Divestiture Trustee appointed pursuant to Section V of this Final Judgment, shall include the entire Divestiture Assets and with respect to the Wireless Business Divestiture Assets and Spectrum License Divestiture Assets, shall be accomplished in such a way as to satisfy plaintiff United States, in its sole discretion upon consultation with any relevant plaintiff state, that these assets can and will be used by the Acquirer(s) as part of a viable, ongoing business engaged in the provision of mobile wireless services. Divestiture of the Divestiture Assets may be made to one or more Acquirers, provided that in each instance it is demonstrated to the sole satisfaction of plaintiff United States upon consultation with any relevant plaintiff state, that the Divestiture Assets will remain viable and the divestiture of such assets will remedy the competitive harm alleged in the Complaint. The divestitures of the Wireless Business Divestiture Assets and Spectrum License Divestiture Assets, whether pursuant to Section IV or Section V of this Final Judgment,

(1) Shall be made to an Acquirer (or Acquirers) that, in plaintiff United State's sole judgment upon consultation with any relevant plaintiff state, has the intent and capability (including the necessary managerial, operational, technical, and financial capability) of competing effectively in the provision of mobile wireless services; and

(2) Shall be accomplished so as to satisfy plaintiff United States in its sole discretion upon consultation with any relevant plaintiff state, that none of the terms of any agreement between the Acquirer (or Acquirers) and any defendant shall give defendants the ability unreasonably to raise the Acquirer's costs, to lower the Acquirer's efficiency, or otherwise to interfere with the ability of the Acquirer to compete effectively.

I. At the option of the Acquirer(s), defendants shall enter into a contract for transition services customarily provided in connection with the sale of a business providing mobile wireless services sufficient to meet all or part of the needs of the Acquirer'(s) needs for a period of up to one year. The terms and conditions of any contractual arrangement meant to satisfy this provision must be reasonably related to market conditions.

J. To the extent that the mobile wireless businesses to be divested use intellectual property, as required to be identified by Section II.L, that cannot be transferred or assigned without the consent of the licensor or other third parties, defendants shall use their best efforts to obtain those consents.

K. In the event plaintiff United States approves retention of any Minority Interests, defendants shall not obtain any additional equity interest in such entity.

V. Appointment of Divestiture Trustee

A. If defendants have not divested the Divestiture Assets within the time period specified in Section IV.A, defendants shall notify plaintiff United States and any relevant plaintiff state of that fact in writing, specifically identifying the Divestiture Assets that have not been divested. Then, upon application of plaintiff United States, upon consultation with any plaintiff state, the Court shall appoint a Divestiture Trustee selected by plaintiff United States and approved by the Court to effect the divestiture of the Divestiture Assets. The Divestiture Trustee, will have all the rights and responsibilities of the Management Trustee appointed pursuant to the Preservation of Assets Stipulation and Order, and will be responsible for:

(1) Accomplishing divestiture of all Divestiture Assets transferred to the Divestiture Trustee from defendants, in accordance with the terms of this final Judgment, to an Acquirer or Acquirers approved by plaintiff United States, upon consultation with any relevant plaintiff state, under Sections IV.A and IV.C of this Final Judgment, and

(2) Exercising the responsibilities of the licensee of any transferred Divestiture Assets and controlling and operating any transferred Wireless Business Divestiture Assets, to ensure that the businesses remain ongoing, economically viable competitors in the provision of mobile wireless services in the five (5) license areas specified in the Wireless Business Divestiture Assets, until they are divested to an Acquirer or Acquirers, and the Divestiture Trustee shall agree to be bound by this Final Judgment.

B. Defendants shall submit a proposed trust agreement (''Trust Agreement'') to plaintiff United States and any relevant plaintiff state, which must be consistent with the terms of this Final Judgment and which must receive approval by plaintiff United States in its sole discretion, upon consultation with any relevant plaintiff state, who shall communicate to defendants within ten (10) business days its approval or disapproval of the proposed Trust Agreement, and which must be executed by the defendants and the Divestiture Trustee within five (5) business days after approval by plaintiff United States; and

C. After obtaining any necessary approvals from the FCC for the assignment of the licenses of the remaining Divestiture Assets to the Divestiture Trustee, defendants shall irrevocably divest the remaining Divestiture Assets to the Divestiture Trustee, who will own such assets (or own the stock of the entity owning such assets, if divestiture is to be effected by the creation of such an entity for sale to Acquirer(s)) and control such assets, subject to the terms of the approved Trust Agreement.

D. After the appointment of a Divestiture Trustee becomes effective, only the Divestiture Trustee shall have the right to sell the Divestiture Assets. The Divestiture Trustee shall have the power and authority to accomplish the divestiture to an Acquirer(s) acceptable to plaintiff United States, in its sole judgment upon consultation with any relevant plaintiff state, at such price and on such terms as are then obtainable upon reasonable effort by the Divestiture Trustee, subject to the provisions of Sections IV, V, and VI of this Final Judgment, and shall have such other powers as this Court deems appropriate. Subject to Section V.G of this Final Judgment, the Divestiture Trustee may hire at the cost and expense of defendants the Management Trustee appointed pursuant to the Preservation of Assets Stipulation and Order, and any investment bankers, attorneys or other agents, who shall he solely accountable to the Divestiture Trustee, reasonably necessary in the Divestiture Trustee's judgment to assist in the divestiture.

E. In addition, notwithstanding any provision to the contrary, plaintiff United States, in its sole discretion upon consultation with any relevant plaintiff state, may require defendants to include additional assets, or allow, with the written approval of plaintiff United States, defendants to substitute substantially similar assets, which substantially relate to the Wireless Business Divestiture Assets to be divested by the Divestiture Trustee to facilitate prompt divestiture to an acceptable Acquirer.

F. Defendants shall not object to a sale by the Divestiture Trustee on any ground other than the Divestiture Trustee's malfeasance. Any such objections by defendants must be conveyed in writing to plaintiff United States, any relevant plaintiff state, and the Divestiture Trustee within ten (10) calendar days after the Divestiture Trustee has provided the notice required under Section VI.

G. The Divestiture Trustee shall serve at the cost and expense of defendants, on such terms and conditions as plaintiff United States approves, and shall account for all monies derived from the sale of the assets sold and all costs and expenses so incurred. After approval by the Court of the Divestiture Trustee's accounting, including fees for its services and those of any professionals and agents retained by the Divestiture Trustee, all remaining money shall be paid to defendants and the trust shall then be terminated. The compensation of the Divestiture Trustee and any professionals and agents retained by the Divestiture Trustee shall be reasonable in light of the value of the Divestiture Assets and based on a fee arrangement providing the Divestiture Trustee with an incentive based on the price and terms of the divestiture, and the speed with which it is accomplished, but timeliness is paramount.

H. Defendants shall use their best efforts to assist the Divestiture Trustee in accomplishing the required divestitures including their best efforts to effect all necessary regulatory approvals and will provide any necessary representations or warranties as appropriate related to sale of the Divestiture Assets. The Divestiture Trustee and any consultants, accountants, attorneys, and other persons retained by the Divestiture Trustee shall have full and complete access to the personnel, books, records, and facilities of the business to be divested, and defendants shall develop financial and other information relevant to the assets to be divested as the Divestiture Trustee may reasonably request, subject to reasonable protection for trade secret or other confidential research, development, or commercial information. Defendants shall take no action to interfere with or to impede the Divestiture Trustee's accomplishment of the divestitures.

I. After its appointment, the Divestiture Trustee shall file monthly reports with plaintiff United states, any relevant plaintiff state, and the Court setting forth the Divestiture Trustee's efforts to accomplish the divestitures ordered under this Final Judgment. To the extent such reports contain information that the Divestiture Trustee deems confidential, such reports shall not be filed in the public docket of the Court. Such reports shall include the name, address, and telephone number of each person who, during the preceding

month, made an offer to acquire, expressed an interest in acquiring, entered into negotiations to acquire, or was contacted or made an inquiry about acquiring, any interest in the Divestiture Assets, and shall describe in detail each contact with any such person. The Divestiture Trustee shall maintain full records of all efforts made to divest the Divestiture Assets.

J. If the Divestiture Trustee has not accomplished such divestitures within six months after its appointment, the Divestiture Trustee shall promptly file with the Court a report setting forth (1) the Divestiture Trustee's efforts to accomplish the required divestitures, (2) the reasons, in the Divestiture Trustee's judgment, why the required divestitures have not been accomplished, and (3) the Divestiture Trustee's recommendations. To the extent such reports contain information that the Divestiture Trustee deems confidential, such reports shall not be filed in the public docket of the Court. The Divestiture Trustee shall at the same time furnish such report to the plaintiff United States and any relevant plaintiff state who shall have the right to make additional recommendations consistent with the purpose of the trust. The Court thereafter shall enter such orders as it shall deem appropriate to carry out the purpose of the Final Judgment, which may, if necessary, include extending the trust and the term of the Divestiture Trustee's appointment by a period requested by plaintiff United States upon consultation with any relevant plaintiff state.

K. After defendants transfer the Divestiture Assets to the Divestiture Trustee, and until those Divestiture Assets have been divested to an Acquirer or Acquirers approved by plaintiff United States pursuant to Section IV.A and IV.H the Divestiture Trustee shall have sole and complete authority to manage and operate the Divestiture Assets and to exercise the responsibilities of the licensee, and shall not be subject to any control or direction by defendants. Defendants shall not retain any economic interest in the Divestiture Assets transferred to the Divestiture Trustee, apart from the right to receive the proceeds of the sale or other disposition of the Divestiture Assets.

L. The Divestiture Trustee shall operate the Wireless Business Divestiture Assets consistent with the Preservation of Assets Stipulation and Order and this Final Judgment, with control over operations, marketing and sales. Defendants shall not attempt to influence the business decisions of the Divestiture trustee concerning the operation and management of the Wireless business Divestiture Assets, and shall not communicate with the Divestiture Trustee concerning divestiture of the Divestiture Assets or take any action to influence, interfere with, or impede the Divestiture trustee's accomplishment of the divestitures required by this Final Judgment, except that defendants may communicate with the Divestiture Trustee to the extent necessary for defendants to comply with this Final Judgment and to provide the Divestiture Trustee, if requested to do so, with whatever resources or cooperation may be required to complete divestiture of the Divestiture Assets and to carry out the requirements of the Preservation of Assets Stipulation and Order and this Final Judgment. Except as provided in this Final Judgment and the Preservation of Assets Stipulation and Order, in no event shall defendants provide to, or receive from, the Divestiture Trustee or the mobile wireless businesses under the Divestiture Trustee's control any non-public or competitively sensitive marketing, sales, or pricing information relating to their respective mobile wireless businesses.

VI. Notice of Proposed Divestitures

A. Within two (2) business days following execution of a definitive divestiture agreement, defendants or the Divestiture Trustee, whichever is then responsible for effecting the divestitures required herein, shall notify plaintiff United States and any relevant plaintiff state in writing of any proposed divestiture required by Section IV or V of this Final Judgment. If the Divestiture Trustee is responsible, it shall similarly notify defendants. The notice shall set forth the details of the proposed divestiture and list the name, address, and telephone number of each person not previously identified who offered or expressed an interest in or desire to acquire any ownership interest in the Divestiture Assets, together with full details of the same.

B. Within fifteen (15) calendar days of receipt by plaintiff United States and any relevant plaintiff state of such notice, plaintiff United States and any relevant plaintiff state may request from defendants, the proposed Acquirer or Acquirers, any other third party, or the Divestiture Trustee if applicable additional information concerning the proposed divestiture, the proposed Acquirer or Acquirers, and any other potential Acquirer. Defendants and the Divestiture Trustee shall furnish any additional information requested within fifteen (15) calendar days of the receipt of the request, unless the parties shall otherwise agree.

C. Within thirty (30) calendar days after receipt of the notice or within twenty (20) calendar days after plaintiff United States and any relevant plaintiff state have been provided the additional information requested from defendants, the proposed Acquirer or Acquirers, any third party, and the Divestiture Trustee, whichever is later, plaintiff United States, upon consultation with any relevant plaintiff state, shall provide written notice to defendants and the Divestiture Trustee, if there is one, stating whether or not it objects to the proposed divestiture. If plaintiff United States provides written notice that it does not object, the divestiture may be consummated, subject only to defendants' limited right to object to the sale under Section V.F of this Final Judgment. Absent written notice that plaintiff United States does not object to the proposed Acquirer or upon objection by plaintiff United States, a divestiture proposed under Section IV or Section V shall not be consummated. Upon objection by defendants under Section V.F, a divestiture proposed under Section V shall not be consummated unless approved by the Court.

VII. Financing

Defendants shall not finance all or any part of any divestiture made pursuant to Section IV or V of this Final Judgment.

VIII. Preservation of Assets

Until the divestitures required by this Final Judgment have been accomplished, defendants shall take all steps necessary to comply with the Preservation of Assets Stipulation and Order entered by this Court. Defendants shall take no action that would jeopardize the divestitures ordered by this Court.

IX. Affidavits

A. Within twenty (20) calendar days of the filing of the Complaint in this matter, and every thirty (30) calendar days thereafter until the divestitures have been completed under Section IV or V of this Final Judgment, defendants shall deliver to plaintiff United States and any relevant plaintiff state and affidavit as to the fact and manner of its compliance with Section IV or V of this Final Judgment. Each such affidavit shall include the name, address, and telephone number of each person who during the preceding thirty (30) days, made an offer to acquire, expressed an interest in acquiring, entered into negotiations to acquire, or was contacted or made an inquiry about acquiring, any interest in the Divestiture

Assets, and shall describe in detail each contact with any such person during that period. Each such affidavit shall also include a description of the efforts defendants have taken to solicit buyers for the Divestiture Assets, and to provide required information to prospective Acquirers, including the limitations, if any, on such information. Assuming the information set forth in the affidavit is true and complete, any objection by plaintiff United States, after consultation with any relevant state, to information provided by defendants, including limitation on information, shall be made within fourteen (14) calendar days of receipt of such affidavit.

B. Within twenty (20) calendar days of the filing of the Complaint in this matter, defendants shall deliver to plaintiff United States and any relevant plaintiff state an affidavit that describes in reasonable detail all actions defendants have taken and all steps defendants have implemented on an ongoing basis to comply with Section VIII of this Final Judgment. Defendants shall deliver to plaintiff United States and any relevant plaintiff state an affidavit describing any changes to the efforts and actions outlined in defendants' earlier affidavits provided pursuant to this section within fifteen (15) calendar days after the change is implemented.

C. Defendants shall keep all records of all efforts made to preserve and divest the Divestiture Assets until one year after such divestitures have been completed.

X. Compliance Inspection

A. For the purposes of determining or securing compliance with this Final Judgment, or of determining whether the Final Judgment should be modified or vacated, and subject to any legally recognized privilege, from time to time duly authorized representatives of the United States Department of Justice, including consultants and other persons retained by the United States, shall, upon written request of a duly authorized representative of the Assistant Attorney General in charge of the Antitrust Division, and on reasonable notice to defendants, be permitted:

(1) Access during defendants' office hours to inspect and copy, or at plaintiff United States' option, to require defendants provide copies of, all books, ledgers, accounts, records and documents in the possession, custody, or control of defendants, relating to any matters contained in this Final Judgment; and

(2) To interview, either informally or on the record, defendants' officers, employees, or agents, who may have their individual counsel present, regarding such matters. The interviews shall be subject to the reasonable convenience of the interviewee and without restraint or interference by defendants.

B. Upon the written request of a duly authorized representative of the Assistant Attorney General in charge of the Antitrust Division, defendants shall submit written reports, under oath if requested, relating to any of the matters contained in this Final Judgment as may be requested.

C. No information or documents obtained by the means provided in this section shall be divulged by plaintiff United States to any person other than an authorized representative of the executive branch of the United States or, pursuant to a customary protective Order or waiver of confidentiality by defendants, the FCC, except in the course of legal proceedings to which the United States is a party (including grand jury proceedings), or for the purpose of securing compliance with this Final Judgment, or as otherwise required by law.

D. If at the time information or documents are furnished by defendants to plaintiff United States, defendants represent and identify in writing the material in any such information or documents to which a claim of protection may be asserted under Rule 26(c)(7) of the Federal Rules of Civil Procedure, and defendants mark each pertinent page of such material, ''Subject to claim of protection under Rule 26(c)(7) of the Federal Rules of Civil Procedure,'' then plaintiff United States shall give defendants ten (10) calendar days notice prior to divulging such material in any legal proceeding (other than a grand jury proceeding).

XI. No Reacquisition

Defendants may not reacquire or lease any part of the Divestiture Assets during the term of this Final Judgment.

XII. Retention of Jurisdiction

This Court retains jurisdiction to enable any party to this Final Judgment to apply to this Court at any time for further orders and directions as may be necessary or appropriate to carry out or construe this Final Judgment, to modify any of its provisions, to enforce compliance, and to punish violations of its provisions.

XIII. Expiration of Final Judgment

Unless this Court grants an extension, this Final Judgment shall expire ten years from the date of its entry.

XIV. Public Interest Determination

Entry of this Final Judgment is in the public interest.

Date: _____

_____

United States District Judge

In the United States District Court for the District of Columbia

United States of America, Department of Justice, Antitrust Division, 1401 H Street, NW., Suite 8000, Washington, DC 20530, State of Connecticut, Office of the Attorney General, 55 Elm Street, Hartford, CT 06106, and State of Texas, Office of the Attorney General, P.O. Box 12548, Austin, TX 78711, Plaintiffs, v. Cingular Wireless Corporation, 5565 Glenridge Connector, Atlanta, GA 30349, SBC Communications Inc., 174 East Houston, San Antonio, TX 78205, Bellsouth Corporation, 1155 Peachtree Street, NE., Atlanta, GA 30309, and AT&T Wireless Services, Inc., 7277 164th Avenue, NE., Building 1, Redmond, WA 98052, Defendants; Complaint

Civil No.: 1:04CV01850 (RBW)
Filed: 10/25/04

The United States of America, acting under the direction of the Attorney General of the United States, and the states of Connecticut and Texas (''plaintiff states''), acting under the direction of their respective Attorneys General, or other authorized officials, bring this civil action to enjoin the merger of two of the largest mobile wireless telecommunications services providers in the United States, Cingular Wireless Corporation (''Cingular'') and AT&T Wireless Services, Inc. (''AT&T Wireless''), and to obtain other relief as appropriate. Plaintiffs allege as follows:

1. On February 17, 2004, Cingular, a joint venture between SBC Communications Inc. (''SBC'') and BellSouth Corporation (''BellSouth''), entered into an agreement to acquire AT&T Wireless under which the two companies would combine their mobile wireless services businesses. Plaintiffs seek to enjoin this transaction because it will substantially lessen competition in several geographic markets for mobile wireless telecommunications services and mobile wireless broadband services (collectively, ''mobile wireless services'').

2. Cingular and AT&T Wireless are the second and third-largest mobile wireless services providers in the

United States, with approximately 24 and 22 million subscribers, respectively. They both provide mobile wireless services in areas throughout the United States and are two of only six providers with a national presence. As a result, Cingular and AT&T Wireless both provide mobile wireless services in hundreds of overlapping geographic areas, and in 13 of these areas the combination of Cingular's and AT&T Wireless's assets and business will likely result in substantially less competition for mobile wireless services. In 10 of these overlapping geographic areas located in the states of Connecticut, Georgia, Kansas, Kentucky, Louisiana, Massachusetts, Missouri, Oklahoma, and Texas, the combination of Cingular and AT&T Wireless will substantially lessen competition for mobile wireless telecommunications services, increasing the likelihood of unilateral actions by the merged firm to increase prices, diminish the quality or quantity of services provided, refrain from or delay making investments in network improvements, and refrain from or delay launching new services, substantially lessening competition for these services. In three of these overlapping geographic areas located in the states of Michigan, Tennessee, and Texas, both Cingular and AT&T Wireless have launched or will likely soon launch mobile wireless broadband services, and the transaction will result in the loss of one of only a few existing and likely mobile wireless broadband services providers, substantially lessening competition for these services.

I. Jurisdiction and Venue

3. Complaint is filed by the United States under Section 15 of the Clayton Act, 15 U.S.C. 25, to prevent and restrain defendants from violating Section 7 of the Clayton Act, 15 U.S.C. 18.

4. Plaintiff states bring this action under Section 16 of the Clayton Act, 15 U.S.C. 26, to prevent and restrain the violation by defendants of Section 7 of the Clayton Act, 15 U.S.C. 18. Plaintiff states, by and through their respective Attorneys General, or other authorized officials, bring this action in their sovereign capacities and as parens patriae on behalf of the citizens, general welfare, and economy of each of their states.

5. Cingular, AT&T Wireless, SBC, and BellSouth are engaged in interstate commerce and in activities substantially affecting interstate commerce. The Court has jurisdiction over this action pursuant to Sections 15 and 16 of the Clayton Act, 15 U.S.C. 25, 26, and 28 U.S.C. 1331, 1337.

6. Cingular, AT&T Wireless, SBC, and BellSouth transact business or are found in the District of Columbia. Venue is proper in this Court pursuant to Section 12 of the Clayton Act, 15 U.S.C. 22 and 28 U.S.C. 1391(b) and (c).

II. The Defendants and the Transaction

7. Cingular, which headquarters in Atlanta, Georgia, is a company organized and existing under the laws of the state of Delaware. Cingular was formed in 2000 by SBC and BellSouth, who own equity interests in it of 60 and 40 percent, respectively, SBC and BellSouth evenly share management control of Cingular. Cingular is the second-largest provider of mobile wireless voice and data services in the United States by number of subscribers; it serves more than 24 million customers. In 2003, Cingular earned revenues of approximately $15.5 billion.

8. SBC, with headquarters in San Antonio, Texas, is a corporation organized and existing under the laws of the state of Delaware. SBC is a regional bell operating company (''RBOC''), one of several regional holding companies formed in 1984 as a result of the breakup of AT&T Corporation's local telephone business. SBC's wireless telecommunications businesses serve 54.7 million access lines in 13 states; Arkansas, California, Connecticut, Illinois, Indiana, Kansas, Michigan, Missouri, Nevada, Ohio, Oklahoma, Texas, and Wisconsin. In 2003, SBC earned approximately $40.8 billion in revenues.

9. BellSouth, an RBOC with headquarters in Atlanta, Georgia, is a corporation organized and existing under the laws of the state of Georgia. BellSouth's wireline telecommunications businesses serves 23.7 million access lines in 9 states: Alabama, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Caroline, South Carolina, and Tennessee. Its total operating revenues for 2003 were approximately $22.6 billion.

10. AT&T Wireless, with headquarters in Redmond, Washington, is a corporation organized and existing under the laws of the state of Delaware. spun off from AT&T Corporation in 2001, it had more than 22 million subscribers as of August 2004 an earned revenues of approximately $16.6 billion in 2003. AT&T Wireless is the third-largest U.S. mobile wireless services provider by number of subscribers.

11. Pursuant to an Agreement and Plan of Merger dated February 17, 2004, Cingular will pay AT&T Wireless shareholders $15 per common share and thereby plans to acquire AT&T Wireless for approximately $41 billion in cash. If this transaction is consummated, Cingular and AT&T Wireless combined would have more than 46 million subscribers, with over $32 billion in revenues, making it the largest mobile wireless sevices provider in the United States, with operations in 49 states covering 97 of the top 100 marketing areas.

III. Trade and Commerce

A. Nature of Trade and Commerce

12. Mobile wireless services allow customers to make and receive telephone calls and use data services using radio transmissions without being confined to a small area during the call or data session, and without the need for unobstructed line-of-sight to the radio tower. This mobility is highly prized by customers, as demonstrated by the more than 160 million people in the United States who own mobile wireless telephones. In 2003, revenues from the sale of mobile wireless services in the United States were nearly $90 billion.

13. The first wireless voice systems were based on analog technology, now referred to as first-generation or ''1G'' technology. These analog systems were launched after the FCC issued the first licenses for mobile wireless telephone service: two cellular licenses (A-block and B-block) in each geographic area in the early to mid-1980s. The licenses are in the 800 MHz range of the radio spectrum, each license consists of 25 MHz of spectrum, and they are issued for each Metropolitan Statistical Area (''MSA'') and Rural Service Area (''RSA'') (collectively, ''Cellular Marketing Areas'' or ''CMAs''), with a total of 734 CMAs covering the entire United States. In 1982, one of the licenses was issued to the incumbent local exchange carrier in the market, and the other was issued by lottery to someone other than the incumbent. Cellular licensees must support analog service until February 2008.

14. In 1995, the FCC allocated and subsequently issued licenses for additional spectrum for the provision of Personal Communications Services (''PCS''), a category of services that includes mobile wireless telephone services comparable to those offered by cellular licensees. These licenses are in the 1.8 GHz range of the radio spectrum and are divided into six blocks: A, B, and C, which consist of 30 MHz each; and D, E, and F, which consist of 10 MHz each. Geographically, the A- and B-block 30 MHz licenses are issued by Major Trading Areas (''MTAs''), and C-, D-, E-, and F-block licenses are issued by Basic Trading Areas

(''BTAs''), several of which comprise each MTA. MTAs and BTAs do not generally correspond to MSAs and RSAs. With the introduction of the PCS licenses, both cellular and PCS licensees began offering digital services, thereby increasing capacity, shrinking handsets, and extending battery life. Unlike the cellular licenses, PCS licensees are not required to provide support for analog or any other technology standard. In 1996, one provider, a specialized mobile radio (''SMR'' or ''dispatch'') spectrum licensee, began to use its SMR spectrum to offer mobile wireless telephone services comparable to those offered by other mobile wireless services providers, in conjunction with its dispatch, or ''push-to-talk,'' service.

15. Today, more than 90 percent of all mobile wireless services customers have digital service, and nearly all mobile wireless voice service has migrated to second-generation or ''2G'' digital technologies: TDMA (time division multiple access), GSM (Global Standard for Mobile, a type of TDMA standard used by all carriers in Europe), and CDMA (code division multiple access). Mobile wireless services providers have chosen to build their networks on these incompatible technologies and most have chosen CDMA or GSM, with TDMA having been orphaned by equipment vendors. (The SMR providers use a fourth incompatible technological standard better suited to the spectrum they own, and, as SMR licensees, they have no obligation to support a specific technology standard.) Even more advanced technologies (''2.5G'') have begun to be deployed for voice and data (e.g., 1xRTT (a/k/a CDMA 2000), GPRS (General Packet Radio Service), and EDGE (Enhanced Data for GSM Evolution)). The data transmission speeds of these technologies vary. For example, 1xRTT provides average user speeds of 70 kilobits per second (''kbps''), and GRPS and EDGE provide average user speeds of 20 to 40 kbps and 80 to 110 kbps, respectively.

16. The U.S. mobile wireless services industry is taking the next evolutionary step in wireless technology to third-generation or ''3G'' technologies (e.g., for GSM, UMTS (Universal Mobile Telecommunications System) and for CDMA, Ev-DO/DV (Evolution Data Only/Data Voice)) that provide for more capacity and higher data throughout. All of the national mobile wireless services providers and some of the regional providers are considering how and where they will deploy 3G services across their networks. The data transmission speeds of these technologies vary. UMTS provides average user speeds of 200 to 300 kbps, whereas Ev-DO provides average user speeds of 300 to 500 kbps.

B. Relevant Product Markets

17. Mobile wireless telecommunications services and mobile wireless broadband services are relevant product markets (collectively, ''mobile wireless services'').

1. Mobile Wireless Telecommunications Services

18. Mobile wireless telecommunications services include both voice and data services provided over a radio network and allow customers to maintain their telephone calls or data sessions without wires, such as when traveling. There are no cost-effective alternatives to mobile wireless telecommunications services. Fixed wireless services are not mobile, and other wireless services have a limited range (e.g., Wi-Fi); neither offers a viable alternative to mobile wireless telecommunications services. It is unlikely that a sufficient number of customers would switch away from mobile telecommunications services to make a small but significant price increase in those services unprofitable. Mobile wireless telecommunications services is a relevant product market under Section 7 of the Clayton Act, 15 U.S.C. 18.

2. Mobile Wireless Broadband Services

19. Mobile wireless broadband services offer data speeds four to six times faster than the current data offerings fully deployed in any mobile wireless services provider's network. Mobile wireless broadband services, which are now being launched using various 3G technologies, offer average data speeds of 200 to 300 kbps, peaking at 2 megabits per second or higher. These speeds rival wireline broadband services at peak speeds. At average speeds, they are comparable to low-end wireline high-speed data offerings and can support bandwidth-intensive services including video conferencing, video streaming, downloading of music and video files, and voice over Internet protocol (''VoIP'') calling, none of which can be used reliably at slower speeds. There are no cost-effective alternatives to mobile wireless broadband services. As with mobile wireless telecommunications services, fixed wireless services and other wireless services that have a limited range (e.g., Wi-Fi) do not offer a viable alternative to mobile wireless broadband services. It is unlikely that a sufficient number of customers would switch away from mobile wireless broadband services to make a small but significant price increase in those services unprofitable. Mobile wireless broadband services is a relevant product market under Section 7 or the Clayton Act, 15 U.S.C. 18.

C. Relevant Geographic Markets

20. The large majority of customers use mobile wireless services in close proximity to their workplaces and homes. Thus, customers purchasing mobile wireless telecommunications services and mobile wireless broadband services choose among mobile wireless services providers that offer services where they are located and travel on a regular basis: home, work, other areas they commonly visit, and areas in between. The number and identity of mobile wireless services providers varies from geographic area to geographic area, along with the quality of their services and the breadth of their geographic coverage, all of which are significant factors in customers' purchasing decisions. Mobile wireless services providers can and do offer different promotions, discounts, calling plans, and equipment subsidies in different geographic areas, effectively varying the actual price for customers by geographic area.

21. The United States comprises numerous local geographic markets for mobile wireless services. These local geographic markets are generally centered around a metropolitan area or a population center and its environs. The FCC has licensed a limited number of mobile wireless services providers in these and other geographic areas based upon the availability of radio spectrum. These FCC spectrum licensing areas therefore often represent the core of the business and social sphere where customers face the same competitive choices for mobile wireless services. The relevant geographic markets in which this transaction will substantially lessen competition in mobile wireless telecommunications services and mobile wireless broadband services are effectively represented, but not defined, by FCC spectrum licensing areas.

22. The relevant geographic markets, under Section 7 of the Clayton Act, 15 U.S.C. 18, where the transaction will substantially lessen competition for mobile wireless telecommunications services are represented by the following FCC spectrum licensing areas: Oklahoma City, Oklahoma (CMA 045), Topeka, Kansas (CMA 179), Pittsfield, Massachusetts (CMA 213), Athens, Georgia (CMS 234), St. Joseph, Missouri (CMA 275), Connecticut RSA–1 (CMA 357), Kentucky RSA–1 (CMA 443), Oklahoma RSA–3 (CMA 598), Texas

RSA–11 (CMA 662), and Shreveport, Louisiana (BTA 419).

23. The relevant geographic markets, under Section 7 of the Clayton Act, 15 U.S.C. 18, where the transaction will substantially lessen competition for mobile wireless broadband services are represented by the following FCC spectrum licensing areas: Dallas-Fort Worth, Texas (CMA 009), Detroit, Michigan (BTA 112), and Knoxville, Tennessee (BTA 232).

24. It is unlikely that a sufficient number of customers would switch to mobile wireless services providers in a different geographic market to make a small but significant price increase in the relevant geographic markets unprofitable for mobile wireless telecommunications services or mobile wireless broadband services.

D. Anticompetitive Effects

1. Mobile Wireless Telecommunications Services

25. Currently, Cingular and AT&T Wireless both own all or part of businesses that offer mobile wireless telecommunications services in the 10 relevant geographic areas. In Athens, Georgia; Topeka, Kansas; Pittsfield, Massachusetts; and St. Joseph, Missouri, AT&T Wireless owns a minority equity interest in Verizon Wireless's business providing mobile wireless telecommunications services. In Shreveport, Louisiana, Cingular owns a minority equity interest in AllTel Corporations' business providing mobile wireless telecommunications services. The minority equity interest range from approximately 9 to 24 percent. Based upon these significant minority equity interests and the specific facts of the relationships, the shares and assets of the mobile wireless services business partially owned by Cingular or AT&T Wireless in these markets should be attributed to either Cingular or AT&T Wireless.

26. The individual market shares of Cingular's and AT&T Wireless's mobile wireless telecommunications services businesses in the relevant geographic markets as measured in terms of subscribers range from 9 to more than 71 percent, and their combined market shares range from 61 to nearly 90 percent. In each relevant geographic market, Cingular or AT&T Wireless has the largest market share, and in all but one, the other is the second-largest mobile wireless telecommunications services provider. In all but one of the relevant geographic markets, Cingular and AT&T Wireless are the original cellular licensees and, as a result, have the network infrastructures with the greatest depth and breadth of coverage. Therefore, Cingular and AT&T Wireless are likely closer substitutes for each other than the other mobile wireless telecommunications services providers in the relevant geographic markets.

27. The relevant geographic markets for mobile wireless telecommunications services are highly concentrated. As measured by the Herfindahl-Hirschman Index (''HHI''), which is commonly employed in merger analysis and is defined and explained in Appendix A to this Complaint, concentration in these markets ranges from approximately 2600 to more than 5300, which is well above the 1800 threshold at which the Department considers a market to be highly concentrated. After Cingular's proposed acquisition of AT&T Wireless is consummated, the HHIs in the relevant geographic markets will range from approximately 4400 to more than 8000, with increases in the HHI as a result of the merger ranging from approximately 1100 to more than 3500, much higher than the thresholds below which the Department considers a transaction unlikely to cause competitive harm.

28. Competition between Cingular and AT&T Wireless in the relevant geographic markets has resulted in lower prices and higher quality in mobile wireless telecommunications services, than would otherwise have existed in these geographic markets. If Cingular's proposed acquisition of AT&T Wireless is consummated, the relevant geographic markets for mobile wireless telecommunications services will become substantially more concentrated, and the competition between Cingular and AT&T Wireless in mobile wireless telecommunications services will be eliminated in these markets. As a result, the loss of competition between Cingular and AT&T Wireless increases the likelihood of unilateral actions by the merged firm in the relevant geographic markets to increase prices, diminish the quality of services provided, refrain from or delay making investments in network improvements, and refrain from or delay launching new services. Therefore, Cingular's proposed acquisition of AT&T Wireless will likely result in substantially less competition in mobile wireless telecommunications services in the relevant geographic markets.

2. Mobile Wireless Broadband Services

29. In the relevant geographic markets for mobile wireless broadband services, Cingular and AT&T Wireless have either launched or are likely soon to launch mobile wireless broadband services. Each has the available spectrum necessary to offer mobile wireless broadband services and has business plans to offer these services in these markets. Not all mobile wireless services providers have sufficient spectrum to launch mobile wireless broadband services in these markets, nor do they all have business plans to do so. In the relevant geographic markets, the current number of mobile wireless services providers that are likely to launch mobile wireless broadband services in the foreseeable future is limited. Because mobile wireless broadband services are nascent, however, HHIs are uninformative.

30. The competition between Cingular and AT&T Wireless has motivated their efforts to develop and launch mobile wireless broadband services in the relevant geographic markets. If Cingular's proposed acquisition of AT&T Wireless is consummated, the relevant geographic markets will lose one of only a few existing and likely mobile wireless broadband services providers. As a result, the loss of competition between Cingular and AT&T Wireless increases the likelihood of unilateral actions by the merged firm in these relevant geographic markets to increase prices, diminish the quality or quantity of services provided, refrain from or delay making investments in network improvements, and refrain from or delay launching mobile wireless broadband services. Therefore, Cingular's proposed acquisition of AT&T Wireless will likely result in substantially less competition in mobile wireless broadband services in the relevant geographic markets.

3. Entry

31. Entry by a new mobile wireless services provider in the relevant geographic markets would be difficult, time-consuming, and expensive, requiring the acquisition of spectrum licenses and the build-out of a network. Therefore, new entry in response to a small but significant price increase for mobile wireless telecommunications services or mobile wireless broadband services by the merged firm in the relevant geographic markets would not be timely, likely, or sufficient to thwart the competitive harm resulting from Cingular's proposed acquisition of AT&T Wireless, if it were to be consummated.

IV. Violation Alleged

32. The effect of Cingular's proposed acquisition of AT&T Wireless, if it were to be consummated, may be substantially to lessen competition in interstate trade and commerce in the relevant geographic markets for mobile

wireless telecommunications services and mobile wireless broadband services, in violation of Section 7 of the Clayton Act, 15 U.S.C. 18.

33. Unless restrained, the transaction will likely have the following effects in mobile wireless telecommunications services and mobile wireless broadband services in the relevant geographic markets, among others:

a. Actual and potential competition between Cingular and AT&T Wireless will be eliminated;

b. Competition in general will be lessened substantially;

c. Prices are likely to increase;

d. The quality and quantity of services are likely to decrease;

e. Incentives to improve wireless networks will be reduced; and

f. Incentives to innovate or launch new services will be reduced.

V. Requested Relief

34. That Cingular's proposed acquisition of AT&T Wireless be adjudged to violate Section 7 of the Clayton Act, 15 U.S.C. 18;

35. That defendants be permanently enjoined from and restrained from carrying out the Agreement and Plan of merger, dated February 17, 2004, or from entering into or carrying out any agreement, understanding, or plan, the effect of which would be to bring the wireless telecommunications services businesses of Cingular and AT&T Wireless under common ownership or control;

36. That plaintiffs be awarded their costs of this action; and

37. That plaintiffs have such other relief as the Court may deem just and proper.

Dated: October 25, 2004.

Respectfully Submitted,

For Plaintiff United States of America:

/s/ _____

R. Hewitt Pate

Assistant Attorney General, Antitrust Division.

/s/ _____

J. Bruce McDonald

Deputy Assistant Attorney General Antitrust Division.

J. Robert Kramer II,

Director of Operations, Antitrust Division.

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/s/ _____

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Rebecca Fisher,

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/s/ _____

John T. Prud'homme, Jr.,

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Signature by the State of Texas on Complaint in *United States of America, State of Connecticut and State of Texas* v. *Cingular Wireless Corporation, SBC Communications Inc., BellSouth Corporation and AT&T Wireless Services, Inc.*

Appendix A—Herfindahl-Hirschman Index

''HHI'' means the Herfindahl-Hirschman Index, a commonly accepted measure of market concentration. It is calculated by squaring the market share of each firm competing in the market and then summing the resulting numbers. For example, for a market consisting of four firms with shares of 30, 30, 20, and 20 percent, the HHI is 2600 ($30^2 + 30^2 + 20^2 + 20^2 = 2600$). (**Note:** Throughout the Complaint, market share percentages have been rounded to the nearest whole number, but HHIs have been estimated using unrounded percentages in order to accurately reflect the concentration of the various markets.) The HHI takes into account the relative size distribution of the firms in a market and approaches zero when a market consists of a large number of small firms. The HHI increases both as the number of firms in the market decreases and as the disparity in size between those firms increases.

Markets in which the HHI is between 1000 and 1800 points are considered to be moderately concentrated, and those in which the HHI is in excess of 1800 points are considered to be highly concentrated. *See Horizontal Merger Guidelines* ¶1.51 (revised Apr. 8, 1997). Transactions that increase the HHI by more than 100 points in concentrated markets presumptively raise antitrust concerns under the guidelines issued by the U.S. Department of Justice and Federal Trade Commission. *See id.*

In the United States District Court for the District of Columbia

United States of America, State of Connecticut and State of Texas, Plaintiffs, v. Cingular Wireless Corporation, SBC Communications Inc., Bellsouth Corporation and AT&T Wireless Services, Inc., Defendants; Preservation of Assets Stipulation and Order

Civil No.: 1:04CV01850 (RBW)

Filed: 10/25/04

It is hereby stipulated and agreed by and between the undersigned parties, subject to approval and entry by the Court, that:

I. Definitions

As used in this Preservation of Assets Stipulation and Order:

A. ''Acquirer'' or ''Acquirers'' means the entity or entities to whom defendants divest the Divestiture Assets.

B. ''AT&T Wireless'' means defendant AT&T Wireless Services, Inc., a Delaware corporation with headquarters in Redmond, Washington, its successors and assigns, and its subsidiaries, divisions, groups, affiliates, partnerships and joint ventures, and their directors, officers, managers, agents, and employees.

C. ''BellSouth'' means defendant BellSouth Corporation, a Georgia corporation with headquarters in Atlanta, Georgia, its successors and assigns, and its subsidiaries, divisions, groups, affiliates, partnerships and joint ventures, and their directors, officers, managers, agents, and employees.

D. ''Cingular'' means defendant Cingular Wireless Corporation, a Delaware corporation with headquarters in Atlanta, Georgia, and Cingular Wireless LLC, a Delaware limited liability company formed as a joint venture between SBC and BellSouth, with headquarters in Atlanta, Georgia, their successors and assigns, and their subsidiaries, divisions, groups, affiliates, partnerships and joint

ventures, and their directors, officers, managers, agents, and employees.

E. ''Divestiture Assets'' means Wireless Business Divestiture Assets, Spectrum License Divestiture Assets, and Minority Interests, including any direct or indirect financial ownership or leasehold interests and any direct or indirect role in management or participation in control therein.

F. ''Minority Interests'' means the equity interests owned by any defendant in the following entities that are the licensees or operators of wireless mobile telephone businesses in the specified Metropolitan Statistical Areas (''MSAs'') and Rural Statistical Areas (''RSAs'') (collectively, Cellular Marketing Areas (''CMAs'')) used to define cellular license areas by the Federal Communications Commission (''FCC''):

(1) Alltel Communications of North Louisiana Cellular Limited Partnership, covering the Shreveport, Louisiana MSA (CMA 100), Monroe, Louisiana MSA (CMA 219), Louisiana RSA–1 (CMA 454), Louisiana RSA–2 (CMA 455) and Louisiana RSA–3 (CMA 456);

Athens Cellular Inc., covering the Athens, Georgia MSA (CMA 234);

(3) CellTelCo, covering the St. Joseph, Missouri MSA (CMA 275);

(4) Pittsfield Cellular Telephone Co., covering the Pittsfield, Massachusetts MSA (CMA 213); and

(5) Topeka Cellular Telephone Co., Inc., covering the Topeka, Kansas MSA (CMA 179).

As an alternative to the divestiture of the Alltel Communications of North Louisiana Cellular Limited Partnership, CellTelCo, and Topeka Cellular Telephone Co., Inc. Minority Interests as required by Section IV of the proposed Final Judgment, defendants may request, at least 20 days prior to consummation of the Transaction, approval from plaintiff United States to retain such interests. Plaintiff United States in its sole discretion may approve this request if it is demonstrated that the retained minority interest will become irrevocably and entirely passive, so long as defendants own the minority interests, and will not significantly diminish competition.

G. ''Multi-line Business Customer'' means a corporate or business customer that contracts with AT&T Wireless for mobile wireless services to provide multiple telephones to its employees or members whose services are provided pursuant to the contract with the corporate or business customer.

H. ''SBC'' means defendant SBC Communications, Inc., a Delaware corporation with its headquarters in San Antonio, Texas, its successors and assigns, and its subsidiaries, divisions, groups, affiliates, partnerships and joint ventures, and their directors, officers, managers, agents, and employees.

I. ''Skagit'' means Skagit Wireless LLC, an Oregon corporation with headquarters in Portland, Oregon, its successors and assigns, and its subsidiaries, divisions, groups, affiliates, partnerships and joint ventures, and their directors, officers, managers, agents, and employees.

J. ''Spectrum License Divestiture Assets'' means a license for 10 MHz of contiguous PCS spectrum in the specified MSAs and Basic Trading Areas (''BTA'') used to define cellular and PCS license areas by the FCC:

(1) The Dallas-Fort Worth, Texas MSA (CMA 009);

(2) The Detroit, Michigan BTA (BTA 112), provided that the license to be transferred does not include any PCS spectrum in Monroe and Sanilac counties; and

(3) The Knoxville, Tennessee BTA (BTA 232), provided that as an alternative to the divestiture of a license for 10 MHz of contiguous PCS spectrum as required by Section IV of the proposed Final Judgment, defendants, with the approval of plaintiff United States in its sole discretion, can restructure AT&T Wireless's existing relationship with Skagit such that (i) defendants have no equity or leasehold interest in, hold no debt of, and have no managerial or operational interest in Skagit's PCS license in the Knoxville Tennessee BTA, and (ii) Skagit's PCS license in the Knoxville Tennessee BTA is contractually committed to be used in a manner that resolves the competitive concerns alleged by plaintiffs in the Complaint.

K. ''Transaction'' means the Agreement and Plan of Merger By and Among AT&T Wireless Services, Inc., Cingular Wireless Corporation, Cingular Wireless LLC, Links I Corporation, SBC Communications Inc., and Bell South Corporation, dated February 17, 2004.

L. ''Wireless Business Divestiture Assets'' means, for each mobile wireless business to be divested under the proposed Final Judgment, all types of assets, tangible and intangible, used by defendants in the operation of the mobile wireless businesses to be divested (including the provision of long distance telecommunications services for wireless calls). ''Wireless Business Divestiture Assets'' shall be construed broadly to accomplish the complete divestitures of the entire business of AT&T Wireless in each of the following MSA and RSA license areas as required by the proposed Final Judgment and to ensure that the divested mobile wireless businesses remain viable, ongoing businesses:

(a) Oklahoma City, Oklahoma MSA (CMA 045);

(b) Connecticut RSA–1 (CMA 357), provided that defendants may retain 10 MHz of AT&T Wireless's PCS spectrum, provided that 10 MHz of contiguous PCS spectrum throughout the RSA is divested to the Acquirer;

(c) Kentucky RSA–1 (CMA 443), provided that defendants may retain 15 MHz of AT&T Wireless's PCS spectrum in Fulton country and 10 MHz of AT&T Wireless's PCS spectrum in the other counties contained within the RSA, provided that 30 MHz of contiguous PCS spectrum in Fulton county and 20 MHz of contiguous PCS spectrum in the other counties contained in the RSA is divested to an Acquirer;

(d) Oklahoma RSA–3 (CMA 598); and

(e) Texas RSA–11 (CMA 662), provided that defendants may retain in Sabine County, 25 MHz of AT&T Wireless's PCS spectrum, and in Angelina, Nacogdoches, and San Augustine counties, defendants may retain 20 MHz of AT&T Wireless's PCS spectrum, provided that 10 MHz of contiguous PCS spectrum throughout the RSA is divested to an Acquirer.

Wireless Business Divestiture Assets shall include, without limitation, all types of real and personal property, monies and financial instruments, equipment, inventory, office furniture, fixed assets and furnishings, supplies and materials, contracts, agreements, leases, commitments, spectrum licenses issued by the FCC and all other licenses, permits and authorizations, operational support systems, cell sites, network infrastructure, switches, customer support and billing systems, interfaces with other service providers, business and customer records and information, customer contracts, customer lists, credit records, accounts, and historic and current business plans which relate primarily to the wireless business being divested, as well as any patents, licenses, sub-licenses, trade secrets, know-how, drawings, blueprints, designs, technical and quality specifications and protocols, quality assurance and control procedures, manuals and other technical information defendants supply to their own employees, customers, suppliers, agents, or licenses, and trademarks, trade names and service marks or other intellectual property, including all intellectual property rights under third-party licenses that are capable of being transferred to an Acquirer either in their entirety, for assets described in (1) below, or through a license obtained through or from the divesting defendant,

for assets described in (2) below; provided that defendants shall only be required to divest Multi-line Business Customer contracts, if 50 percent or more of the Multi-line Business Customer's subscribers reside or work within any of the five (5) license areas described herein, and further, any subscribers who obtain mobile wireless services through any such contract retained by defendants and who are located within the five (5) geographic areas identified above, shall be given the option to terminate their relationship with defendants, without financial cost, within one year of the closing of the Transaction. Defendants shall provide written notice to these subscribers within 45 days after the closing of the Transaction.

These divestitures of the Wireless Business Divestiture Assets as defined in Section II.L shall be accomplished by:

(1) Transferring to the Acquirer(s) the complete ownership and/or other rights to the assets (other than those assets used substantially in the operations of AT&T Wireless's overall wireless business which must be retained to continue the existing operations of the wireless properties that defendants are not required to divest, and that either are not capable of being divided between the divested wireless businesses and those not divested, or are assets that the defendants and the Acquirer(s) agree, subject to approval of plaintiff United States upon consultation with any relevant plaintiff state, shall not be divided); and

(2) Granting to the Acquirer(s) an option to obtain a non-exclusive, transferable license from defendants for a reasonable period, subject to approval of plaintiff United States upon consultation with any relevant plaintiff state, at the election of an Acquirer to use any of AT&T Wireless's retained assets under paragraph (1) above, used in the operation of the wireless business being divested, so as to enable the Acquirer to continue to operate the divested wireless business without impairment. Defendants shall identify in a schedule submitted to plaintiffs and filed with the Court, as expeditiously as possible following the filing of the Complaint and in any event prior to any divestitures and before the approval by the Court of the proposed Final Judgment, any intellectual property rights under third-party licenses that are used by the wireless businesses being divested but that defendants could not transfer to an Acquirer entirely or by license without third-party consent, and the specific reasons why such consent is necessary and how such consent would be obtained for each asset.

II. Objectives

The Final Judgment filed in this case is meant to ensure defendants' prompt divestiture of the Divestiture Assets for the purpose of preserving viable competitors in the provision of mobile wireless services in order to remedy the effects that plaintiffs allege would otherwise result from Cingular's acquisition of AT&T Wireless. This Preservation of Assets Stipulation and Order ensures, prior to such divestitures, that competition is maintained during the pendency of the ordered divestitures, and that the Wireless Business Divestiture Assets remain an ongoing business concern and the Divestiture Assets remain economically viable. The Divestiture Assets will remain, as provided herein, preserved, independent and uninfluenced by defendants.

III. Jurisdiction and Venue

This Court has jurisdiction over the subject matter of this action and each of the parties hereto, and venue of this action is proper in the United States District Court for the District of Columbia. The Complaint states a claim upon which relief may be granted against defendants under Section 7 of the Clayton Act, 15 U.S.C. 18.

IV. Compliance With and Entry of Final Judgment

A. The parties stipulate that a proposed Final Judgment in the form attached hereto as Exhibit A may be filed with and entered by the Court, upon the motion of any party or upon the Court's own motion, at any time after compliance with the requirements of the Antitrust Procedures and Penalties Act, 15 U.S.C. 16, and without further notice to any party or other proceedings, provided that no plaintiff has withdrawn its consent, which it may do at any time before the entry of the proposed Final Judgment by serving notice thereof on defendants and other plaintiffs and by filing that notice with the Court.

B. Defendants shall abide by and comply with the provisions of the proposed Final Judgment, pending the Judgment's entry by the Court, or until expiration of time for all appeals of any Court ruling declining entry of the proposed Final Judgment, and shall, from the date of the signing of this Stipulation by the parties, comply with all the terms and provisions of the proposed Final Judgment as though the same were in full force and effect as an order of the Court.

C. Defendants shall not consummate the transaction sought to be enjoined by the Complaint herein before the Court has signed this Preservation of Assets Stipulation and Order.

D. This Stipulation shall apply with equal force and effect to any amended proposed Final Judgment agreed upon in writing by the parties and submitted to the Court.

E. In the event (1) any plaintiff has withdrawn its consent, as provided in Section IV.A above, or (2) the proposed Final Judgment is not entered pursuant to this Stipulation, the time has expired for all appeals of any Court declining entry of the proposed Final Judgment, and the Court has not otherwise ordered continued compliance with the terms and provisions of the proposed Final Judgment, then the parties are released from all further obligations under this Stipulation, and the making of this Stipulation shall be without prejudice to any party in this or any other proceeding.

F. Defendants represent that the divestitures ordered in the proposed Final Judgment can and will be made, and that defendants will later raise no claim of mistake, hardship or difficulty of compliance as grounds for asking the Court to modify any of the provisions contained therein.

V. Management Trustee

A. Plaintiff United States nominates Joseph J. Simons as Management Trustee in this case. The plaintiff states consent to, and defendants have no objection to, his immediate appointment by this Court. Accordingly, this Court appoints Joseph J. Simons as Management Trustee to serve as manager of the Divestiture Assets until the Divestiture Assets are sold or transferred to a Divestiture Trustee pursuant to Section V of the proposed Final Judgment. Nothing in this Stipulation shall be interpreted to prevent the Management Trustee from becoming the Divestiture Trustee pursuant to Section V of the proposed Final Judgment.

B. Within five (5) business days of the entry of this Stipulation by the Court, defendants shall enter into a trust agreement with Mr. Simons subject to the approval of plaintiff United States in its sole discretion upon consultation with plaintiff states, that will grant the rights, powers, and authorities necessary to permit him to perform the duties and responsibilities of the Management Trustee pursuant to this Stipulation. The trust agreement shall enable him to assume all rights, powers, and authorities necessary to perform his duties and responsibilities, pursuant to this Stipulation and the proposed Final Judgment and consistent with their

purposes. Mr. Simons or any other subsequently appointed Management Trustee shall serve at the cost and expense of defendants, on such terms and conditions as plaintiff United States approves upon consultation with plaintiff states, with a fee arrangement that is reasonable in light of the person's experience and responsibilities.

C. The Management Trustee will have the following powers and responsibilities with respect to the Divestiture Assets:

(1) The Management Trustee will have the power to manage the Divestiture Assets in the ordinary course of business consistent with this Stipulation. Only with the prior written approval of plaintiff United States upon consultation with plaintiff states, may the Management Trustee make any decision, take any action, or enter any transaction that is outside the ordinary course of business;

(2) The Management Trustee shall have a duty to, consistent with the terms of this Stipulation and the proposed Final Judgment, monitor the organization of the Divestiture Assets; manage the Divestiture Assets in order to maximize their value so as to permit expeditious divestitures in a manner consistent with the proposed Final Judgment; maintain the independence of the Divestiture Assets from defendants; control and operate the Wireless Business Divestiture Assets to ensure that the Wireless Business Divestiture Assets remain an independent, ongoing, economically viable competitor to the other mobile wireless services providers; and assure defendants' compliance with their obligations pursuant to this Stipulation and the proposed Final Judgment;

(3) The Management Trustee shall have the authority to employ, at the cost and expense of defendants, such consultants, accountants, attorneys, and other representatives and assistants as are reasonably necessary to carry out the Management Trustee's duties and responsibilities;

(4) The Management Trustee and any consultants, accountants, attorneys, and any other persons retained by the Management Trustee, shall have full and complete access to all personnel, books, records, documents, and facilities of the Divestiture Assets or to any other relevant information as the Management Trustee may reasonably request, including, but not limited to, all documents and records kept in the normal course of business that relate to the Divestiture Assets. Defendants shall develop such financial or other information as the Management Trustee may request and shall cooperate with the Management Trustee. Defendants shall take no action to interfere with or impede the Management Trustee's ability to monitor defendants' compliance with this Stipulation and the proposed Final Judgment or otherwise to perform his duties and responsibilities consistent with the terms of this Stipulation and the proposed Final Judgment;

(5) The Management Trustee will ensure that the Divestiture Assets shall be staffed with sufficient employees to maintain their viability and competitiveness. To the extent that any employees whose principal responsibilities related to the Divestiture Assets leave or have left the Divestiture Assets prior to divestiture of the Divestiture Assets, the Management Trustee may replace departing or departed employees with persons who have similar experience and expertise or determine not to replace such departing or departed employees; and

(6) Thirty (30) days after the Management Trustee has been appointed by the Court, and every thirty (30) days thereafter until the Divestiture Assets are either transferred to an Acquirer or to the Divestiture Trustee, the Management Trustee shall report in writing to the plaintiffs concerning the efforts to accomplish the purposes of this Stipulation and the proposed Final Judgment. Included within that report shall be the Management Trustee's assessment of the extent to which the Divestiture Assets are meeing (or exceeding) their projected goals as are reflected in existing or revised operating plans, budgets, projections or any other regularly prepared financial statements and the extent to which defendants are fulfilling their responsibilities under this Stipulation and the proposed Final Judgment.

D. The following limitations shall apply to the Management Trustee:

(1) The Management Trustee shall not be involved, in any way, in the operations of the other businesses of defendants;

(2) The Management Trustee shall have no financial interests affected by defendants' revenues, profits or profit margins, except that the Management Trustee's compensation for managing the Divestiture Assets may include economic incentives dependent on the financial performance of the Divestiture Assets provided that those incentives are consistent with the objectives of this Stipulation and the proposed Final Judgment and are approved by plaintiff United States upon consultation with plaintiffs states; and

(3) The Management Trustee shall be prohibited from performing any further work for defendants for two (2) years after the close of the divestiture transactions.

E. Defendants and the Management Trustee will take all reasonable efforts to preserve the confidentiality of information that is material to the operation of either the Divestiture Assets or defendants' businesses. Defendants' personnel supplying services to the Divestiture Assets pursuant to this Stipulation must retain and maintain the confidentiality of any and all confidential information material to the Divestiture Assets. Except as permitted by this Stipulation and the proposed Final Judgment, such persons shall be prohibited from providing, discussing, exchanging, circulating or otherwise furnishing the confidential information of the Divestiture Assets to or with any person whose employment involves any of defendants' businesses, except as necessary to fulfill the purposes of this Stipulation and the proposed Final Judgment.

F. If in the judgment of the Management Trustee, defendants fail to provide the services listed in Section VI of this Stipulation to the satisfaction of the Management Trustee, upon notification to defendants and approval by plaintiff United States upon consultation with plaintiff states, the Management Trustee may engage third parties unaffiliated with the defendants to provide those services for the Divestiture Assets, at the cost and expense of defendants, provided that defendants may have reasonable access to information to satisfy themselves that after the services have been provided, the Divestiture Assets are in compliance with all applicable laws, rules, and regulations.

G. At the option of the Management Trustee, defendants may also provide other products and services, on an arms-length basis provided that the Management Trustee is not obligated to obtain any other product or service from defendants and may acquire any such products or services from third parties unaffiliated with defendants.

H. If the Management Trustee ceases to act or fails to act diligently and consistently with the purposes of this Stipulation and the proposed Final Judgment, if the Management Trustee proposed by plaintiff United States is not approved by this Court or resigns, or if for any other reason the Management Trustee ceases to serve in his or her capacity as Management Trustee, the United States may select upon consultation with any relevant plaintiff state, a substitute Management Trustee. In this event, plaintiff United States will

identify to defendants the individual or entity it proposes to select as Management Trustee. Defendants must make any such objection to this selection within five (5) business days after plaintiff United States notifies defendants of the Management Trustee's selection. Upon application of the United States, the Court shall approve and appoint a substitute Management Trustee. Within five (5) business days of such appointment, defendants shall enter into a trust agreement with the Management Trustee subject to the approval of plaintiff United States in its sole discretion upon consultation with plaintiff states, as described in Section V.B of this Stipulation.

VI. Preservation of Assets

Until the divestitures required by the proposed Final Judgment have been accomplished, except as otherwise approved in advance in writing by plaintiff United States upon consultation with plaintiff states:

A. Defendants and the Management Trustee shall preserve, maintain, and continue to support the Divestiture Assets, take all steps necessary to manage the Divestiture Assets in order to maximize their revenue, profitability and viability so to permit expeditious divestitures in a manner consistent with this Stipulation and the proposed Final Judgment.

B. The Wireless Business Divestiture Assets shall be operated by the Management Trustee as part of an independent, ongoing, economically viable competitive business to other mobile wireless services providers operating in the same license area. Defendants and the Management Trustee shall take all steps necessary to ensure that:

(1) The management, sales, and operations of the Wireless Business Divestiture Assets are independent from defendants' other operations; provided at the request of the Management Trustee, defendants shall include the marketing, pricing and sales of the mobile wireless services generated by the Wireless Business Divestiture Assets in the license areas served by the Wireless Business Divestiture Assets within its marketing, promotional, and service offerings, in the ordinary course of business, in any national, regional, and local marketing programs. Nothing in this Section shall prohibit the Management Trustee from developing his own reasonable marketing, sales, pricing or promotional offers, which shall be funded and supported by defendants;

(2) The Wireless Business Divestiture Assets are maintained by adhering to normal and planned repair, capital improvement, upgrade and maintenance schedules;

(3) The management of the Wireless Business Divestiture Assets will not be influenced by defendants;

(4) The books, records, competitively sensitive sales, marketing and pricing information, and decision-making concerning marketing, pricing or sales of mobile wireless services generated by the Wireless Business Divestiture Assets will be kept separate and apart from defendants' other operations; and

(5) The management of the Wireless Business Divestiture Assets acts to maintain and increase the sales and revenues of the mobile wireless services generated by the Wireless Business Divestiture Assets, and maintain at previously approved levels for 2004 and 2005, whichever are higher, all promotional, advertising, sales, marketing, and technical support for the Wireless Business Divestiture Assets.

C. The management of the Spectrum License Divestiture Assets and the Minority Interests shall be held entirely separate, distinct, and apart from those of defendants' other operations.

D. Defendants shall provide sufficient working capital and lines and sources of credit as deemed necessary by the Management Trustee to continue to maintain the Divestiture Assets consistent with this Stipulation.

E. Except (1) as recommended by the Management Trustee and approved by plaintiff United States upon consultation with plaintiff states, or (2) as part of a divestiture approved by plaintiff United States upon consultation with any relevant plaintiff state, in accordance with the terms of the proposed Final Judgment, defendants shall not remove, sell, lease, assign, transfer, pledge or otherwise dispose of any of the Divestiture Assets outside the ordinary course of business.

F. The Management Trustee, with defendants' cooperation consistent with this Stipulation and the proposed Final Judgment, shall maintain, in accordance with sound accounting principles, separate, accurate, and complete financial ledgers, books and records that report on a periodic basis, such as the last business day of every month, consistent with past practices, the assets, liabilities, expenses, revenues, and income of the Divestiture Assets.

G. Defendants shall take no action that would jeopardize, delay, or impede the sale of the Divestiture Assets nor shall defendants take any action that would interfere with the ability of any Divestiture Trustee appointed pursuant to the proposed Final Judgment to operate and manage the Divestiture Assets or to complete the divestitures pursuant to the proposed Final Judgment to an Acquirer(s) acceptable to plaintiff United States.

H. Upon the filing of the Complaint in the action, defendants shall appoint sufficient employees for each of the Wireless Business Divestiture Assets, who are familiar with and have had responsibility for the management, operation, marketing, and sales of the Divestiture Assets, to assist the Management Trustee with his duties and responsibilities hereunder.

I. Except for employees (1) whose primary employment responsibilities relate to the Divestiture Assets, or (2) who are involved in providing support services to the Divestiture Assets pursuant to Sections V and VI of this Stipulation and Section V of the proposed Final Judgment, defendants shall not permit any other of their employees, officers, or directors to be involved in the operations of the Divestiture Assets.

J. Except as required by law in the course of (1) complying with this Stipulation and the proposed Final Judgment; (2) overseeing compliance with policies and standards concerning the safety, health, and environmental aspects of the operations of the Divestiture Assets and the integrity of their financial controls; (3) defending legal claims, investigations or enforcement actions threatened or brought against the Divestiture Assets; or (4) obtaining legal advice, defendants' employees (excluding employees (a) whose primary employment responsibilities relate to the Divestiture Assets, or (b) who are involved in providing support services to the Divestiture Assets pursuant to Sections V and VI of this Stipulation and Sections V of the proposed Final Judgment) shall not receive, or have access to, or use any material confidential information, not in the public domain, of the Divestiture Assets. Defendants may receive aggregate financial information relating to the Divestiture Assets to the extent necessary to allow defendants to prepare the defendants' consolidated financial reports, tax returns, reports required by securities laws, and personnel reports. Any such information that is obtained pursuant to this subparagraph shall be used only for the purposes set forth in this subparagraph.

K. Defendants may offer a bonus or severance to employees whose primary employment responsibilities relate to the Divestiture Assets, that continue their employment until divestiture (in addition to any other bonus or

severance to which the employees would otherwise be entitled).

L. Until the Divestiture Assets are divested to an Acquirer(s) acceptable to plaintiff United States upon consultation with any relevant plaintiff state, defendants shall provide to the Divestiture Assets, at no cost, support services needed to maintain the Divestiture Assets in the ordinary course of business, including but not limited to:

(1) Federal and state regulatory policy development and compliance;

(2) Human resources administrative services;

(3) Environmental, health and safety services, and developing corporate policies and ensuring compliance with federal and state regulations and corporate policies;

(4) Preparation of tax returns;

(5) Financial accounting and reporting services;

(6) Audit services;

(7) Legal services;

(8) Routine network maintenance, repair, improvements, and upgrades;

(9) Switching, call completion, and other services necessary to allow subscribers to use mobile wireless services and complete calls; and

(10) Billing, customer care and customer service related functions necessary to maintain the subscriber account and relationship.

M. Within twenty (20) days after the filing of the Complaint, defendants will notify plaintiff United States and plaintiff states in writing of the steps defendants have taken to comply with this Section.

N. This Preservation of Assets Stipulation and Order shall remain in effect until consummation of the divestitures required by the proposed Final Judgment or until further order of the Court.

Dated: October 25, 2004

Respectfully submitted,

For Plaintiff United States

/s/ _____

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/s/ _____

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Rebecca Fisher,

/s/ _____

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/s/ _____

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Signature by the State of Texas on Preservation of Assets Stipulation and Order in *United States of America, State of Connecticut and State of Texas* v. *Cingular Wireless Corporation, SBC Communications Inc., BellSouth Corporation and AT&T Wireless Services Inc.*

For Defendants Cingular Wireless Corporation and SBC Communications Inc.

/s/ _____

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/s/ _____

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For Defendant AT&T Wireless Services, Inc.

/s/ _____

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Order

It is so ordered by the Court, this ____ day of _____, 2004.

/s/ _____

United States District Judge

[FR Doc. 04–25323 Filed 11–12–04; 8:45 am]

BILLING CODE 4410–11–M

DEPARTMENT OF LABOR

Employment and Training Administration

Workforce Security Programs: Unemployment Insurance Program Letter Interpreting Federal Law

The Employment and Training Administration interprets Federal law requirements pertaining to unemployment compensation. These interpretations are issued in Unemployment Insurance Program Letters (UIPLs) to the State Workforce Agencies. UIPL 30–04, Change 1 is published in the **Federal Register** in order to inform the public.

This UIPL provides additional guidance to the states regarding enacting legislation which conforms to the ''SUTA Dumping Prevention Act of 2004,'' which was signed by the President on August 9, 2004.

Dated: November 8, 2004.

Emily Stover DeRocco,

Assistant Secretary of Labor.

Employment and Training Administration, Advisory System, U.S. Department of Labor, Washington, DC 20210

Advisory: Unemployment Insurance Program Letter No. 30–04 Change 1

To: State Workforce Agencies.

From: Cheryl Atkinson, Administrator, Office of Workforce Security.

Subject: SUTA Dumping—Amendments to Federal Law Affecting the Federal-State Unemployment Compensation Program—Additional Guidance.

1. *Purpose.* To provide additional guidance to states concerning the amendments to Federal law designed to prohibit ''SUTA Dumping.''

2. *References.* Public Law (Pub. L.) 108–295, the ''SUTA Dumping Prevention Act of 2004,'' signed by the President on August 9, 2004; the Social Security Act (SSA); the Internal Revenue Code (IRC), including the Federal Unemployment Tax Act (FUTA); and Unemployment Insurance Program Letters (UIPLs) 30–04, 14–84, and 29–83, Change 3.

3. *Background.* UIPL 30–04 informed states of the amendments to Federal unemployment compensation (UC) law made by Pub. L. 108–295, the ''SUTA Dumping Prevention Act of 2004.'' Pub. L. 108–295 amended the SSA by adding section 303(k) to establish a nationwide minimum standard for curbing SUTA dumping. States will need to amend their UC laws to conform with the new legislation.

Since the issuance of UIPL 30–04, the Department of Labor has received requests for clarification and other questions on the Federal SUTA dumping requirements. This UIPL is issued to respond to these requests and questions. As was UIPL 30–04, it is a question and answer (Q&A) format. States are especially directed to Q&As 1, 2, 14, and 15, which include additions and modifications to the draft legislative language provided with UIPL 30–04.

4. *Action.* State administrators should distribute this advisory to appropriate staff. States must adhere to the requirements of Federal law contained in this advisory.

5. *Inquiries.* Questions should be addressed to your Regional Office.

6. *Attachment.*

Questions and Answers (Q&As)

Mandatory Transfers—Section 303(k)(1)(A), SSA

1–1. Question: In anticipation of a major layoff, Employer A transfers the portion of its business and workforce which it will be laying off to a small company, Employer B. Since there is substantially common ownership, experience is also transferred. Employer B then lays off all of the transferred workforce and is charged for the resulting UC payments. Employer B then either ceases operating or operates with a greatly reduced workforce, thereby minimizing its UC costs. May the transfer of experience from Employer A to Employer B be voided in this case? If not, what can be done to avoid this type of SUTA dumping?

Answer: Since there is substantially common ownership, experience must be transferred from Employer A to Employer B under the mandatory transfer provisions.

Although Federal law does not require states to prevent this type of SUTA dumping, states may take action. (States which charge benefits to the separating employer may be particularly vulnerable to this type of SUTA dumping.) If the state determines that a substantial purpose of the transfer of trade or business was to obtain a lower rate, then both Employer A and Employer B's accounts could be treated as a single account for experience rating purposes. This will prevent Employer A from escaping its poor experience. It is consistent with Federal law both because Section 303(k)(2)(B), SSA, permits states to define ''employer'' and because Section 3303(a)(1), FUTA, has long permitted the establishment of joint accounts. To this end, the draft legislative language contained in Attachment II to UIPL 30–04 is revised as follows:

• By inserting ''(1)'' after ''(a)'' in the provision addressing mandatory transfers, and

• By inserting the following new language:

(2) If, following a transfer of experience under paragraph (1), the Commissioner determines that a substantial purpose of the transfer of trade or business was to obtain a reduced liability for contributions, then the experience rating accounts of the employers involved shall be combined into a single account and a single rate assigned to such account.

The Department recommends that states consider addressing this matter.

Alternatively, nothing prohibits a state from revisiting its determination that Employer B was a separate legal entity for UC purposes. If, for example, the state determines that Employer B has no business existence separate and apart from Employer A, and, therefore, under its law should not have been established as a separate employer for UC purposes, then its establishment as a separate employer may be voided and its experience will revert to Employer A. (Note this approach would not cover transfers to a long-established business that has a separate business identity.)

1–2. Question: Although the answer to Q&A 5 of UIPL 30–04 provides that an ''employer's workforce is necessarily a part of its business,'' the draft legislative language attached to that UIPL does not specifically address transferring workforce. Instead, it simply refers to transfers of trade or business. May the draft legislative language be modified to specifically cite transfers of workforce or employees?

Answer: Yes. The draft legislative language is just that—draft language. It may, therefore, be modified to explicitly provide that transfers of trade or business include situations where employees are transferred. The following language is added at the end of subsection (a) of the draft legislative language as optional language that the state may consider using:

The transfer of some or all of an employer's workforce to another employer shall be considered a transfer of trade or business when, as the result of such transfer, the transferring employer no longer performs trade or business with respect to the transferred workforce, and such trade or business is performed by the employer to whom the workforce is transferred.

Care should be taken to assure the state law does not require transfers of experience where an employee is ''moved'' from one employer to another, without any transfer of trade or business. See Q&A 1–7.

1–3. Question: The answer to Q&A 6 in UIPL 30–04 indicates that the Department is not defining a ''bright line'' test of what constitutes ''substantially common ownership, management, or control.'' Does this mean state law may contain a test of ''substantially common'' that requires more than 90 percent commonality? Or more than 50 percent commonality?

Answer: No, a 90 percent test would be a ''substantial majority'' test, while a 50 percent test would be a simple ''majority'' test. Congress could have specified either of these tests, but it instead chose a test of ''substantial'' commonality. Therefore, ''substantially'' could include less than 50% common ownership, management, or control. ''Substantial'' common management, for example, might even occur where Company A and Company B share only one manager, but that one manager exercises pervasive control as the chief executive officer of both companies.

1–4. Question: The answer to Q&A 8 in UIPL 30–04 ''strongly recommends that states reassign rates immediately upon completion of the transfer'' of experience to avoid a SUTA dump between the completion of a transfer and assignment of a new rate. If a state currently lacks the capability to assign two different rates to the same employer for the same year, may it retroactively change the employers' rates to the beginning of the rate year to reflect the transferred experience?

Answer: No. Section 3303(a)(1), FUTA, requires that ''reduced rates'' be assigned to an employer based on ''his'' experience during ''not less than the 3 consecutive years immediately preceding the computation date.'' If a rate based on transferred experience is assigned to an employer for a period before it becomes ''his'' experience, the employer cannot be said to be receiving a rate based on ''his'' experience for that period.

States have other options to address this concern. States may establish a different employer account number for the employer(s) and assign the recalculated rate to that new account number.

States may also retroactively impose the state's standard rate of contributions or the state's highest rate of contributions since these rates are not ''reduced rates'' subject to FUTA. (*See* UIPL 14–84 for guidance in determining the state's standard rate. Caution should be taken in using standard rates since in some states the standard rate may be lower than the employer's experience rate, either prior to or after any transfer.) Although this approach is consistent with FUTA, states should consider whether retroactively imposing higher rates on employers is equitable since employers will not have budgeted for retroactive costs and because the rates are not based on experience.

1–5. Question: Recalculating an employer's reduced rate in the middle of the rate year may be administratively cumbersome. May a state simply assign the employer the higher of the two rates for the remainder of the rate year? For example, assume Employer A has a rate of 5.0 percent and is purchased by Employer B which has a rate of 4.0 percent. May the state assign a rate of 5.0 percent to Employer B for the remainder of the rate year? (This method is authorized by UIPL 29–83, Change 3, which discusses transfers of experience, but only when Employer B is not an existing employer.)

Answer: Yes, the state may assign the higher of the two rates. FUTA's experience rating requirements apply to ''reduced rates.'' This approach always serves to increase the employer's rate. As noted in UIPL 29–83, Change 3, ''Since assigning the highest rate results in an increased rate (even though it may be less than the standard rate), there is no conflict with FUTA.'' Although UIPL 29–83, Change 3, addressed only cases where the successor was not an existing employer, this principle also applies to cases where the successor is an employer.

States should note that this approach may raise fairness issues. For example, assuming substantial commonality of ownership, management, or control at the time of the transfer or trade or business, an employer with a workforce of 10 individuals and an experience rate of 5.4 percent could have its trade/business and experience transferred to an employer with a workforce of 1,000 individuals and an experience rate of 2.0 percent. The result of assigning a higher rate would be a significantly higher rate on a significantly larger workforce.

1–6. Question: The answer to Q&A 8 in UIPL 30–04 provides for the option of ''immediately'' recalculating an employer's rate ''after the completion of the transfer of trade or business.'' This could be problematic since this rate change could occur in the middle of a quarter. May the recalculated rate take effect with the start of the quarter following the transfer?

Answer: Yes. Since nothing in the SUTA dumping amendments requires rates be

recalculated prior to the next time the state calculates rates for all employers, states have latitude in this matter.

1–7. Question: The answer to Q&A 9 in UIPL 30–04, says that where ''[a]n employee of one legal entity is moved to another legal entity,'' no transfer of experience is required. (Emphasis added.) However, the answer to Q&A 13 in that UIPL says the SUTA Dumping amendment applies to ''all transfers, large and small.'' What is the distinction between the two?

Answer: Q&A 13 applies to cases where there is a transfer of trade or business. (Q&As 5 and 14 in UIPL 30–04 and 1–2 in this UIPL also apply to situations where trade or business is transferred.)

The answer to Q&A 9 applies to cases where an employee is ''moved'' from one legal entity to another, but where there is no transfer of trade or business. For example, an owner of two separate legal entities ''moves'' an individual from head of widget making for Entity A to head of graphic design for Entity B, but does not transfer any of the widget-making trade/business to Entity B. In this case, no trade or business is transferred and the ''move'' of the individual is in the nature of a reassignment.

In cases where no trade or business has been transferred, experience may not be transferred. Therefore, when an employee's ''move'' is merely in the nature of a reassignment, the state may not transfer experience.

1–8. Question: State law allows employers to voluntarily combine their experience rating histories into joint accounts under certain conditions. Does the SUTA dumping legislation affect this?

Answer: No. Joint accounts may continue to be established in accordance with state law.

The SSA's mandatory transfer provisions affect joint accounts in the same way they affect individual employer accounts. That is, if an employer participating in a joint account transfers trade or business to another employer and a transfer of experience is required under provisions of state law implementing the SSA's mandatory transfer provisions, then any subsequent calculation of the experience rate of the joint account must take into account this transfer.

1–9. Question: Do the amendments mandating a transfer of experience affect what constitute taxable wages?

Answer: The amendments address the transfer of experience and of rates based on that experience. They do not affect determinations of what constitute taxable wages under the state's law. As a result, after trade and business is transferred, the state may either give effect to taxable wages paid by the predecessor in determining whether the taxable wage base is met, or ''restart'' the taxable wage base for the individual at zero.

1–10. Question: Do the mandatory transfer provisions for SUTA Dumping apply when an employer is ''reorganized?''

Answer: The keys under section 303(k)(1)(A), SSA, are whether there is a transfer of trade or business and whether there is substantially common ownership, management, or control. Thus, the answer depends on whether the reorganization involves a transfer of trade or business between entities under substantially common ownership, management or control.

As used in bankruptcy law, a reorganization is a ''financial restructuring of a corporation, esp. in the repayment of debts, under a plan created by a trustee and approved by a court.'' (Black's Law Dictionary (8th edition, 2004).) Thus, if a single employer simply ''financially restructures'' itself, without transferring trade or business, then the mandatory transfer provisions do not apply.

In other cases, reorganizations are mergers of corporations which involve a transfer of trade or business. For example, a reorganization may be a ''restructuring of a corporation, as by a merger or recapitalization, in order to improve its tax treatment under the Internal Revenue Code.'' (Black's Law Dictionary (8th edition, 2004).) When there is a merger, the mandatory transfer provisions will apply if there is substantially common ownership, management, or control at the time of the transfer of trade or business.

Note the mandatory transfer provision of Section 303(k)(1)(A), SSA, does not speak in terms of ''acquisitions.'' In many reorganizations, there may be mergers involving stock swaps or stock-for-asset exchanges, and it may be argued that no ''acquisition'' has occurred, even though workforce has been moved to another legal entity within a corporate umbrella. For purposes of the mandatory SUTA dumping amendments, whether there has been an ''acquisition'' is immaterial. What is significant is whether trade or business was transferred when, at the time of the transfer, there is substantially common ownership, management, or control. If this occurs, then the experience must also be transferred.

Required Penalties—Section 303(k)(1)(D), SSA

1–11. Question: The draft legislative language attached to UIPL 30–04 provides that, in addition to any civil penalty, ''any violation of this section *may be* prosecuted as a'' criminal offense. (Emphasis added.) Does this mean that inclusion of criminal penalties is optional on the part of the state?

Answer: No, section 303(k)(1)(D), SSA, clearly requires that state law must provide that ''meaningful civil and criminal penalties'' are imposed under certain circumstances. (*See* Q&A 19 in UIPL 30–04.) The draft legislative language quoted in the question merely indicates that the state has discretion to apply criminal penalties as appropriate. As noted in Q&A 20 in UIPL 30–04, ''States will take into account the amounts at issue and the likelihood of successful prosecution in determining which cases will result in criminal prosecutions.''

1–12. Question: State law must provide for the imposition of penalties for persons who ''knowingly'' violate or attempt to violate those provisions of state law that implement section 303(k), SSA, and for those who ''knowingly'' advise another person to violate such provisions. Since it is often difficult to prove that an action is done ''knowingly,'' may state law provide that penalties may be imposed using a lower level of proof?

Answer: Yes. The ''knowingly'' test is the minimum standard that state law must contain to meet the requirements of Section 303(k)(1)(D), SSA. States must assure that any such test is at least as encompassing as the ''knowingly'' standard.

Statute of Limitations

1–13. Question: Assume a ''SUTA dump'' occurred five years before the state identified it. The state's statute of limitations prevents the state from assessing contributions more than three years prior to the date of detection. Does this statute of limitations conflict with the SUTA dumping amendments?

Answer: No. Nothing in the SUTA dumping legislation overrides a state's statute of limitations. As a result, in the above example, the state may limit its assessment of contributions to the three-year period provided in its statute of limitations.

Draft Legislative Language

1–14. Question: Subsection (c)(1) of the draft legislative language attached to UIPL 30–4 provides for civil penalties for persons knowingly violating or attempting to violate ''subsections (a) *and* (b) or any other provision of this Chapter related to determining the assignment of a contribution rate? (Emphasis added.) Should the ''and'' be an ''or''?

Answer: Yes. The word ''and'' could be read to mean that the person must have violated, or attempted to violate, both the mandatory transfer provision and the prohibited transfer provision. Therefore the draft legislative language should be corrected by changing ''and'' to ''or''.

Also, note there is a typo in subsection (e)(2) of the draft legislative language. ''Trade *of* business'' should be corrected to ''Trade *or* business.'' (Emphasis added.)

1–15. Question: Subsection (c)(4) of the draft legislative language attached to UIPL 30–4 provides that ''In addition to the penalty imposed by paragraph (1), any violation of this section may be prosecuted.* * *'' May ''section'' be changed to ''Chapter''?

Answer: Yes. Using the word ''chapter'' will have the effect of making the criminal penalties applicable to any other provision of the state's UC law related to determining the assignment of a contribution rate. Note that states are not required to apply the penalties they develop for SUTA dumping to other violations of state law. (*See* Q&A 24 in UIPL 30–04.)

[FR Doc. E4–3162 Filed 11–12–04; 8:45 am]

BILLING CODE 4510–30–P

MISSISSIPPI RIVER COMMISSION

Sunshine Act Meetings

AGENCY HOLDING THE MEETING: Mississippi River Commission.

TIME AND DATE: 1 p.m., December 15, 2004.

PLACE: Mississippi River Commission Headquarters Building, 1400 Walnut Street, Vicksburg, MS.

STATUS: Open to the public for observation, but not for participation.

MATTERS TO BE CONSIDERED: The Commission will consider the Louisiana Coastal Area Ecosystem Restoration Study, Final Report and Environmental Impact Statement.

CONTACT PERSON FOR MORE INFORMATION: Mr. Stephen Gambrell, telephone (601) 634–5766.

Brenda S. Bowen,

Army Federal Register Liaison Officer.

[FR Doc. 04–25391 Filed 11–10–04; 11:22 am]

BILLING CODE 3710–GX–M

NUCLEAR REGULATORY COMMISSION

[NUREG–1600]

NRC Enforcement Policy

AGENCY: Nuclear Regulatory Commission.

ACTION: Policy statement: revision.

SUMMARY: The Nuclear Regulatory Commission (NRC) is revising its General Statement of Policy and Procedure for NRC Enforcement Actions (NUREG–1600) (Enforcement Policy or Policy) to include an administrative change that provides that the appropriate Regional Administrator will issue all Notices of Enforcement Discretion (NOEDs) for power reactors.

DATES: This revision is effective November 15, 2004. Comments on this revision to the Enforcement Policy may be submitted on or before December 15, 2004.

ADDRESSES: Submit written comments to: Michael T. Lesar, Chief, Rules and Directives Branch, Division of Administrative Services, Office of Administration, Mail Stop: T6D59, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001. Hand deliver comments to: 11555 Rockville Pike, Rockville, Maryland, between 7:30 a.m. and 4:15 p.m., Federal workdays. Copies of comments received may be examined at the NRC Public Document Room, Room O1F21, 11555 Rockville Pike, Rockville, MD. You may also e-mail comments to *nrcrep@nrc.gov*.

The NRC maintains the current Enforcement Policy on its Web site at *http://www.nrc.gov*, select What We Do, Enforcement, then Enforcement Policy.

FOR FURTHER INFORMATION CONTACT: Herbert N. Berkow, Office of Nuclear Reactor Regulation, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001, (301) 415–1395, e-mail (*HNB@nrc.gov*) or Renée Pedersen, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001, (301) 415–2742, e-mail (*RMP@nrc.gov*).

SUPPLEMENTARY INFORMATION: Section VII.C of the Enforcement Policy describes the circumstances when the staff may exercise enforcement discretion in the form of a NOED for power reactors.

On occasion, circumstances may arise where a licensee's compliance with a Technical Specification (TS) Limiting Condition for Operation (LCO) or other license condition would involve: (1) An unnecessary plant transient; (2) performance of testing, inspection, or system realignment that is inappropriate with the specific plant conditions; or, (3) unnecessary delays in plant startup without a corresponding health and safety benefit. The staff may also grant enforcement discretion in cases involving severe weather or other natural phenomena. This decision is based upon balancing the public health and safety or common defense and security of not operating against the potential radiological or other hazards associated with continued operation, resulting in a determination that safety will not be impacted unacceptably by exercising this discretion. The Commission is to be informed expeditiously following the granting of a NOED in such situations.

In these circumstances, the NRC staff may choose to not enforce the applicable TS or other license condition. This enforcement discretion, designated as a NOED, is only exercised if the NRC staff is clearly satisfied that the action is consistent with protecting the public health and safety. NRC guidance for implementing the NOED policy for power reactors is provided in the *NRC Inspection Manual* Part 9900 guidance.

The Enforcement Policy and implementing guidance have historically recognized the distinction between: (1) Those instances where a noncompliance is temporary and nonrecurring when an amendment is not practical, and (2) those instances where a noncompliance will occur during the brief period of time required for the NRC staff to process an emergency or exigent license amendment under the provisions of 10 CFR 50.91(a)(5) or (6). In the first situation, the Regional Administrator has issued the NOED and subsequently documented the decision for granting the NOED. In the second situation, the Director, Office of Nuclear Reactor Regulation (NRR) has issued the NOED and subsequently documented the decision for granting the NOED. In other words, the current distinction between region-issued and NRR-issued NOEDs for power reactors is based on the duration of the NOED and whether or not a follow-up license amendment is appropriate.

This revision of the Enforcement Policy eliminates the distinction between region-issued and NRR-issued NOEDs for power reactors. Although historically most NOEDs have been issued and documented by the cognizant regions without follow-up license amendments, all NOED requests have been evaluated and decisions made jointly by the regional and NRR staffs. Thus, the distinction is unnecessary.

The Enforcement Policy revision specifies that the associated regional and headquarters staff will together determine the appropriateness of granting a requested NOED. If the NOED is determined to be appropriate, regional staff will complete the documentation process associated with granting the NOED.

The revision provides that, for all power reactor NOED determinations, the Regional Administrator, or his or her designee, may issue a NOED after consultation with headquarters and therefore eliminates the need to categorize NOEDs as regional- or headquarters-lead. This clarification will provide a more predictable, clear, and consistent process for licensees when requesting NRC to consider granting a NOED.

This policy revision, as well as other NOED process improvements, was discussed with representatives of the Nuclear Energy Institute (NEI) and other stakeholders at a public meeting with the NRC staff on July 14, 2004. The NRC plans on completely revising and reissuing its Part 9900 guidance later in the year. In addition to the Enforcement Policy revision, other process improvements include emphasizing that the license amendment process should be used in preference to NOEDs whenever possible and developing improved guidance to address the NOED request requirement to demonstrate no net increase in radiological risk. In addition, other concurrent improvements to the NOED process will result in most NOEDs having follow-up license amendments regardless of the NOED duration.

The revision to the Enforcement Policy is strictly administrative in nature and will support simplification of the NOED process by providing a clear understanding of the roles and responsibilities of NRC regional and headquarters staff associated with issuance of NOEDs.

It is anticipated that the Enforcement Policy revision will have minimal, if any, impact on external stakeholders.

Paperwork Reduction Act

This policy statement does not contain new or amended information collection requirements subject to the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*) Existing requirements were approved by the Office of Management and Budget (OMB), approval number 3150–0136. The approved information collection requirements contained in this policy statement appear in Section VII.C.

Public Protection Notification

The NRC may not conduct or sponsor, and a person in not required to respond to, collection of information unless it displays a currently valid OMB control number.

Small Business Regulatory Enforcement Fairness Act

In accordance with the Small Business Regulatory Enforcement Fairness Act of 1996, the NRC had determined that this action is not a major rule and has verified this determination with the Office of Information and Regulatory Affairs of OMB.

Accordingly, the proposed revision to the NRC Enforcement Policy reads as follows:

General Statement of Policy and Procedure for NRC Enforcement Actions

* * * * *

VII. Exercise of Discretion

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C. Notice of Enforcement Discretion for Power Reactors and Gaseous Diffusion Plants

On occasion, circumstances may arise where a power reactor's compliance with a Technical Specification (TS) Limiting Condition for Operation or with other license conditions would involve an unnecessary plant transient or performance of testing, inspection, or system realignment that is inappropriate with the specific plant conditions, or unnecessary delays in plant startup without a corresponding health and safety benefit. Similarly, for a gaseous diffusion plant (GDP), circumstances may arise where compliance with a Technical Safety Requirement (TSR) or technical specification or other certificate condition would unnecessarily call for a total plant shutdown or, notwithstanding that a safety, safeguards, or security feature was degraded or inoperable, compliance would unnecessarily place the plant in a transient or condition where those features could be required.

In these circumstances, the NRC staff may choose not to enforce the applicable TS, TSR, or other license or certificate condition. This enforcement discretion, designated as a Notice of Enforcement Discretion (NOED), will only be exercised if the NRC staff is clearly satisfied that the action is consistent with protecting the public health and safety. The NRC staff may also grant enforcement discretion in cases involving severe weather or other natural phenomena, based upon balancing the public health and safety or common defense and security of not operating against the potential radiological or other hazards associated with continued operation, and a determination that safety will not be impacted unacceptably by exercising this discretion. The Commission is to be informed expeditiously following the granting of a NOED in these situations. A licensee or certificate holder seeking the issuance of a NOED must provide a written justification, or in circumstances where good cause is shown, oral justification followed as soon as possible by written justification, that documents the safety basis for the request and provides whatever other information necessary for the NRC staff to make a decision on whether to issue a NOED.

For power reactors, the appropriate Regional Administrator, or his or her designee, may issue a NOED after consultation with the Director, Office of Nuclear Reactor Regulation, or his or her designee, to determine the appropriateness of granting a NOED where (1) the noncompliance is temporary and nonrecurring when an amendment is not practical or (2) if the expected noncompliance will occur during the brief period of time it requires the NRC staff to process an emergency or exigent license amendment under the provisions of 10 CFR 50.91 (a)(5() or (6). For gaseous diffusion plants, the appropriate Regional Administrator, or his or her designee, may issue and document a NOED where the noncompliance is temporary and nonrecurring and when an amendment is not practical. The Director, Office of Nuclear Materials Safety and Safeguards, or his or her designee, may issue a NOED if the expected noncompliance will occur during the brief period of time it requires the NRC staff to process a certificate amendment under 10 CFR 76.45. The person exercising enforcement discretion will document the decision.

For an operating reactor, this exercise of enforcement discretion is intended to minimize the potential safety consequences of unnecessary plant transients with the accompanying operational risks and impacts or to eliminate testing, inspection, or system realignment which is inappropriate for the particular plant conditions. For plants in a shutdown condition, exercising enforcement discretion is intended to reduce shutdown risk by, again, avoiding testing, inspection or system realignment which is inappropriate for the particular plant conditions, in that, it does not provide a safety benefit or may, in fact, be detrimental to safety in the particular plant condition. Exercising enforcement discretion for plants attempting to startup is less likely than exercising it for an operating plant, as simply delaying startup does not usually leave the plant in a condition in which it could experience undesirable transients. In such cases, the Commission would expect that discretion would be exercised with respect to equipment or systems only when it has at least concluded that, notwithstanding the conditions of the license: (1) The equipment or system does not perform a safety function in the mode in which operation is to occur; (2) the safety function performed by the equipment or system is of only marginal safety benefit, provided remaining in the current mode increases the likelihood of an unnecessary plant transient; or (3) the TS or other license condition requires a test, inspection, or system realignment that is inappropriate for the particular plant conditions, in that it does not provide a safety benefit, or may, in fact, be detrimental to safety in the particular plant condition.

For GDPs, the exercise of enforcement discretion would be used where compliance with a certificate condition would involve an unnecessary plant shutdown or, notwithstanding that a safety, safeguards, or security feature was degraded or inoperable, compliance would unnecessarily place the plant in a transient or condition where those features could be required. Such regulatory flexibility is needed because a total plant shutdown is not necessarily the best response to a plant condition. GDPs are designed to operate continuously and have never been shut down. Although portions can be shut down for maintenance, the NRC staff has been informed by the certificate holder that restart from a total plant shutdown may not be practical and the staff agrees that the design of a GDP

does not make restart practical. Hence, the decision to place either GDP in plant-wide shutdown condition would be made only after determining that there is inadequate safety, safeguards, or security and considering the total impact of the shutdown on safety, the environment, safeguards, and security. A NOED would not be used for noncompliances with other than certificate requirements, or for situations where the certificate holder cannot demonstrate adequate safety, safeguards, or security.

The decision to exercise enforcement discretion does not change the fact that a violation will occur nor does it imply that enforcement discretion is being exercised for any violation that may have led to the violation at issue. In each case where the NRC staff has chosen to issue a NOED, enforcement action will normally be taken for the root causes, to the extent violations were involved, that led to the noncompliance for which enforcement discretion was used. The enforcement action is intended to emphasize that licensees and certificate holders should not rely on the NRC's authority to exercise enforcement discretion as a routine substitute for compliance or for requesting a license or certificate amendment.

Finally, it is expected that the NRC staff will exercise enforcement discretion in this area infrequently. Although a plant must shut down, refueling activities may be suspended, or plant startup may be delayed, absent the exercise of enforcement discretion, the NRC staff is under no obligation to take such a step merely because it has been requested. The decision to forego enforcement is discretionary. When enforcement discretion is to be exercised, it is to be exercised only if the NRC staff is clearly satisfied that the action is warranted from a health and safety perspective.

* * * * *

Dated at Rockville, MD, this 8th day of November, 2004.

For the Nuclear Regulatory Commission.

Annette L. Vietti-Cook,

Secretary of the Commission.

[FR Doc. 04–25260 Filed 11–12–04; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

[Docket No. 030–34325]

Notice of Availability of Environmental Assessment and Finding of No Significant Impact for License Amendment for Release of Facility for Unrestricted Use for the Department of Veterans Affairs Chicago Health Care System Lakeside Campus—Medical Sciences Building, Chicago, IL

AGENCY: Nuclear Regulatory Commission.

ACTION: Notice of availability.

FOR FURTHER INFORMATION CONTACT: William Snell, Senior Health Physicist, Decommissioning Branch, Division of Nuclear Material Safety, Region III, U.S. Nuclear Regulatory Commission, 2443 Warrenville Road, Lisle, Illinois 60532; telephone: (630) 829–9871; fax number: (630) 515–1259; e-mail: *wgs@nrc.gov.*

SUPPLEMENTARY INFORMATION:

I. Introduction

The Nuclear Regulatory Commission (NRC) is issuing a license amendment to Material License No. 03–23853–01VA issued to the Department of Veterans Affairs (DVA) (the licensee), to authorize release of its Chicago Health Care System, Lakeside Campus—Medical Sciences Building in Chicago, Illinois for unrestricted use, and has prepared an Environmental Assessment (EA) in support of this amendment in accordance with the requirements of 10 CFR part 51. Based on the EA, the NRC has concluded that a Finding of No Significant Impact (FONSI) is appropriate. The amendment will be issued following the publication of this notice.

II. EA Summary

The purpose of the proposed amendment is to allow for the release of the licensee's Chicago, Illinois facility for unrestricted use. The DVA has occupied the Chicago Health Care System, Lakeside Campus—Medical Sciences Building since 1978, and during that period was authorized to use byproduct, source, and special nuclear material for medical diagnosis, therapy, and research. The Chicago, Illinois facility is a permittee under the DVA NRC Master Material License (MML) Number 03–23853–01VA, and on October 1, 2004, requested the NRC release the facility for unrestricted use. The approval is consistent with a March 17, 2003, Letter of Understanding (LOU) between the NRC and DVA for DVA permittees. The LOU requires the DVA to submit for NRC review, permittee requests for the release of buildings for unrestricted use where radioactive materials with a half-life greater than 120 days were used. The DVA identified four isotopes with half-lives greater than 120 days that it used in the Medical Sciences Building: hydrogen-3, carbon-14, sodium-22, and chlorine-36. The DVA has conducted surveys of the facility and provided information to the NRC to demonstrate that the site meets the licensee termination criteria in subpart E of 10 CFR part 20 for unrestricted release.

The staff has prepared an EA in support of the proposed license amendment. Based on its review, the staff determined there were no radiological or non-radiological environmental impacts associated with the action since no radiological remediation activities were required to complete the proposed action. The staff has determined that the proposed action is administrative and/or procedural in nature and will not affect listed species or critical habitat. Likewise, NRC staff has determined that the proposed action is not the type of activity that has the potential to cause effects on historic properties because it is an administrative and/or procedural action.

III. Finding of No Significant Impact

The staff has prepared an EA in support of the proposed license amendment to release the site for unrestricted use. The staff has found that the radiological environmental impacts from the proposed amendment are bounded by the impacts evaluated by NUREG–1496, Volumes 1–3, ''Generic Environmental Impact Statement in Support of Rulemaking on Radiological Criteria for License Termination of NRC-Licensed Facilities'' (ML042310492, ML042320379, and ML042330385). The staff has also found that the non-radiological impacts are not significant. On the basis of the EA, NRC has concluded that there are no significant environmental impacts from the proposed amendment and has determined not to prepare an environmental impact statement.

IV. Further Information

Documents related to this action, including the application for amendment and supporting documentation, are available electronically at the NRC's Electronic Reading Room at *http://www.nrc.gov/reading-rm/adams.html.* From this site, you can access the NRC's Agencywide Document Access and Management System (ADAMS), which provides text

and image files of NRC's public documents. The ADAMS accession numbers for the documents related to this notice are: the DVA letter dated October 1, 2004 (Accession No. ML042920457); the Final Status Survey Report, VA Chicago—Lakeside Campus, Medical Sciences Building, September 9, 2004 (Accession No. ML042920463); and the EA summarized above (Accession No. ML043010491). Please note that on October 25, 2004, the NRC terminated public access to ADAMS and initiated an additional security review of publicly available documents to ensure that potentially sensitive information is removed from the ADAMS database accessible through the NRC's web site. Interested members of the public may obtain copies of the referenced documents for review and/or copying by contacting the Public Document Room pending resumption of public access to ADAMS. The NRC Public Documents Room is located at NRC Headquarters in Rockville, MD, and can be contacted at (800) 397–4209, (301) 415–4737 or by e-mail to *pdr@nrc.gov*.

These documents may also be viewed electronically on the public computers located at the NRC's PDR, O 1 F21, One White Flint North, 11555 Rockville Pike, Rockville, MD 20852. The PDR reproduction contractor will copy documents for a fee.

Dated in Lisle, Illinois, this 4th day of November 2004.

For the Nuclear Regulatory Commission,

Kenneth G. O'Brien,

Chief, Decommissioning Branch, Division of Nuclear Materials Safety, Region III.

[FR Doc. 04–25258 Filed 11–12–04; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

Advisory Committee on Nuclear Waste; Notice of Meeting

The Advisory Committee on Nuclear Waste (ACNW) will hold its 155th meeting on November 16–18, 2004, Room T–2B3, 11545 Rockville Pike, Rockville, Maryland.

The schedule for this meeting is as follows:

Tuesday, November 16, 2004

10:30 a.m.–10:40 a.m.: Opening Statement (Open)—The ACNW Chairman will open the meeting with brief opening remarks.

10:40 a.m.–11:40 a.m.: NMSS Division Directors' Semi-Annual Briefing (Open)—The Committee will be briefed by the Director, Division of High Level Waste Repository Safety and the Director, Division of Waste Management and Environmental Protection on recent activities of interest.

11:40 a.m.–12:40 p.m.: International Transportation Meetings (Open)—The Director, SFPO will report on recent international transportation-related meetings/activities of interest.

2 p.m.–3 p.m.: Format and Content of the U.S. Department of Energy Yucca Mountain License Application (Open)—The Committee will be briefed by a DOE representative on the general DOE format and content of the forthcoming DOE license application.

3:15 p.m.–5:15 p.m.: ACNW 2005 Action Plan (Open)—The ACNW Committee will continue its discussion of potential topics for inclusion in its draft 2005 Action Plan.

Wednesday, November 17, 2004

8:30 a.m.–8:35 a.m.: Opening Statement (Open)—The ACNW Chairman will make opening remarks regarding the conduct of today's sessions.

8:35 a.m.–10 a.m.: Working Group Planning Session (Open)—The Committee Members will discuss potential future activities including proposed 2005 working group meetings.

10 a.m.–12 Noon: Preparation of ACNW Reports (Open)—The Committee will discuss potential ACNW reports on matters discussed during this meeting. It may also discuss possible reports on matters discussed during prior meetings.

Thursday, November 18, 2004

8:30 a.m.–8:35 a.m.: Opening Remarks by the ACNW Chairman (Open)—The Chairman will make opening remarks regarding the conduct of today's sessions.

8:35 a.m.–12 Noon: Miscellaneous (Open)—The Committee will discuss matters related to the conduct of Committee activities and matters and specific issues that were not completed during previous meetings, as time and availability of information permit.

Procedures for the conduct of and participation in ACNW meetings were published in the **Federal Register** on October 18, 2004 (69 FR 61416). In accordance with these procedures, oral or written statements may be presented by members of the public. Electronic recordings will be permitted only during those portions of the meeting that are open to the public. Persons desiring to make oral statements should notify Mr. Howard J. Larson, (Telephone (301) 415–6805), between 7:30 a.m. and 4:00 p.m. e.t., as far in advance as practicable so that appropriate arrangements can be made to schedule the necessary time during the meeting for such statements. Use of still, motion picture, and television cameras during this meeting will be limited to selected portions of the meeting as determined by the ACNW Chairman. Information regarding the time to be set aside for taking pictures may be obtained by contacting the ACNW office prior to the meeting. In view of the possibility that the schedule for ACNW meetings may be adjusted by the Chairman as necessary to facilitate the conduct of the meeting, persons planning to attend should notify Mr. Howard J. Larson as to their particular needs.

Further information regarding topics to be discussed, whether the meeting has been canceled or rescheduled, the Chairman's ruling on requests for the opportunity to present oral statements and the time allotted, therefore can be obtained by contacting Mr. Howard J. Larson.

ACNW meeting agenda, meeting transcripts, and letter reports are available through the NRC Public Document Room at *pdr@nrc.gov,* or by calling the PDR at 1–800–397–4209, or from the Publicly Available Records System (PARS) component of NRC's document system (ADAMS) which is accessible from the NRC Web site at *http://www.nrc.gov/reading-rm/adams.html* or *http://www.nrc.gov/reading-rm/doc-collections/* (ACRS & ACNW Mtg schedules/agendas).

Video Teleconferencing service is available for observing open sessions of ACNW meetings. Those wishing to use this service for observing ACNW meetings should contact Mr. Theron Brown, ACNW Audiovisual Technician (301) 415–8066), between 7:30 a.m. and 3:45 p.m. e.t., at least 10 days before the meeting to ensure the availability of this service. Individuals or organizations requesting this service will be responsible for telephone line charges and for providing the equipment and facilities that they use to establish the video teleconferencing link. The availability of video teleconferencing services is not guaranteed.

Dated: November 8, 2004.

Andrew L. Bates,

Advisory Committee Management Officer.

[FR Doc. 04–25259 Filed 11–12–04; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

[Docket No. 40–8904]

Establishment of the U.S. Department of Energy as the Long-Term Custodian of the L-Bar Uranium Mill Tailings Site Near Seboyeta, NM, and Termination of the Sohio Western Mining Company Source Materials License for the L-Bar Site

AGENCY: Nuclear Regulatory Commission.

ACTION: Notice of establishment of the U.S. Department of Energy (DOE) as the long-term custodian of the L-Bar uranium mill tailings site near Seboyeta, New Mexico, under the general license provisions of 10 CFR 40.28, and termination of the Sohio Western Mining Company specific Source Materials License SUA–1472 for the L-Bar site.

FOR FURTHER INFORMATION CONTACT: Rick Weller, Project Manager, Fuel Cycle Facilities Branch, Division of Fuel Cycle Safety and Safeguards, Office of Nuclear Material Safety and Safeguards, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001. Telephone: (301) 415–7287; fax number: (301) 415–5955; e-mail: *rmw2@nrc.gov.*

SUPPLEMENTARY INFORMATION:

I. Introduction

On September 22, 2004, the Sohio Western Mining Company (SWMC) transferred ownership of the L-Bar uranium mill tailings site near Seboyeta, New Mexico, to the DOE, as required by 10 CFR 40, Appendix A, Criterion 11, prior to termination of SWMC's specific license. Subsequently, by letter dated October 13, 2004, the DOE submitted the final Long-Term Surveillance Plan (LTSP) for the L-Bar site for review by the U.S. Nuclear Regulatory Commission (NRC). Based on the review of the LTSP, the NRC has determined that the LTSP satisfies the requirements in 10 CFR part 40, Appendix A, Criterion 12, and § 40.28 for the long-term surveillance of a tailings disposal site. Accordingly, notice is hereby given that the NRC has accepted the LTSP for the L-Bar site. This acceptance establishes the DOE as the long-term custodian and caretaker of the L-Bar site under the general license specified in 10 CFR 40.28. In a concurrent action, the NRC has terminated the SWMC specific Source Materials License SUA–1472 for the L-Bar site. These actions complete all requirements for closure of the L-Bar site under the Uranium Mill Tailings Radiation Control Act of 1978, as amended. These actions do not require an environmental assessment as they are categorically excluded under 10 CFR 51.22(c)(11).

II. Further Information

The NRC has prepared correspondence which documents the actions that establish the DOE as the long-term custodian of the L-Bar site under the general license specified in 10 CFR 40.28 and terminate the SWMC specific Source Materials License SUA–1472 for the L-Bar site. In accordance with 10 CFR 2.390 of the NRC's ''Rules of Practice,'' copies of this correspondence, as well as the L-Bar LTSP submitted by DOE letter dated October 13, 2004, are available electronically at the NRC's Electronic Reading Room at *http://www.nrc.gov/reading-rm/adams.html.* From this site, you can access the NRC's Agencywide Document Access and Management System (ADAMS), which provides text and image files of NRC's public documents. The ADAMS accession numbers for the documents related to this notice are listed below. If you do not have access to ADAMS or if there are problems in accessing the documents located in ADAMS, contact the NRC Public Document Room (PDR) Reference staff at 1–800–397–4209, 301–415–4737, or by e-mail to *pdr@nrc.gov.*

Documents Related to This Notice

1. Letter dated October 13, 2004, from J. Sink, DOE, to G. Janosko, NRC, submitting the final LTSP for the L-Bar site. ML042920474.

2. Letter dated October 21, 2004, from G. Janosko, NRC, to J. Sink, DOE, accepting the final LTSP for the L-Bar site. ML043020020.

3. Letter dated October 21, 2004, from G. Janosko, NRC, to J. Trummel, Kennecott Energy Company, terminating the SWMC specific Source Materials License SUA–1472 for the L-Bar site. ML043020032.

These documents may also be viewed electronically on the public computers located at the NRC's PDR, O 1 F21, One White Flint North, 11555 Rockville Pike, Rockville, MD 20852. The PDR reproduction contractor will copy documents for a fee.

Dated in Rockville, Maryland, this 5th day of November, 2004.

For the Nuclear Regulatory Commission.

Gary S. Janosko,

Chief, Fuel Cycle Facilities Branch, Division of Fuel Cycle Safety and Safeguards, Office of Nuclear Material Safety and Safeguards.

[FR Doc. 04–25257 Filed 11–12–04; 8:45 am]

BILLING CODE 7590–01–P

PENSION BENEFIT GUARANTY CORPORATION

Required Interest Rate Assumption for Determining Variable-Rate Premium; Interest Assumptions for Multiemployer Plan Valuations Following Mass Withdrawal

AGENCY: Pension Benefit Guaranty Corporation.

ACTION: Notice of interest rates and assumptions.

SUMMARY: This notice informs the public of the interest rates and assumptions to be used under certain Pension Benefit Guaranty Corporation regulations. These rates and assumptions are published elsewhere (or can be derived from rates published elsewhere), but are collected and published in this notice for the convenience of the public. Interest rates are also published on the PBGC's Web site (*http://wow.pbgc.go*).

DATES: The required interest rate for determining the variable-rate premium under part 4006 applies to premium payment years beginning in November 2004. The interest assumptions for performing multiemployer plan valuations following mass withdrawal under part 4281 apply to valuation dates occurring in December 2004.

FOR FURTHER INFORMATION CONTACT: Harold J. Ashier, Assistant General Counsel, Office of the General Counsel, Pension Benefit Guaranty Corporation, 1200 K Street, NW., Washington, DC 20005, 202–326–4024. (TTY/TDD users may call the Federal relay service toll-free at 1–800–877–8339 and ask to be connected to 202–326–4024.)

SUPPLEMENTARY INFORMATION:

Variable-Rate Premiums

Section 4006(a)(3)(E)(iii)(II) of the Employee Retirement Income Security Act of 1974 (ERISA) and § 4006.4(b)(1) of the PBGC's regulation on Premium Rates (29 CFR part 4006) prescribe use of an assumed interest rate (the ''required interest rate'') in determining a single-employer plan's variable-rate premium. Pursuant to the Pension Funding Equity Act of 2004, for premium payment years beginning in 2004 or 2005, the required interest rate is the ''applicable percentage'' (currently 85 percent) of the annual rate of interest determined by the Secretary of the Treasury on amounts invested conservatively in long-term investment grade corporate bonds for the month preceding the beginning of the plan year for which premiums are being paid. Thus, the required interest rate to be used in determining variable-rate premiums for premium payment years

beginning in November 2004 is 4.73 percent (*i.e.*, 85 percent of the 5.57 percent composite corporate bond rate for October 2004 as determined by the Treasury).

The following table lists the required interest rates to be used in determining variable-rate premiums for premium payment years beginning between December 2003 and November 2004. Note that the required interest rate for premium payment years beginning in December 2003 was determined under the Job Creation and Worker Assistance Act of 2002, and that the required interest rates for premium payment years beginning in January through November 2004 were determined under the Pension Funding Equity Act of 2004.

For premium payment years beginning in:	The required interest rate is:
December 2003*	5.12
January 2004**	4.94
February 2004**	4.83
March 2004**	4.79
April 2004**	4.62
May 2004**	4.98
June 2004**	5.26
July 2004**	5.25
August 2004**	5.10
September 2004**	4.95
October 2004**	4.79
November 2004**	4.73

* The required interest rate for premium payment years beginning in December 2003 was determined under the Job Creation and Worker Assistance Act of 2002.

** The required interest rates for premium payment years beginning in January through November 2004 were determined under the Pension Funding Equity Act of 2004.

Multiemployer Plan Valuations Following Mass Withdrawal

The PBGC's regulation on Duties of Plan Sponsor Following Mass Withdrawal (29 CFR part 4281) prescribes the use of interest assumptions under the PBGC's regulation on Allocation of Assets in Single-Employer Plans (29 CFR part 4044). The interest assumptions applicable to valuation dates in December 2004 under part 4044 are contained in an amendment to part 4044 published elsewhere in today's **Federal Register**. Tables showing the assumptions applicable to prior periods are codified in appendix B to 29 CFR part 4044.

Issued in Washington, DC, on this day of November 2004.

Joseph H. Grant,

Deputy Executive Director and Chief Operating Officer, Pension Benefit Guaranty Corporation.

[FR Doc. 04–25321 Filed 11–12–04; 8:45 am]

BILLING CODE 7708–01–P

RAILROAD RETIREMENT BOARD

Agency Forms Submitted for OMB Review

Summary: In accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35), the Railroad Retirement Board (RRB) has submitted the following proposal(s) for the collection of information to the Office of Management and Budget for review and approval.

Summary of Proposal(s)

(1) *Collection title:* Report of Medicaid State Office on Beneficiary's Buy-In-Status.

(2) *Form(s) submitted:* RL–380–F.

(3) *OMB Number:* 3220–0185.

(4) *Expiration date of current OMB clearance:* 02/28/2005.

(5) *Type of request:* Extension of a currently approved collection.

(6) *Respondents:* State, local or tribal government.

(7) *Estimated annual number of respondents:* 600.

(8) *Total annual responses:* 600.

(9) *Total annual reporting hours:* 100.

(10) *Collection description:* Under the Railroad Retirement Act, the Railroad Retirement Board administers the Medicare program for persons covered by the railroad retirement system. The collection obtains the information needed to determine if certain railroad beneficiaries are entitled to receive Supplementary Medical Insurance program coverage under a state buy-in agreement in states in which they reside.

Additional Information or Comments

Copies of the forms and supporting documents can be obtained from Charles Mierzwa, the agency clearance officer (312–751–3363).

Comments regarding the information collection should be addressed to Ronald J. Hodapp, Railroad Retirement Board, 844 North Rush Street, Chicago, Illinois, 60611–2092 and to the OMB Desk Officer for the RRB, at the Office of Management and Budget, Room 10230, New Executive Office Building, Washington, DC 20503.

Charles Mierzwa,

Clearance Officer.

[FR Doc. 04–25290 Filed 11–12–04; 8:45 am]

BILLING CODE 7905–01–P

SECURITIES AND EXCHANGE COMMISSION

Sunshine Act Meeting

Notice is hereby given, pursuant to the provisions of the Government in the Sunshine Act, Pub. L. 94–409, that the Securities and Exchange Commission will hold the following meeting during the week of November 15, 2004:

A closed meeting will be held on Tuesday, November 16, 2004, at 2 p.m.

Commissioners, Counsel to the Commissioners, the Secretary to the Commission, and recording secretaries will attend the closed meeting. Certain staff members who have an interest in the matters may also be present.

The General Counsel of the Commission, or his designee, has certified that, in his opinion, one or more of the exemptions set forth in 5 U.S.C. 552b(c)(3), (5), (6), (7), (9)(B), and (10) and 17 CFR 200.402(a)(3), (5), (7), 9(ii) and (10), permit consideration of the scheduled matters at the closed meeting.

Commissioner Atkins, as duty officer, voted to consider the items listed for the closed meeting in closed session.

The subject matter of the closed meeting scheduled for Tuesday, November 16, 2004, will be:

Formal orders of investigations;

Institution and settlement of injunctive actions; and

Institution and settlement of administrative proceedings of an enforcement nature.

At times, changes in Commission priorities require alterations in the scheduling of meeting items. For further information and to ascertain what, if any, matters have been added, deleted or postponed, please contact:

The Office of the Secretary at (202) 942–7070.

Dated: November 9, 2004.

Jonathan G. Katz,

Secretary.

[FR Doc. 04–25381 Filed 11–10–04; 11:00 am]

BILLING CODE 8010–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–50642; File No. SR–FICC–2004–06]

Self-Regulatory Organizations; Fixed Income Clearing Corporation; Notice of Filing of Proposed Rule Change To Institute Fines for Late Payment of Cash Obligations and Margin and To Institute Informal Hearing Procedures for Fine Disputes

November 5, 2004.

Pursuant to section 19(b)(1) of the Securities Exchange Act of 1934 (''Act''),[1] notice is hereby given that on March 18, 2004, the Fixed Income

[1] 15 U.S.C. 78s(b)(1).

Clearing Corporation (''FICC'') filed with the Securities and Exchange Commission (''Commission'') and on April 16, 2004, amended the proposed rule change described in items I, II, and III below, which items have been prepared primarily by FICC. The Commission is publishing this notice to solicit comments on the proposed rule change from interested parties.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The purpose of the proposed rule change is to institute at the Mortgage Backed Securities Division (''MBSD'') (i) fines for the late payment of cash obligation items [2] and margin deficits and (ii) informal hearing procedures for disputed MBSD fines.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, FICC included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in item IV below. FICC has prepared summaries, set forth in sections (A), (B), and (C) below, of the most significant aspects of these statements.[3]

(A) Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

The purpose of the proposed rule change is to institute at the MBSD (i) fines for the late payment of cash obligation items and margin deficits and (ii) informal hearing procedures for disputed MBSD fines.

1. Fines for Late Payments

The MBSD has for some time imposed fees in order to promote greater compliance with its cash obligation and margin payment deadlines.[4] Fees differ from fines in that fines must be reported by FICC to the Commission. FICC management believes that, consistent with the practice of the Government Securities Division (''GSD'') of FICC, assessments for late payment of margin and cash obligation items should be categorized as fines. Management believes that this change will provide a greater incentive for participant compliance with appropriate payment timeframes which will reduce risk to all MBSD participants.

2. Procedures Relating to Disputed Fines

The rules of the MBSD currently contain procedures whereby a participant can dispute any fine assessment through a formal appeal process. FICC believes that, consistent with the practice of the GSD, the fine process would be more effective and equitable and would provide participants with additional due process if an initial less formal dispute process was also included in MBSD's rules. The initial dispute process would be utilized by participants prior to availing themselves of the formal appeal process. A participant that becomes subject to a fine would have the opportunity within seven calendar days to dispute the fine by explaining in writing any mitigating circumstances that contributed to the participant's infraction and to request a fine waiver. Based on such written documentation provided by the participant, management would have the discretion to waive a fine if it believed that sufficient mitigating circumstances had been shown by the participant. If management waives a fine, it would have to inform the Membership and Risk Management Committee (''Committee'') at the next regularly scheduled Committee meeting and would have to explain management's reasons for doing so. The Committee would then have the opportunity to overrule management's action with respect to the waiver. If management chooses to not waive a fine or if its waiver is overruled by the Committee, the participant would have the right to pursue the formal hearing process currently provided for in the FICC Rules.

FICC is proposing to make parallel changes with respect to the fine dispute process to the MBSD's EPN rules.

In addition, FICC is proposing certain technical changes to the MBSD's Schedules of Charges to (i) delete references to ''MBSCC'' and replace them with references to ''MBSD'' and (ii) eliminate obsolete fees which are no longer being charged by the MBSD.

FICC believes that the proposed rule change is consistent with the requirements of section 17A of the Act [5] and the rules and regulations thereunder applicable to FICC because it is designed to perfect the mechanism of a national system for the prompt and accurate clearance and settlement of securities transactions by (i) encouraging participants to make timely payments of cash obligation items and margin to MBSD and (ii) clearly setting forth in FICC's rules procedures for management's review and possible waiver of fines which should provide members with a more efficient and less burdensome method for the possible resolution of disputed fines before a full hearing takes place.

(B) Self-Regulatory Organization's Statement on Burden on Competition

FICC does not believe that the proposed rule change will have any impact or impose any burden on competition.

(C) Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants or Others

Written comments relating to the proposed rule change have not yet been solicited or received. FICC will notify the Commission of any written comments received by FICC.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Within 35 days of the date of publication of this notice in the **Federal Register** or within such longer period (i) as the Commission may designate up to ninety days of such date if it finds such longer period to be appropriate and publishes its reasons for so finding or (ii) as to which the self-regulatory organization consents, the Commission will:

(A) By order approve such proposed rule change or

(B) Institute proceedings to determine whether the proposed rule change should be disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an E-mail to *rule-comments@sec.gov*. Please include File Number SR–FICC–2004–06 on the subject line.

[2] Cash obligation items are cash receivables/payables that have been assigned a due date by the MBSD.

[3] The Commission has modified the text of the summaries prepared by FICC.

[4] Currently, the MBSD rules state that failure to pay a cash settlement obligation will result in the assessment of a fine. However, the MBSD Schedule of Charges refers to such charges as ''fees,'' and they have been processed as fees by MBSD in the past.

[5] 15 U.S.C. 78q–1.

Paper Comments

• Send paper comments in triplicate to Jonathan G. Katz, Secretary, Securities and Exchange Commission, 450 Fifth Street, NW., Washington, DC 20549–0609.

All submissions should refer to File Number SR–FICC–2004–06. This file number should be included on the subject line if e-mail is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Section, 450 Fifth Street, NW., Washington, DC 20549. Copies of such filing also will be available for inspection and copying at the principal office of FICC and on FICC's Web site at *http://www.ficc.com*. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly.

All submissions should refer to File Number SR–FICC–2004–06 and should be submitted on or before December 6, 2004.

For the Commission by the Division of Market Regulation, pursuant to delegated authority.[6]

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. E4–3157 Filed 11–12–04; 8:45 am]

BILLING CODE 8010–01–P

[6] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–50640; File No. SR–NASD–2004–172]

Self-Regulatory Organizations; National Association of Securities Dealers, Inc.; Notice of Filing and Immediate Effectiveness of Proposed Rule Change Regarding Pilot Modifications and Minor Modifications to the Nasdaq Opening Process for Nasdaq-Listed Stocks

November 5, 2004.

Pursuant to section 19(b)(1) of the Securities Exchange Act of 1934 (''Act''),[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on November 3, 2004, the National Association of Securities Dealers, Inc. (''NASD''), through its subsidiary, The Nasdaq Stock Market, Inc. (''Nasdaq''), filed with the Securities and Exchange Commission (''Commission'') the proposed rule change as described in items I and II below, which items have been prepared by Nasdaq. Nasdaq has designated the proposed rule change as ''non-controversial'' under section 19(b)(3)(A) of the Act [3] and Rule 19b–4(f)(6) thereunder,[4] which renders the proposed rule change effective upon filing with the Commission. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

Nasdaq is filing the proposed rule change to modify the opening process for Nasdaq securities as follows: (1) Establish a three-month pilot during which Nasdaq would reject the entry of Total Day Orders prior to 9:25 a.m.; (2) clarify the language of Rule 4704(a)(8) which governs the suspension between 9:28 and 9:30 a.m. of requests for cancellation or modification of Regular Hours Orders; and (3) clarify the language of Rule 4120(a)(7) which governs the opening of stocks that are subject to a trade halt. The text of the proposed rule change is set forth below.[5] Proposed new language is in italics; proposed deletions are in [brackets].[6]

* * * * *

4120. Trading Halts

(a) No Change.

(b) Procedure for Initiating a Trading Halt.

(1)–(6) No Change.

(7) A trading halt initiated under Rule 4120(a)(7) shall be terminated when Nasdaq releases the security for trading. Prior to terminating the halt, there will be a 15-minute period during which market participants may enter quotes in that security in Nasdaq systems. [If the inside market is not locked or crossed at the conclusion of that 15-minute period, Nasdaq will release the security for trading and terminate the halt. If the inside market is locked or crossed at the conclusion of the initial 15-minute period, Nasdaq will extend the halt for an additional 15 minutes during which quotations may be entered in Nasdaq systems.] At the conclusion of the [second] 15-minute period, the halt shall be terminated and the security released for trading.

* * * * *

4701. Definitions

(a)–(rr) No Change.

(ss) The term ''Total Day'' or ''X Order'' shall mean,

(a) No Change.

(b) For orders in Nasdaq-listed securities so designated, that if after entry into the Nasdaq Market Center, the order is not fully executed, the order (or unexecuted portion thereof) shall remain available for potential display [between 7:30 a.m. and 4:00 p.m. and for potential] *and* execution between 9:25 a.m. and 4:00 p.m., after which it shall be returned to the entering party. *X Orders entered prior to 9:25 a.m. will be rejected back to the entering party.*

(tt)–(uu) No Change.

* * * * *

4704. Opening Process for Nasdaq-Listed Securities

(a) Definitions. For the purposes of this rule the term:

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] 15 U.S.C. 78s(b)(3)(A).

[4] 17 CFR 240.19b–4(f)(6).

[5] The proposed rule change is marked to show changes from the rule text appearing in the NASD Manual available at *www.nasd.com* and the rule text approved by the Commission in Securities Exchange Act Release No. 50405 (September 16, 2004), 69 FR 57118 (September 23, 2004) (SR–NASD–2004–071), and amended in Securities Exchange Act Release No. 50602 (October 28, 2004), 69 FR 64350 (November 4, 2004) (SR–NASD–2004–152). This sentence was corrected by the Commission to reflect the fact that the NASD Manual available at *www.nasd.com* has not been updated to include the rule text for NASD Rule 4704. Telephone conversation between Jeffrey S. Davis, Associate Vice President and Associate General Counsel, Nasdaq, and Ann E. Leddy, Special Counsel, Division of Market Regulation (''Division''), Commission (November 4, 2004).

[6] The Commission corrected proposed rule text on Nasdaq's behalf to mark changes in Rule 4704(a)(8) and new subparagraph (b)(3). Telephone conversation between Jeffrey S. Davis, Associate Vice President and Associate General Counsel, Nasdaq, and Ann E. Leddy, Special Counsel, Division, Commission (November 4, 2004).

(1)–(7) No Change.

(8) ''Regular Hours Orders'' shall mean any order that may be entered into the system and designated with a time-in-force of IOC, DAY, or GTC. Regular Hours Orders shall be available for execution only during the opening and then during normal trading hours. Regular Hours Orders shall be designated as ''Early Regular Hours Orders'' if entered into the system prior to 9:28 a.m. and designated as ''Late Regular Hours Orders'' if entered into the system at 9:28 a.m. or after. Beginning at 9:28 a.m., requests to cancel or modify Regular Hours Orders shall be suspended until after completion of the Opening Cross at which time such requests shall be processed*, to the extent that such orders remain available within the system.*

(b) Trading Prior To Normal Market Hours. The system shall open all eligible Quotes[/Orders] in Nasdaq-listed securities at 9:25 a.m. in the following manner to prevent the creation of locked/crossed markets.

(1) At 9:25 a.m., the system shall open all Quotes [and limit priced X Orders] in time priority. Quotes [and X Orders] whose limit price does not lock or cross the book shall be added to the book in strict time priority. Quotes [and X Orders] whose limit price would lock or cross the book shall be placed in an ''In Queue'' state.

(2) Next, the system shall begin processing the In Queue Quotes[, IOX Orders, and X Orders] in strict time priority against the best bid (ask) if the In Queue order is a sell (buy) order. If an In Queue Quote [or X Order] is not executable when it is next in time for execution, the system shall automatically add that Quote [or X Order] to the book.

[(3) All Quotes and X Orders that are entered while the system is completing subparagraphs (1) and (2) shall be added to the In Queue file in strict time priority.]

([4]*3*) Once the process set forth in subparagraphs (1)–([3]*2*) is complete, the system shall begin processing Quotes and X and IOX Orders in accordance with their entry parameters

(5)–(6) Re-numbered as (4) and (5).

(c)–(d) No Change.

* * * * *

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, Nasdaq included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in item IV below. Nasdaq has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

Nasdaq has previously proposed to create two new voluntary opening processes—the Modified Opening Process and the Nasdaq Opening Cross—that together constitute the beginning of the trading day for all Nasdaq-listed securities. The Commission approved that proposal on September 16, 2004.[7] Upon implementation of the Opening Cross, Nasdaq has identified several modifications to the operation and rules governing the pre-opening trading environment that it believes would improve the fair and orderly opening of the market in Nasdaq listed securities.

Specifically, upon implementing the improved pre-opening trading environment set forth in Rule 4704(b), Nasdaq identified a harmful unintended consequence of the Modified Opening Process (''MOP'') by which Nasdaq establishes its opening order book and unlocks and uncrosses the market. As described in SR–NASD–2004–071, firms have three options for determining the price at which their carryover quotes are opened at 9:25: (1) The last quotation price entered during the previous day; (2) the last quotation price the firm enters after 7:30 and before 9:25 a.m.; or (3) the quote limits for Nasdaq, currently $.01 (bid) and $2,000 (ask). Many Nasdaq participants have programmed their quotation management systems to select the first option, carrying over the final quotation entered during the previous trading day. At the same time, a small number of firms have entered X Orders into Nasdaq's system that cross the market by a significant amount, in some cases by as much as 20 dollars. When Nasdaq applies the MOP, which automatically executes orders that would cross the market, the system executes those X Orders that are significantly away from the market against the stale carryover quotations of other members resulting in inferior executions.

To address this situation quickly, Nasdaq proposes to change the pre-opening trading environment for a three-month pilot period. Specifically, Nasdaq proposes to move the beginning entry time for X Orders from 7:30 a.m. to 9:25 a.m. As a result, X Orders would not participate in the market opening process described in Rule 4704(b), which begins at 9:25 a.m., and there would be no risk of X Orders automatically executing against a stale quote during that process. Nasdaq believes that this proposed change is necessary and sufficient to address quickly the harmful unintended consequence described above and preserve a fair and orderly opening of trading in Nadsaq. Nasdaq is aware that these changes impose a burden on some firms, but it has concluded that this approach would be the fastest way to effectively address the situation and improve the quality of executions in the MOP. It is important to note that participation in pre-opening trading is completely voluntary on firms' part, that the actual opening of the market and concomitant market maker obligations would continue to begin at 9:30 a.m. as is the case today.

In addition, Nasdaq is already designing further system modifications that would address the problem on a permanent basis. Specifically, Nasdaq is considering three potential changes: (1) Applying the Market Opening Process at 9 a.m. rather than 9:25 as currently approved; (2) extending the availability of Total Day and Total Immediate or Cancel Orders to 9 a.m. from 9:25 as currently approved; and (3) establishing a system default that protects market participants from unexpected executions upon the opening of Nasdaq's execution functionality at 9 a.m. These modifications would provide a more efficient long-term solution, but they would take longer to implement than simply rejecting X Orders until 9:25. Nasdaq believes it is imperative to address the situation quickly and to simultaneously pursue a long-term solution.

Nasdaq has identified two additional technical modifications, unrelated to the substantive proposal at hand, that it believes would eliminate potential confusion about the effect of Nasdaq's approved rules. First, Nasdaq proposes to clarify that requests for suspension or modification of orders governed by Rule 4704(a)(8) would be processed only if such orders remain available for execution within Nasdaq's system. Such orders would not be available if, for example, the system executed the order during the Nasdaq Opening Cross or during the opening process for non-cross eligible Nasdaq securities.

[7] *See,* Securities Exchange Act Release No. 50405 (September 16, 2004), 69 FR 57118 (September 23, 2004) (SR–NASD–2004–071).

Second, Nasdaq proposes to modify the language of Rule 4120(a)(7) to clarify the manner in which Nasdaq will open trading in stocks that are the subject of an initial public offering (''IPO''). Currently Rule 4120(a)(7) provides for up to two 15-minute Quote Only Periods prior to the release of trading in an IPO. The second quote only period is necessary only in the event that the market is locked or crossed at the end of the first quote only period. The MOP is designed to create an unlocked and uncrossed bid and offer for the opening of trading, and to execute quotes and orders that would lock or cross the market in a fair and orderly manner. Because Nasdaq would apply the MOP at the close of the first 15-minute Quote Only Period, and the MOP will automatically unlock/uncross the market, the second 15-minute period is unnecessary.

2. Statutory Basis

Nasdaq believes that the proposed rule change is consistent with the provisions of section 15A of the Act,[8] in general, and with section 15A(b)(6) of the Act,[9] in particular, in that section 15A(b)(6) requires, among other things, that the NASD's rules be designed to protect investors and the public interest. Nasdaq believes that its current proposal is consistent with the NASD's obligations under these provisions of the Act because it would result in a more orderly opening for all Nasdaq stocks. The proposed rule change would create a fair, orderly, and unified opening for Nasdaq stocks, prevent the occurrence of locked and crossed markets in halted securities, and preserve price discovery and transparency that is vital to an effective opening of trading.

B. Self-Regulatory Organization's Statement on Burden on Competition

Nasdaq does not believe that the proposed rule change would result in any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants or Others

Nasdaq neither solicited nor received written comments with respect to the proposed rule change.

[8] 15 U.S.C. 78*o*–3.

[9] 15 U.S.C. 78*o*–3(b)(6).

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Because the foregoing proposed rule change does not:

(i) Significantly affect the protection of investors or the public interest;

(ii) Impose any significant burden on competition; and

(iii) Become operative for 30 days from the date on which it was filed, or such shorter time as the Commission may designate, if consistent with the protection of investors and the public interest,[10] it has become effective pursuant to section 19(b)(3)(A) of the Act[11] and Rule 19b–4(f)(6) thereunder.[12] At any time within 60 days of the filing of the proposed rule change, the Commission may summarily abrogate such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act.

Nasdaq has requested that the Commission waive the 30-day operative delay. The Commission believes that waiving the 30-day operative delay is consistent with the protection of investors and the public interest because it will allow Nasdaq to implement the proposed pilot without delay, which should provide a temporary remedy to the problem posed by X Orders automatically executing against stale quotes during the MOP. The Commission also believes that waiving the 30-day operative delay would permit Nasdaq to effect the clarifying changes to Rule 4120(b)(7) and Rule 4704(a)(8) without delay. For this reason, the Commission designates the proposal to be effective and operative upon filing with the Commission.[13]

[10] The Commission revised this section to add the representations on Nasdaq's behalf that the proposed rule change does not significantly affect the protection of investors or the public interest and does not impose any significant burden on competition. Nasdaq made these representations in the filing itself but failed to include them in the exhibit. Telephone conversation between Jeffrey S. Davis, Associate Vice President and Associate General Counsel, Nasdaq, and Ann E. Leddy, Special Counsel, Division, Commission (November 4, 2004).

[11] 15 U.S.C. 78s(b)(3)(A).

[12] 17 CFR 240.19b–4(f)(6). The Commission notes that Nasdaq provided written notice of its intent to file the proposed rule change, along with a brief description and text of the proposed rule change at least five business days prior to the date of filing of the proposed rule change.

[13] For purposes only of waiving the 30-day operative delay of the proposed rule change, the Commission considered the proposed rule's impact on efficiency, competition, and capital formation. 15 U.S.C. 78c(f).

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form *(http://www.sec.gov/rules/sro.shtml);* or
- Send an e-mail to *rule-comments@sec.gov.* Please include File Number SR–NASD–2004–172 on the subject line.

Paper Comments

- Send paper comments in triplicate to Jonathan G. Katz, Secretary, Securities and Exchange Commission, 450 Fifth Street, NW., Washington, DC 20549–0609.

All submissions should refer to File Number SR–NASD–2004–172. This file number should be included on the subject line if e-mail is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site *(http://www.sec.gov/rules/sro.shtml).* Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Room. Copies of such filing also will be available for inspection and copying at the principal office of the NASD. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–NASD–2004–172 and should be submitted on or before December 6, 2004.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[14]

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. E4–3160 Filed 11–12–04; 8:45 am]

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SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–50647; File No. SR–NASD–2004–158]

Self-Regulatory Organizations; Notice of Filing and Immediate Effectiveness of Proposed Rule Change by the National Association of Securities Dealers, Inc. To Establish Fee for Direct ECN Connections to the Nasdaq Market Center

November 8, 2004.

Pursuant to section 19(b)(1) of the Securities Exchange Act of 1934 (''Act''),[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on October 22, 2004, the National Association of Securities Dealers, Inc. (''NASD''), through its subsidiary, the Nasdaq Stock Market, Inc. (''Nasdaq''), filed with the Securities and Exchange Commission (''Commission'') the proposed rule change as described in items I, II, and III below, which Items have been prepared by Nasdaq. Nasdaq has designated this proposal as one establishing or changing a due, fee, or other charge imposed by the self-regulatory organization under section 19(b)(3)(A)(ii) of the Act[3] and Rule 19b–4(f)(2) thereunder,[4] which renders the rule effective upon Commission receipt of this filing. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of the Substance of the Proposed Rule Change

Nasdaq proposes to establish a fee for direct connections by electronic communication networks (''ECNs'') to the Nasdaq Market Center. Nasdaq will implement the proposed rule change immediately. The text of the proposed rule change is below. Proposed new language is in italic.

7000. Charges for Services and Equipment

7010. System Services

(a)–(e) No change.

(f) Nasdaq Workstation™ Service.

(1) (A) The following charges shall apply to the receipt of Level 2 or Level 3 Nasdaq Service via equipment and communications linkages prescribed for the Nasdaq Workstation II Service:

Service Charge	$2,035/month per service delivery platform (''SDP'') connected via T1 circuits; $1,000/month per SDP connected via Digital Subscriber Line (''DSL''), plus $1,000 per DSL early termination fee if service is terminated within 60 days of installation.
Display Charge	$525/month per logon for the first 150 logons; $200/month for each additional logon.
Additional Circuit/SDP Charge	$3,235/month.
PD and SDP Maintenance:	
Monthly maintenance agreement	$55/presentation device (''PD'') logon or SDP/month.
Hourly fee for maintenance provided without monthly maintenance agreement.	$195 per hour (two hour minimum), plus cost of parts.
ECN Direct Connection	*$1,000 per port pair per month.*

(2) No change.

(g)–(w) No change.

* * * * *

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, Nasdaq included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in item IV below. Nasdaq has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

Currently, ECNs connect to Nasdaq through an application programming interface (''API'') protocol that relies upon a Service Delivery Platform (''SDP''), a server machine containing Nasdaq-installed software that is located at the premises of the ECN. Nasdaq is now introducing an option for ECNs to connect to Nasdaq through a dedicated point-to-point linkage to Nasdaq Market Center host computers, rather than through an SDP. Nasdaq believes that allowing ECNs to establish a direct connection will enhance their ability to interact with the Nasdaq Market Center in an efficient manner, and that those ECNs that continue to quote in Nasdaq will respond favorably to being allowed to establish direct connections. In fact, one such ECN has already commenced testing such a connection and is prepared to avail itself of the service once it is made available. Accordingly, Nasdaq is proposing to offer such connections at a fee of $1,000 per port pair per month, as an alternative to an SPD/API connection. This fee compares favorably with the current fee of $2,035 per SPD per month.[5]

2. Statutory Basis

Nasdaq believes that the proposed rule change is consistent with the provisions of section 15A of the Act,[6] in general, and sections 15A(b)(5) of the Act,[7] in particular, in that it provides for the equitable allocation of reasonable dues, fees and other charges among members and issuers and other persons using any facility or system which the NASD operates or controls. The proposed rule change will provide ECNs

[14] 17 CFR 200.30–3(a)(12).

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] 15 U.S.C. 78s(b)(3)(A)(ii).

[4] 17 CFR 240.19b–4(f)(2).

[5] NASD Rules provide that order-delivery ECNs must respond to messages sent to them by the system within 5 seconds on average, and in no event later than 30 seconds for any one message. Nasdaq recently filed a related proposed rule change to NASD Rule 4710 to provide that the response time of an order-delivery ECN may be measured either by the ECN's SDP (in the case of ECN's using SDPs) or by the Nasdaq Market Center (in the case of ECNs opting to establish direct connections. *See* SR–NASD–2004–156 (October 15, 2004).

[6] 15 U.S.C. 78o–3.

[7] 15 U.S.C. 78o–3(5).

with a cost-effective means to establish direct connections, which can be expected to improve the speed and certainty of execution in the market, to the benefit of all market participants.

B. Self-Regulatory Organization's Statement on Burden on Competition

Nasdaq does not believe that the proposed rule change will result in any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

Written comments were neither solicited nor received.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The foregoing rule change has become effective pursuant to section 19(b)(3)(A)(ii) of the Act [8] and subparagraph (f)(2) of Rule 19b–4 thereunder,[9] because it establishes or changes a due, fee, or other charge. At any time within 60 days of the filing of the proposed rule change, the Commission may summarily abrogate such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change, as amended, is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an e-mail to *rule-comments@sec.gov.* Please include File Number SR–NASD–2004–158 on the subject line.

Paper Comments

- Send paper comments in triplicate to Jonathan G. Katz, Secretary, Securities and Exchange Commission, 450 Fifth Street, NW., Washington, DC 20549–0609.

All submissions should refer to File Number SR–NASD–2004–158. This file number should be included on the subject line if e-mail is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Section, 450 Fifth Street, NW., Washington, DC 20549. Copies of such filing also will be available for inspection and copying at the principal office of the NASD. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–NASD–2004–158 and should be submitted on or before December 6, 2004.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[10]

Jill M. Peterson,

Assistant Secretary.

[FR Doc. E4–3163 Filed 11–12–04; 8:45 am]

BILLING CODE 8010–01–P

[8] 15 U.S.C. 78s(b)(3)(a)(ii).

[9] 17 CFR 240.19b–4(f)(2).

[10] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–50643; File No. SR–PCX–2004–98]

Self-Regulatory Organizations; Notice of Filing and Immediate Effectiveness of Proposed Rule Change by the Pacific Exchange, Inc. To Extend Until 1:15 (Pacific Time) the Core Trading Session and Change the Closing Auction Time for Certain ETFs

November 5, 2004.

Pursuant to section 19(b)(1) of the Securities Exchange Act of 1934 (''Act'') [1] and Rule 19b–4 thereunder,[2] notice is hereby given that on October 12, 2004, the Pacific Exchange, Inc. (''PCX'' or ''Exchange'') filed with the Securities and Exchange Commission (''Commission'') the proposed rule change as described in items I, II, and III below, which items have been prepared by the PCX. On November 3, 2004, the PCX filed Amendment No. 1 to the proposed rule change.[3] The Exchange proposed the rule change under section 19(b)(3)(A) of the Act [4] and Rule 19b–4(f)(6) thereunder,[5] which renders it effective upon filing.[6] The Commission is publishing this notice to solicit comments on the proposed rule change, as amended, from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The PCX, through its wholly owned subsidiary PCX Equities, Inc. (''PCXE''), proposes to amend its Core Trading Session rule (PCXE Rule 7.34(a)(2)) and its Closing Auction rule (PCXE 7.35) as they apply to certain Exchange Traded Funds (''ETFs'').

The text of the proposed rule change, as amended, is below. Proposed new language is in italics; proposed deletions are in brackets.

* * * * *

Rule 7.34 Trading Sessions

(a) (1) No change.

(2) Core Trading Session. The Core Trading Session shall begin for each security at 6:30:00 am (Pacific Time) or at the conclusion of the Market Order Auction, whichever comes later, and conclude at 1:00:00 pm (Pacific Time).

(A) The Core Trading Session for the Exchange Traded Funds, defined in PCXE Rules 5.1(b)(13), 5.2(j)(3), and 8.100, shall conclude at 1:15:00 pm (Pacific Time) unless otherwise determined by the Corporation.

(3) No change.

(b)–(f) No change.

Rule 7.35 Auctions

(a)–(d) No change.

(e) (1)–(3) No change.

(A)–(C) No change.

(D) Notwithstanding other provisions of PCXE Rule 7.35(e):

i. The Closing Auction for the Exchange Traded Funds defined in PCXE Rules 5.1(b)(13), 5.2(j)(3), and

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] *See* Letter from Mai Shiver, Director, Regulatory Policy, PCX, to Nancy Sanow, Assistant Director, Division of Market Regulation, Commission, dated November 2, 2004 (''Amendment No. 1''). Amendment No. 1 replaced and superseded the original filing in its entirety.

[4] 15 U.S.C. 78s(b)(3)(A).

[5] 17 CFR 240.19b–4(f)(6).

[6] For purpose of calculating the 60-day period within which the Commission may summarily abrogate the proposed rule change under section 19(b)(3)(C) of the Act, the Commission considers that period to commence on November 3, 2004, the date that the PCX filed Amendment No. 1.

8.100 and determination of the Closing Auction Price as defined in PCXE Rule 7.35(e)(3) will commence at 1:15 p.m. (Pacific Time) unless otherwise determined by the Corporation.

ii. Between 1:13 p.m. (Pacific Time) and the conclusion of the Closing Auction, Market-On-Close and Limit-On-Close Orders for the Exchange Traded Funds defined in PCXE Rules 5.1(b)(13), 5.2(j)(3), and 8.100 may not be cancelled.

iii. Between 1:13 pm (Pacific Time) and the conclusion of the Closing Auction, Market-on-Close Orders and Limit-on-Close Orders for the Exchange Traded Funds defined in PCXE Rules 5.1(b)(13), 5.2(j)(3), and 8.100 may not be entered on the same side as the Imbalance. Market-on-Close Orders and Limit-on-Close Orders for these Exchange Traded Funds that create equilibrium and thereafter convert the Imbalance from a buy to a sell (or convert the Imbalance from a sell to a buy) Imbalance will be rejected.

* * * * *

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the Exchange included statements concerning the purpose of, and basis for, the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in item IV below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

As part of its continuing efforts to enhance participation on its Archipelago Exchange (''ArcaEx'') facility, the PCX is proposing to include certain ETFs [7] in its Closing Auction process [8] and to delay the commencement of the Closing Auction and the conclusion of the Core Trading Session [9] for these ETFs. Currently the Closing Auction commences at the end of regular trading hours [10] for all securities on ArcaEx other than ETFs. Unlike other securities in which regular trading hours cease at 1 p.m. (Pacific time), ETFs generally trade on other exchanges until 1:15 p.m. (Pacific time). Accordingly, the Exchange seeks to modify its Closing Auction start time for the ETFs defined in PCXE Rules 5.1(b)(13), 5.2(j)(3), and 8.100 to 1:15 p.m. (Pacific Time) unless otherwise determined. Consistently, the Exchange seeks to change the conclusion of the Core Trading Session for this same group of ETFs to 1:15:00 pm (Pacific Time) to coincide with the time of the closing session.

In conjunction with modifying the Closing Auction start time, the PCX seeks to modify the timing of the determination of the Closing Auction Price as described in PCXE Rule 7.35(e)(3) to 1:15 p.m. (Pacific time) for these ETFs. In addition, the Exchange seeks to modify the freeze period for entering Market-on-Close and Limit-on-Close Orders for the Closing Auction as defined in PCXE Rule 7.35(e)(2)(iii) to 1:13 p.m. (Pacific time) for these ETFs in order to limit the freeze period to two minutes before the Closing Auction, as is the case for the Closing Auctions for other securities. All other Closing Auction times described in PCXE Rule 7.35(e) will remain unchanged. For example, the dissemination of the Indicative Match Price [11] and Imbalances [12] associated with the Closing Auction for these ETFs as described in PCXE Rule 7.35(e)(1) will commence at 12 p.m. (Pacific time) and end upon the conclusion of the Closing Auction. Similarly, the determination of re-opening after trading halts as described in PCXE Rule 7.35(f) for these ETFs will be consistent with other securities traded on ArcaEx.

The PCX believes that implementing these rules to affect commencement times for the Closing Auctions and conclusion times for Core Trading Sessions for certain ETFs will provide investors and ETP Holders [13] with greater opportunities for executing ETF orders at the close and will result in the Closing Auction being priced for such securities within the range of prices then found at the end of the day's regular trading session.

2. Statutory Basis

The Exchange believes that the proposed rule change is consistent with section 6(b) of the Act,[14] in general, and furthers the objectives of section 6(b)(5) of the Act,[15] in particular, in that it is designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to foster cooperation and coordination with persons engaged in facilitating transactions in securities, and to remove impediments to and perfect the mechanism of a free and open market and a national market system.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

Written comments on the proposed rule change were neither solicited nor received.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

PCX has designated that the proposed rule change as a ''non-controversial'' rule change pursuant to section 19(b)(3)(A) of the Act [16] and subparagraph (f)(6) of Rule 19b–4 thereunder.[17] The Exchange has stated that the foregoing rule change: (1) Does not significantly affect the protection of investors or the public interest; (2) does not impose any significant burden on competition; and (3) by its terms does not become operative for 30 days after the date of this filing, or such shorter time as the Commission may designate, if consistent with the protection of investors and the public interest.[18]

The PCX has requested that the Commission waive the 30-day operative delay. The Commission believes that

[7] The three ETFs that the Exchange seeks to include in this proposal are all subject to the delayed closing auction commencement time on the American Stock Exchange (''Amex''), and are as follows: Unit Investment Trusts as defined in PCXE Rule 5.1(b)(13) (Amex Rule 1, Commentary .03); Investment Company Units as defined in PCXE Rule 5.2(j)(3) (Amex Rule 1000A, Commentary .02(f)—known as Index Fund Shares); and Portfolio Depositary Receipts (''PDRs'') as defined in the PCXE Rule 8.100 (Amex Rule 1000, Commentary .02).

[8] *See* PCXE Rule 7.35(e).

[9] *See* PCXE Rule 7.34(a)(2).

[10] PCXE Rule 7.35(e) specifies that the Closing Auction occurs at 1 p.m. (Pacific time).

[11] *See* PCXE Rule 1.1(r).

[12] *See* PCXE Rule 1.1(q).

[13] *See* PCXE Rule 1.1(n).

[14] 15 U.S.C. 78f(b).

[15] 15 U.S.C. 78f(b)(5).

[16] 15 U.S.C. 78s(b)(3)(A).

[17] 17 CFR 240.19b–4(f)(6).

[18] Rule 19b–4(f)(6)(iii) under the Act also requires that a self-regulatory organization provide the Commission with written notice of its intent to file a proposed rule change, along with a brief description and text of the proposed rule change, at least five days prior to the date of filing the proposed rule change. The Exchange complied with this requirement.

PCX's proposal does not raise any new regulatory issues because the Commission previously has approved trading of the same ETFs until 4:15 p.m. (eastern time) on the Amex.[19] Therefore, the Commission believes that waiving the 30-day operative delay is consistent with the protection of investors and the public interest. The Commission hereby waives the 30-day operative delay.

At any time within 60 days of the filing of the proposed rule change, the Commission may summarily abrogate the rule change if it appears to the Commission that the action is necessary or appropriate in the public interest, for the protection of investors, or would otherwise further the purposes of the Act.[20]

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an e-mail to *rule-comments@sec.gov*. Please include File No. SR–PCX–2004–98 on the subject line.

Paper Comments

- Send paper comments in triplicate to Jonathan G. Katz, Secretary, Securities and Exchange Commission, 450 Fifth Street, NW., Washington, DC 20549–0609.

All submissions should refer to File No. SR–PCX–2004–98. This file number should be included on the subject line if e-mail is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Room, 450 Fifth Street, NW., Washington, DC 20549. Copies of such filing will also be available for inspection and copying at the principal office of the PCX. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File No. SR–PCX–2004–98 and should be submitted on or before December 6, 2004.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[21]

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. E4–3158 Filed 11–12–04; 8:45 am]

BILLING CODE 8010–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–50645; File No. SR–PCX–2004–59]

Self-Regulatory Organizations; Notice of Filing of Proposed Rule Change and Amendment Nos. 1 and 2 Thereto by the Pacific Exchange, Inc. Relating to a New Order Modifier Entitled ''Proactive if Locked Reserve''

November 5, 2004.

Pursuant to section 19(b)(1) of the Securities Exchange Act of 1934 (''Act''),[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on July 1, 2004, the Pacific Exchange, Inc. (''PCX'' or ''Exchange''), through its wholly-owned subsidiary PCX Equities, Inc. (''PCXE''), filed with the Securities and Exchange Commission (''Commission'') the proposed rule change as described in items I, II, and III below, which items have been prepared by the PCX. On October 26, 2004, the PCX submitted Amendment No. 1 to the proposed rule change.[3] On October 28, 2004, the PCX submitted Amendment No. 2 to the proposed rule change.[4] The Commission is publishing this notice to solicit comments on the proposed rule change, as amended, from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The PCX proposes to amend its rules governing the Archipelago Exchange (''ArcaEx''), the equities trading facility of PCXE, by adding new processing capability for ArcaEx Reserve Orders in situations where a Reserve Order in an exchange-listed security is locked by another market. Below is the text of the proposed rule change. Proposed new language is *italicized*; proposed deletions are in [brackets].

* * * * *

Rule 7

Equities Trading

Orders and Modifiers

* * * * *

Rule 7.31 Orders and Modifiers

* * * * *

(hh) Proactive if Locked Reserve. A Reserve Order that will route to another market center pursuant to PCXE Rule 7.37(d) for the away market's displayed size up to such reserve amount in the instance in which the other market center has locked the order and the locking market has not resolved the locked market situation in a timely manner based upon average response times from ITS Participants. In the event that the order routed from the Archipelago Exchange to the other market center is not executed in its entirety, the Archipelago Exchange shall post the order or portion thereof in the ArcaEx Book. Proactive if Locked Reserve will apply only to exchange-listed securities.

* * * * *

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the Exchange included statements concerning the purpose of, and basis for, the proposed rule change, as amended, and discussed any comments it received

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[19] Securities Act Release No. 30394 (February 21, 1992), 57 FR 7409 (March 2, 1992) (SR–Amex–90–06) (approving the trading of Unit Investment Trusts); Securities Act Release No. 36947 (March 8, 1996), 61 FR 10606 (March 14, 1996) (SR–Amex–95–43) (approving the trading of Index Fund Shares); Securities Act Release No. 31591 (December 11, 1992), 57 FR 60253 (December 18, 1992) (SR–Amex–92–18) (approving the trading of PDRs).

[20] *See supra* note 6.

[21] 17 CFR 200.30–3(a)(12).

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] *See* letter from Steven B. Matlin, Senior Counsel, Regulatory Policy, PCX, to Nancy J. Sanow, Assistant Director, Division of Market Regulation (''Division''), Commission, dated October 25, 2004 and accompanying Form 19b–4 (''Amendment No. 1''). Amendment No. 1 replaced and superceded the originally filed proposed rule change.

[4] *See* letter from Steven B. Matlin, Senior Counsel, Regulatory Policy, PCX, to Nancy J. Sanow, Assistant Director, Division, Commission, dated October 25, 2004 (''Amendment No. 2''). Amendment No. 2 made technical corrections to the proposed rule text of the proposed rule change, as amended.

on the proposed rule change. The text of these statements may be examined at the places specified in item IV below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

The PCX states that, as part of its continuing efforts to enhance participation on the ArcaEx facility, it is proposing to include additional processing capability for ArcaEx Reserve Orders in exchange-listed securities. The new order modifier would be entitled ''Proactive if Locked Reserve'' and would be utilized when a Reserve Order in an exchange-listed security is locked by another market and the offending market has not shipped a commitment or moved their quote to clear the lock.

Currently, PCXE Rule 7.56 describes interaction between markets in exchange-listed securities when an order in the ArcaEx Book is locked by an away market. Specifically, the ITS Plan and the provisions of this rule require that, in locked market situations, upon receiving a locked market complaint, the offending market shall either ship a commitment to trade to the market that was locked or move its quote so as to unlock the market.[5] The Exchange states that, in many cases, however, away markets that lock or cross ArcaEx do not adequately respond to complaints or do not move quotes to unlock or uncross the market. The proposed Proactive if Locked Reserve order modifier is designed to address this issue.

Under the proposed rule change, Equity Trading Permit Holders (''ETP Holders'') using the Proactive if Locked Reserve modifier would be able to request, for exchange-listed securities, that the away market's displayed size up to the reserve amount for a Reserve Order[6] be shipped to an away market when the Reserve Order has been locked (or crossed) by the away market and there has been no resolution of the locked (or crossed) market by the offending away market. According to the Exchange, if the away market does not promptly respond to a locked market complaint as provided for under the ITS Plan, ArcaEx would proactively ship commitments to the offending market under the Proactive if Locked Reserve process.[7]

For example, assume ArcaEx posts a Reserve order with a Proactive if Locked Reserve Modifier for 50,000 Buy at 30.10, with 1,000 shares displayed and 49,000 shares in reserve. An away market subsequently locks this quote by offering 10,000 shares at 30.10. ArcaEx would first send an ITS complaint to the offending away market, indicating that the away market has locked a quote on ArcaEx. ArcaEx would simultaneously begin to monitor the time elapsing before receiving a response to its complaint. If the away market does not respond within a sufficient amount of time based upon average response times from ITS Participants, ArcaEx would ship 10,000 shares of the 49,000 shares in reserve to the away market (*i.e.*, the away market's displayed quote) from the ArcaEx Reserve order at 30.10. In the above example, ArcaEx would ship as many shares as it had in reserve for the order with a Proactive if Locked Reserve Modifier to match the away market's displayed quote. Accordingly, if the away market was offering 50,000 shares at 30.10 instead of 10,000 shares, ArcaEx would ship all 49,000 shares in the Reserve order while keeping the 1,000 shares displayed.

The proposed Proactive if Locked Reserve modifier is utilized only if the offending market does not respond to the ArcaEx ITS complaint within an acceptable time period, based upon average response times from ITS Participants. If the away market declines the ArcaEx commitment, ArcaEx would post the declined total back to the Reserve order,[8] for example, showing 1,000 shares Buy at 30.10 with a reserve amount of 49,000 shares. If the order is executed by the away market, and ArcaEx remains locked (or crossed), ArcaEx would ship the away market's display amount from the reserve portion of the Reserve Order to the offending market again, until the order is depleted. The display portion of the Reserve Order, however, will continue to be displayed and will not ship to the away market.

Furthermore, in the instance where a limit order in the Arca Book that is at the same price as, but superior in time to, the Proactive if Locked Reserve Order is locked by an away market, ArcaEx would follow the aforementioned procedures. Specifically, ArcaEx would first send an ITS complaint to the offending away market indicating that the away market locked the ArcaEx limit order. If the away market does not respond within a sufficient amount of time based upon average response times from ITS Participants, ArcaEx would ship from the Proactive if Locked Reserve Order the away market's displayed size up to the reserve amount. The limit order and display portion of the Proactive if Locked Reserve Order would continue to be displayed. Any portion of the Proactive if Locked Reserve Order that is sent to the away market and subsequently declined would be re-posted in the Arca Book pursuant to the description above.

The PCX believes that the proactive shipping of commitments facilitated by the proposed Proactive if Locked Reserve modifier will mitigate locked or crossed markets, prevent unresponsive away markets from delaying executions, and provide increased opportunities for executing orders. The Exchange believes that the Proactive if Locked Reserve modifier will therefore aid enhanced order interaction and foster price competition. The PCX believes that the proposal also promotes a more efficient and effective market operation, and enhances the investment choices available to investors over a broad range of trading scenarios.

2. Statutory Basis

The Exchange believes that the proposed rule change is consistent with section 6(b) of the Act[9] in general, and furthers the objectives of section 6(b)(5) of the Act[10] in particular, because it is designed to promote just and equitable principles of trade, to foster cooperation and coordination with persons engaged in facilitating transactions in securities, and to remove impediments and perfect the mechanism of a free and open market, and, in general, to protect investors and the public interest.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

[5] *See* ITS Plan Exhibit B, Section (d).

[6] Reserve Orders, defined in PCXE Rule 7.31, are limit orders with a portion of the size displayed and with a reserve portion of the size not displayed.

[7] *See* ITS Plan Exhibit B, Section (d).

[8] The Exchange states that any portion of an order which is sent to an away market and declined would re-enter ArcaEx as part of the original Reserve Order with its original time priority in accordance with PCXE Rule 7.36. To the extent the Reserve Order is executed in its entirety in the interim, the portion of the order that was sent to an away market and declined would establish a new time priority upon re-posting in the Arca Book pursuant to PCXE Rule 7.36.

[9] 15 U.S.C. 78f(b).

[10] 15 U.S.C. 78f(b)(5).

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

Written comments on the proposed rule change were neither solicited nor received.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Within 35 days of the date of publication of this notice in the **Federal Register** or within such longer period (i) as the Commission may designate up to 90 days of such date if it finds such longer period to be appropriate and publishes its reasons for so finding, or (ii) as to which the Exchange consents, the Commission will:

(A) By order approve such proposed rule change; or

(B) Institute proceedings to determine whether the proposed rule change should be disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

• Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or

• Send an e-mail to *rule-comments@sec.gov*. Please include File Number SR–PCX–2004–59 on the subject line.

Paper Comments

• Send paper comments in triplicate to Jonathan G. Katz, Secretary, Securities and Exchange Commission, 450 Fifth Street, NW., Washington, DC 20549–0609.

All submissions should refer to File Number SR–PCX–2004–59. This file number should be included on the subject line if e-mail is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Section, 450 Fifth Street, NW., Washington, DC 20549. Copies of such filing also will be available for inspection and copying at the principal office of the PCX. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–PCX–2004–59 and should be submitted on or before December 6, 2004.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[11]

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. E4–3159 Filed 11–12–04; 8:45 am]

BILLING CODE 8010–01–P

SMALL BUSINESS ADMINISTRATION

[License No. 02/72–0610]

Gefus SBIC, L.P.; Notice Seeking Exemption Under Section 312 of the Small Business Investment Act, Conflicts of Interest

Notice is hereby given that Gefus SBIC, L.P., 375 Park Avenue, Suite 2401, New York, NY 10152, a Federal Licensee under the Small Business Investment Act of 1958, as amended (''the Act''), in connection with the financing of a small concern, has sought an exemption under section 312 of the Act and section 107.730, Financings which Constitute Conflicts of Interest of the Small Business Administration (''SBA'') Rules and Regulations (13 CFR 107.730). Gefus SBIC, L.P. proposes to provide equity/debt security financing to Idetic, Inc. The financing is contemplated for operating expenses and for general corporate purposes.

The financing is brought within the purview of § 107.730(a)(1) of the Regulations because Gefus Capital Partners I, L.P. , Gefus Strategic Partners I, L.P., Inman Ventures I, L.P. and Admiral Bobby Inman, all Associates of Gefus SBIC, L.P., own more than ten percent of Idetic, Inc.

[11] 17 CFR 200.30–3(a)(12).

Notice is hereby given that any interested person may submit written comments on the transaction to the Associate Administrator for Investment, U.S. Small Business Administration, 409 Third Street, SW., Washington, DC 20416.

Dated: November 9, 2004.

Harry Haskins,

Acting Associate Administrator for Investment.

[FR Doc. 04–25312 Filed 11–12–04; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

Psilos Group Partners II SBIC, L.P; License No. 02/72–0617; Notice Seeking Exemption Under Section 312 of the Small Business Investment Act, Conflicts of Interest

Notice is hereby given that Psilos Group Partners II SBIC, L.P., 625 Avenue of the Americas, Fourth Floor, New York, NY 10011, a Federal Licensee under the Small Business Investment Act of 1958, as amended (''the Act''), in connection with the financing of a small concern, has sought an exemption under Section 312 of the Act and Section 107.730, Financings which Constitute Conflicts of Interest of the Small Business Administration (''SBA'') Rules and Regulations (13 CFR 107.730 (2000). Psilos Group Partners II SBIC, L.P. proposes to provide equity/debt security financing to Caregiver Services, Inc. The financing is contemplated for national sales force expansion and working capital.

The financing is brought within the purview of Sec. 107.730(a)(1) of the Regulations because Psilos Group Partners, L.P., CCP/Psilos GerAssist, LLC, Psilos Group Partners II, L.P. and Psilos Group Partners IIA, L.P., all Associates of Psilos Group Partners II SBIC, L.P., collectively own more than ten percent of Caregiver Services, Inc.

Notice is hereby given that any interested person may submit written comments on the transaction to the Associate Administrator for Investment, U.S. Small Business Administration, 409 Third Street, SW., Washington, DC 20416.

Dated: November 2, 2004.

Jeffrey Pierson,

Associate Administrator for Investment.

[FR Doc. 04–25227 Filed 11–12–04; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

Telesoft Partners II SBIC, L.P.; License No. 09/79–0432; Notice Seeking Exemption Under Section 312 of the Small Business Investment Act, Conflicts of Interest

Notice is hereby given that Telesoft Partners II SBIC, L.P., 1450 Fashion Island Blvd., Suite 610, San Mateo, CA 94404, a Federal Licensee under the Small Business Investment Act of 1958, as amended (''the Act''), in connection with the financing of a small concern, has sought an exemption under Section 312 of the Act and Section 107.730, Financings which Constitute Conflicts of Interest of the Small Business Administration (''SBA'') Rules and Regulations (13 CFR 107.730). Telesoft Partners II SBIC, L.P. proposes to provide equity/debt security financing to CreekPath Systems, Inc. The financing is contemplated for working capital and general corporate purposes.

The financing is brought within the purview of § 107.730(a)(1) of the Regulations because Telesoft Partners II QP, L.P., Telesoft Partners II, L.P. and Telesoft NP Employee Fund, LLC, all Associates of Telesoft Partners II SBIC, L.P., own more than ten percent of CreekPath Systems, Inc.

Notice is hereby given that any interested person may submit written comments on the transaction to the Associate Administrator for Investment, U.S. Small Business Administration, 409 Third Street, SW., Washington, DC 20416.

Dated: November 2, 2004.

Jeffrey Pierson,

Associate Administrator for Investment.

[FR Doc. 04–25228 Filed 11–12–04; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

Telesoft Partners II SBIC, L.P.; License No. 09/79–0432; Notice Seeking Exemption Under Section 312 of the Small Business Investment Act, Conflicts of Interest

Notice is hereby given that Telesoft Partners II SBIC, L.P., 1450 Fashion Island Blvd., Suite 610, San Mateo, CA 94404, a Federal Licensee under the Small Business Investment Act of 1958, as amended (''the Act''), in connection with the financing of a small concern, has sought an exemption under Section 312 of the Act and Section 107.730, Financings which Constitute Conflicts of Interest of the Small Business Administration (''SBA'') Rules and Regulations (13 CFR 107.730). Telesoft Partners II SBIC, L.P. proposes to provide equity/debt security financing to LogLogic, Inc. The financing is contemplated for working capital and general corporate purposes.

The financing is brought within the purview of § 107.730(a)(1) of the Regulations because Telesoft Partners II QP, L.P., Telesoft Partners II, L.P. and Telesoft NP Employee Fund, LLC, all Associates of Telesoft Partners II SBIC, L.P., own more than ten percent of LogLogic, Inc.

Notice is hereby given that any interested person may submit written comments on the transaction to the Associate Administrator for Investment, U.S. Small Business Administration, 409 Third Street, SW., Washington, DC 20416.

Dated: November 2, 2004.

Jeffrey Pierson,

Associate Administrator for Investment.

[FR Doc. 04–25229 Filed 11–12–04; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

[Declaration of Disaster #P056; Amendment #1]

State of Georgia

In accordance with a notice received from the Department of Homeland Security—Federal Emergency Management Agency—effective October 30, 2004, the above numbered Public Assistance declaration is hereby amended to establish the incident period for this disaster as beginning September 3, 2004, and continuing through October 30, 2004.

All other information remains the same, *i.e.*, the deadline for filing applications for physical damage is November 23, 2004.

(Catalog of Federal Domestic Assistance Program Nos. 59008.)

Dated: November 8, 2004.

Herbert L. Mitchell,

Associate Administrator for Disaster Assistance.

[FR Doc. 04–25310 Filed 11–12–04; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

[Declaration of Disaster #3629; Amendment #3]

State of Georgia

In accordance with a notice received from the Department of Homeland Security—Federal Emergency Management Agency—effective October 30, 2004, the above numbered declaration is hereby amended to establish the incident period for this disaster as beginning September 14, 2004, and continuing through October 30, 2004.

All other information remains the same, *i.e.*, the deadline for filing applications for physical damage is November 17, 2004, and for economic injury the deadline is June 20, 2005.

(Catalog of Federal Domestic Assistance Program Nos. 59002 and 59008.)

Dated: November 8, 2004.

Herbert L. Mitchell,

Associate Administrator for Disaster Assistance.

[FR Doc. 04–25311 Filed 11–12–04; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

Small Business Size Standards: Waiver of the Nonmanufacturer Rule

AGENCY: U.S. Small Business Administration.

ACTION: Notice of waiver of the nonmanufacturer rule for sporting and athletic goods manufacturing.

SUMMARY: The U.S. Small Business Administration (SBA) is granting a waiver of the Nonmanufacturer Rule for Sporting and Athletic Goods Manufacturing. The basis for waivers is that no small business manufacturers are supplying these classes of products to the Federal government. The effect of a waiver would be to allow otherwise qualified regular dealers to supply the products of any domestic manufacturer on a Federal contract set aside for small businesses, service disabled veteran-owned small businesses, SBA's Very Small Business Program or awarded through the SBA's 8(a) Business Development Program.

DATE: This waiver is effective November 30, 2004.

FOR FURTHER INFORMATI0N CONTACT: Edith Butler, Program Analyst, by telephone at (202) 619–0422; by FAX at (202) 205–7280; or by e-mail at *edith.butler@sba.gov*.

SUPPLEMENTARY INFORMATION: Section 8(a)(17) of the Small Business Act, (Act) 15 U.S.C. 637(a)(17), requires that recipients of Federal contracts set aside for small businesses, service disabled veteran-owned small businesses, SBA's Very Small Business Program or awarded through the SBA's 8(a) Business Development Program provide the product of a small business manufacturer or processor, if the recipient is other than the actual

manufacturer or processor of the product.

This requirement is commonly referred to as the Nonmanufacturer Rule. The SBA regulations imposing this requirement are found at 13 CFR 121.406(b). Section 8(a)(17)(b)(iv) of the Act authorizes SBA to waive the Nonmanufacturer Rule for any ''class of products'' for which there are no small business manufacturers or processors available to participate in the Federal market.

As implemented in SBA's regulations at 13 CFR 121.1204, in order to be considered available to participate in the Federal market for a class of products, a small business manufacturer must have submitted a proposal for a contract solicitation or received a contract from the Federal government within the last 24 months. The SBA defines ''class of products'' based on six digit coding systems. The first coding system is the Office of Management and Budget North American Industry Classification System (NAICS). The second is the Product and Service Code established by the Federal Procurement Data System.

The SBA received a request on July 15, 2004 to waive the Nonmanufacturer Rule for Sporting and Athletic Goods Manufacturing. In response, on July 30, 2004, SBA published in the **Federal Register** a notice of intent to waive the Nonmanufacturer Rule for Sporting and Athletic Goods Manufacturing.

SBA explained in the notice that it was soliciting comments and sources of small business manufacturers of this class of products. In response to this notice, comments were received from interested parties. SBA has determined from these sources that there are no small business manufacturers of this class of products, and is therefore granting the waiver of the Nonmanufacturer Rule for Sporting and Athletic Goods Manufacturing, NAICS 339920.

Authority: 15 U.S.C. 637(a)(17).

Dated: November 3, 2004.

Arthur Collins,

Deputy Associate Administrator for Government Contracting.

[FR Doc. 04–24973 Filed 11–12–04; 8:45 am]

BILLING CODE 8025–01–P

OFFICE OF THE UNITED STATES TRADE REPRESENTATIVE

Andean Trade Preference Act (ATPA), as Amended: Notice Regarding the 2003 and 2004 Annual Reviews

AGENCY: Office of the United States Trade Representative.

ACTION: Notice.

SUMMARY: The Office of the United States Trade Representative (USTR) received petitions in September 2004 to review certain practices in certain beneficiary developing countries to determine whether such countries are in compliance with the ATPA eligibility criteria. This notice publishes a list of the September 2004 petitions that were filed in response to the announcement of the annual review. In addition, this notice specifies the status of those petitions filed in 2003 that have remained under review.

FOR FURTHER INFORMATION CONTACT: Bennett M. Harman, Deputy Assistant U.S. Trade Representative for Latin America, at (202) 395–9446.

SUPPLEMENTARY INFORMATION: The ATPA (19 U.S.C. 3201 *et seq.*), as renewed and amended by the Andean Trade Promotion and Drug Eradication Act of 2002 (ATPDEA) in the Trade Act of 2002 (Pub. L. 107–210), provides trade benefits for eligible Andean countries. Pursuant to section 3103(d) of the ATPDEA, USTR promulgated regulations (15 CFR part 2016) (68 FR 43922) regarding the review of eligibility of countries for the benefits of the ATPA, as amended.

In a **Federal Register** notice dated August 14, 2003, USTR initiated the 2003 ATPA Annual Review and announced a deadline of September 15, 2003, for the filing of petitions (68 FR 48657). Several of these petitions requested the review of certain practices in certain beneficiary developing countries regarding compliance with the eligibility criteria set forth in sections 203(c) and (d) and section 204(b)(6)(B) of the ATPA, as amended (19 U.S.C. 3203 (c) and (d); 19 U.S.C. 3203(b)(6)(B)).

In a **Federal Register** notice dated November 13, 2003, USTR published a list of the responsive petitions filed pursuant to the announcement of the annual review. The Trade Policy Staff Committee (TPSC) has conducted a preliminary review of these petitions. 15 CFR 2016.2(b) provides for announcement of the results of the preliminary review on or about December 1. 15 CFR 2016.2(b) also provides for modification of the schedule if specified by **Federal Register** notice. In a **Federal Register** notice dated December 30, 2003, USTR modified the schedule for this review, specifying that the results would be announced on or about March 31, 2004. In a **Federal Register** notice dated April 5, 2004, USTR modified the schedule for this review. In a **Federal Register** notice dated July 21, 2004, USTR announced that the Trade Policy Staff Committee had determined that certain of the petitions do not require action and terminated their review. The TPSC also decided to modify the date of the announcement of the results of preliminary review for the remaining 2003 petitions to coincide with the 2004 review: Engelhard—Peru; Princeton Dover—Peru; LeTourneau—Peru; Duke Energy—Peru; AFL–CIO—Ecuador; Human Rights Watch—Ecuador; and US/LEAP—Ecuador.

In a **Federal Register** notice dated August 17, 2004, USTR initiated the 2004 ATPA Annual Review and announced a deadline of September 15, 2004 for the filing of petitions (69 FR 51138). Following is the list of responsive petitions that were filed for the 2004 review:

Ecuador—American Cast Iron Pipe Company
Ecuador—Chevron Texaco
Ecuador—Electrolux Home Products, Inc.
Peru—Parsons Corporation

USTR also received updated information regarding certain matters under consideration from the 2003 ATPA review:

Ecuador—Human Rights Watch
Ecuador—U.S./Labor Education in the Americas Project
Peru—LeTourneau of Peru

USTR will announce the results of the preliminary review of the 2004 petitions and the remaining 2003 petitions on or about December 1, 2004.

Carmen Suro-Bredie,

Chairman, Trade Policy Staff Committee.

[FR Doc. 04–25240 Filed 11–12–04; 8:45 am]

BILLING CODE 3190–W4–P

OFFICE OF THE UNITED STATES TRADE REPRESENTATIVE

Generalized System of Preferences (GSP): Extension of Deadline for Submission of Petitions for the 2004 Annual GSP Product and Country Eligibility Practices Review

AGENCY: Office of the United States Trade Representative.

ACTION: Notice.

SUMMARY: This notice extends the deadline for the submission of petitions

for the 2004 Annual GSP Product and Country Eligibility Practices Review to December 13, 2004. Notification of which petitions are accepted for the 2004 Annual GSP Review and of other relevant dates will be published in the **Federal Register**.

ADDRESSES: Submit petitions by electronic mail (e-mail) to *FR0441@ustr.gov.* If unable to submit petitions by e-mail, contact the GSP Subcommittee of the Trade Policy Staff Committee (TPSC), Office of the United States Trade Representative (USTR), 1724 F Street, NW., Room F–220, Washington, DC 20508, at (202) 395–6971.

FOR FURTHER INFORMATION CONTACT: The GSP Subcommittee of the Trade Policy Staff Committee (TPSC), Office of the United States Trade Representative (USTR), 1724 F Street, NW., Room F–220, Washington, DC 20508. The telephone number is (202) 395–6971.

SUPPLEMENTARY INFORMATION: The GSP provides for the duty-free importation of designated articles when imported from beneficiary developing countries. The GSP is authorized by Title V of the Trade Act of 1974 (19 U.S.C. 2461, *et seq.*), as amended (the ''Trade Act''), and is implemented in accordance with Executive Order 11888 of November 24, 1975, as modified by subsequent Executive Orders and Presidential Proclamations.

2004 Annual GSP Review

The GSP regulations (15 CFR part 2007) provide the schedule of dates for conducting an annual review, unless otherwise specified by **Federal Register** notice. Notice is hereby given that, in order to be considered in the 2004 Annual GSP Product and Country Eligibility Practices Review, all petitions to modify the list of articles eligible for duty-free treatment under GSP or to review the GSP status of any beneficiary developing country must be received by the GSP Subcommittee of the Trade Policy Staff Committee no later than 5 p.m. on December 13, 2004. Petitions submitted after the extended deadline will not be considered for review.

Interested parties, including foreign governments, may submit petitions to: (1) Designate additional articles as eligible for GSP benefits, including to designate articles as eligible for GSP benefits only for countries designated as least-developed beneficiary developing countries, or only for countries designated as beneficiary sub-Saharan African countries under the African Growth and Opportunity Act (AGOA); (2) withdraw, suspend or limit the application of duty-free treatment accorded under the GSP with respect to any article, either for all beneficiary developing countries, least-developed beneficiary developing countries or beneficiary sub-Saharan African countries, or for any of these countries individually; (3) waive the ''competitive need limitations'' for individual beneficiary developing countries with respect to specific GSP-eligible articles (these limits do not apply to either least-developed beneficiary developing countries or beneficiary sub-Saharan African countries); and (4) otherwise modify GSP coverage. As specified in 15 CFR 2007.1, all product petitions must include a detailed description of the product and the subheading of the Harmonized Tariff Schedule of the United States (HTSUS) under which the product is classified.

Any person may also submit petitions to review the designation of any beneficiary developing country, including any least-developed beneficiary developing country, with respect to any of the designation criteria listed in sections 502(b) or 502(c) of the Trade Act (19 U.S.C. 2462(b) and (c)) (petitions to review the designation of beneficiary Sub-Saharan African countries are considered in the Annual Review of the AGOA, a separate administrative process not governed by the GSP regulations). Such petitions must comply with the requirements of 15 CFR 2007.0(b).

Requirements for Submissions

All such submissions must conform to the GSP regulations set forth at 15 CFR part 2007, except as modified below. These regulations are reprinted in ''A Guide to the U.S. Generalized System of Preferences (GSP)'' (August 1991) (''GSP Guidebook''), available at *http://www.ustr.gov.*

Any person or party making a submission is strongly advised to review the GSP regulations. Submissions that do not provide the information required by sections 2007.0 and 2007.1 of the GSP regulations will not be accepted for review, except upon a detailed showing in the submission that the petitioner made a good faith effort to obtain the information required. Petitions with respect to waivers of the ''competitive need limitations'' must meet the information requirements for product addition requests in section 2007.1(c) of the GSP regulations. A model petition format is available from the GSP Subcommittee and is included in the GSP Guidebook. Petitioners are requested to use this model petition format so as to ensure that all information requirements are met. Furthermore, interested parties submitting petitions that request action with respect to specific products should list on the first page of the petition the following information after typing ''2004 Annual GSP Review'': (1) The requested action; (2) the HTSUS subheading in which the product is classified; and (3) if applicable, the beneficiary developing country. Petitions and requests must be submitted, in English, to the Chairman of the GSP Subcommittee, Trade Policy Staff Committee, and must be received no later than December 13, 2004. Submissions in response to this notice will be available for public inspection by appointment with the staff of the USTR Public Reading Room, except for information granted ''business confidential'' status pursuant to 15 CFR 2003.6. If the submission contains business confidential information, a non-confidential version of the submission must also be submitted that indicates where confidential information was redacted by inserting asterisks where material was deleted. In addition, the confidential submission must be clearly marked ''BUSINESS CONFIDENTIAL'' in large, bold letters at the top and bottom of each and every page of the document. The public version that does not contain business confidential information must also be clearly marked in large, bold letters at the top and bottom of each and every page (either ''PUBLIC VERSION'' or ''NON–CONFIDENTIAL''). Documents that are submitted without any marking might not be accepted or will be considered public documents.

In order to facilitate prompt consideration of submissions, USTR strongly urges and prefers electronic mail (e-mail) submissions in response to this notice. Hand-delivered submissions will not be accepted. E-mail submissions should be single copy transmissions in English with the total submission including attachments not to exceed 50 pages in 12-point type and 3 megabytes as a digital file attached to an e-mail transmission. E-mail submissions should use the following subject line: ''2004 Annual GSP Review-Petition.'' Documents must be submitted as either WordPerfect (''.WPD''), MSWord (''.DOC''), or text (''.TXT'') file. Documents cannot be submitted as electronic image files or contain imbedded images (for example, ''.JPG'', ''.TIF'', ''.PDF'', ''.BMP'', or ''.GIF'') as these type files are generally excessively large. E-mail submissions containing such files will not be accepted. Supporting documentation submitted as spreadsheets are acceptable as Quattro Pro or Excel, pre-formatted for printing

on 8½ by 11 inch paper. To the extent possible, any data attachments to the submission should be included in the same file as the submission itself, and not as separate files. E-mail submissions should not include separate cover letters or messages in the message area of the e-mail; information that might appear in any cover letter should be included directly in the attached file containing the submission itself, including identifying information on the sender, including sender's e-mail address.

For any document containing business confidential information submitted as an electronic attached file to an e-mail transmission, in addition to the proper marking at the top and bottom of each page as previously specified, the file name of the business confidential version should begin with the characters ''BC–'', and the file name of the public version should begin with the characters ''P–''. The ''P–'' or ''BC–'' should be followed by the name of the person or party (government, company, union, association, etc.) submitting the petition. Submissions by e-mail should not include separate cover letters or messages in the message area of the e-mail; information that might appear in any cover letter should be included directly in the attached file containing the submission itself. The electronic mail address for these submissions is *FR0441@USTR.GOV*.

Documents not submitted in accordance with the GSP regulations as modified by these instructions might not be considered in this review.

Public versions of all documents relating to this review will be available for review approximately 30 days after the due date by appointment in the USTR Public Reading Room, 1724 F Street, NW., Washington, DC. Availability of documents may be ascertained, and appointments may be made from 9:30 a.m. to noon and 1 p.m. to 4 p.m., Monday through Friday, by calling (202) 395–6186.

Dated:

H.J. Rosenbaum,

Acting Executive Director GSP; Acting Chairman, GSP Subcommittee of the Trade Policy Staff Committee.

[FR Doc. 04–25264 Filed 11–12–04; 8:45 am]

BILLING CODE 3190–W5–P

DEPARTMENT OF TRANSPORTATION

Office of the Secretary

Notice of Disclosure

AGENCY: Office of the Secretary (OST), Department of Transportation.

ACTION: Notice on disclosure of higher prices for airfares purchased over the telephone via telephone reservations centers or at airline ticket offices, and surcharges that may be listed separately in fare advertisements.

SUMMARY: The Department is publishing the following notice disclosure of higher prices for airfares purchased over the telephone via telephone reservations centers or at airline ticket offices, and surcharges that be listed separately in fare advertisements.

FOR FURTHER INFORMATION CONTACT: Nicholas Lowry, Attorney, Office of Aviation Enforcement and Proceedings (C–70), 400 7th Street, SW., Washington, DC 20590 (202) 366–9349.

This notice is intended to provide guidance on two matters related to compliance with 14 CFR 399.84, the Department's rule on full fare advertising, and the underlying statutory proscription in 49 U.S.C. 41712 against unfair and deceptive trade practices. First, we address the disclosure in fare advertisements of higher prices, recently introduced by several air carriers, for tickets purchased at ticket counters or by telephone.[1] Second, by this notice, we are advising carriers of the current policy of the Office of Aviation Enforcement and Proceedings (Aviation Enforcement Office) with regard to the disclosure of ''government-approved'' surcharges.

A number of air carriers and foreign air carriers have recently started charging higher prices for tickets purchased by telephone or at ticket offices. Such airlines advertise base fares on the Internet or in print or other media, make the advertised fares available for purchase via the Internet only, and charge higher prices if customers purchase their tickets via an airline's telephone reservation system or at its airport or city ticket counter. Section 399.84 mandates that the advertised fare be the full fare to be paid by the customer. Any practice of excluding from advertised fares extra ''fees'' charged to customers that purchase tickets over the telephone through airline reservation centers, or at airport or city ticket counters, therefore, would violate 14 CFR 399.84, and constitute an unfair and deceptive trade practice and an unfair method of competition in violation of 49 U.S.C. 41712.

In order to avoid enforcement action, carriers and their agents who charge more for tickets not purchased over the Internet (*e.g.* by telephone or at ticket offices) must prominently disclose to customers that specific fares advertised are available only for tickets purchased via the Internet. In addition, we believe that 49 U.S.C. 41712 and 14 CFR 399.84 require carriers to state in such advertising that tickets cost more than the advertised price if purchased over the telephone or at an airport or city ticket office. Moreover, we believe it would be informative and beneficial for consumers if carriers also state the amount of the increased price in the advertisements, for example, by stating that tickets cost $5 more if purchased by telephone or at an airport or city ticket office. However, this increase in price may not be characterized as a carrier-imposed ''fee'' lest the advertisement run afoul of the full fare advertising rule.[2] Accordingly, the Aviation Enforcement Office will pursue enforcement action with regard to the advertisements in question if the increased fare is merely described in terms of a service, processing, administrative, ticketing center, call center, or similar carrier-imposed ''fee.''

Carriers, however, may use the aforementioned ''fee'' terms when describing the additional charge for telephone and/or ticket counter purchases in contexts that do not list specific fares and are thus not subject to 14 CFR 399.84. Carriers may disclose such charges and refer to them as ''fees,'' for example, in an audio introduction on an airline telephone reservation system, stating that tickets purchased over the telephone via the airline telephone reservation system, and/or at airline ticket counters, are subject to an additional carrier-imposed ''fee,'' so long as the total fares eventually quoted to consumers include the ''fee.''

A second topic we wish to address relates to ''government-approved surcharges.'' In the past, we have not pursued enforcement action against carriers that listed in fare advertisements ''government-imposed and government-approved'' surcharges separately from the base fare quotations, so long as the existence of these

[1] Some carriers have referred to this increase in the price for tickets bought from them over the telephone or at a ticket counter as a ''service fee'' or by a similar phrase. However, in the context of the full fare advertising rule, such carrier-imposed ''fees'' are a part of the fare and must be treated as such in airfare advertising.

[2] The full-fare advertising rule was adopted in large part to eliminate the prior practice where sellers of air transportation hid the true price of tickets by listing ''service fees'' in the fine print of advertisements. The Aviation Enforcement Office, therefore, does not believe the increased price of tickets purchased at ticket counters or by telephone should be referred to in terms of a ''service fee'' in fare advertisement because this could lead to significant confusion and a return to the prior unacceptable advertising practice.

surcharges and their amounts were stated elsewhere in the advertisement. The ''government-approved'' surcharges were limited to security surcharges approved in the mid-1980's that affected foreign air transportation only and were approved by both the foreign government involved and the U.S. government. Recently, tariff regulation, owing to expanded open-skies agreements and other factors, has been revised to the extent that there is no longer a consistent practice of joint approvals of surcharges, in many instances resulting in the filing of tariffs that may include surcharges that are approved by only one government. In addition, the desire of carriers to pass on the higher costs of certain expenses discretely, such as insurance and fuel, has led to such expenses being filed separately from the ''base'' fare in tariffs, a situation that the Department cannot effectively monitor.[3] In view of these developments, the Enforcement Office will no longer allow the separate listing of ''government-approved'' surcharges in fare advertising. We will consider the separate listing of such charges in fare advertisements an unfair and deceptive trade practice and unfair method of competition in violation of 14 CFR 399.84 and 49 U.S.C. 41712 and will pursue enforcement action where such violations are found. With respect to ''government-imposed'' surcharges, for example PFCs and foreign airport charges, however, our policy remains that such charges may be omitted from the fare quotations provided that they are not *ad valorem* in nature, that they are collected on a per-passenger basis, and that their existence and amount are clearly indicated in the advertisement so that the consumer can determine the full fare to be paid.

Questions concerning this notice or the applicability of the Department's fare advertising rules may be addressed to the Office of Aviation Enforcement and Proceedings.

Dated: November 5, 2004.

Samuel Podberesky,

Assistant General Counsel for Aviation Enforcement and Proceedings.

An electronic version of this document is available on the World Wide Web at *http://dms.dot.gov/reports* and *http://airconsumer.ost.dot.gov/rules/index.htm.*

[FR Doc. 04–25253 Filed 11–12–04; 8:45 am]

BILLING CODE 4910–62–P

[3] In open-skies and other markets governed by bilateral agreements containing double-disapproval pricing articles, the Department has exempted carriers from fare filing. See 14 CFR part 293. See also, Letter from Paul L. Gretch, Director of International Aviation, to air carriers dated October 14, 2004, which was distributed electronically by ATPCO to its members.

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

[Summary Notice No. PE–2004–79]

Petitions for Exemption; Summary of Petitions Received

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of petition for exemption received.

SUMMARY: Pursuant to FAA's rulemaking provisions governing the application, processing, and disposition of petitions for exemption, part 11 of Title 14, Code of Federal Regulations (14 CFR), this notice contains a summary of certain petitions seeking relief from specified requirements of 14 CFR. The purpose of this notice is to improve the public's awareness of, and participation in, this aspect of FAA's regulatory activities. Neither publication of this notice nor the inclusion or omission of information in the summary is intended to affect the legal status of any petition or its final disposition.

DATES: Comments on petitions received must identify the petition docket number involved and must be received on or before December 6, 2004.

ADDRESSES: You may submit comments identified by DOT DMS Docket Number FAA–2004–18751 by any of the following methods:

- *Web Site: http://dms.dot.gov.* Follow the instructions for submitting comments on the DOT electronic docket site.
- *Fax:* 1–202–493–2251.
- *Mail:* Docket Management Facility; U.S. Department of Transportation, 400 Seventh Street, SW., Nassif Building, Room PL–401, Washington, DC 20590–0001.
- *Hand Delivery:* Room PL–401 on the plaza level of the Nassif Building, 400 Seventh Street, SW., Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

Docket: For access to the docket to read background documents or comments received, go to *http://dms.dot.gov* at any time or to Room PL–401 on the plaza level of the Nassif Building, 400 Seventh Street, SW., Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: John Linsenmeyer (202) 267–5174 or Susan Lender (202) 267–8029, Office of Rulemaking (ARM–1), Federal Aviation Administration, 800 Independence Avenue, SW., Washington, DC 20591.

This notice is published pursuant to 14 CFR 11.85 and 11.91.

Issued in Washington, DC, on November 5, 2004.

Anthony F. Fazio,

Director, Office of Rulemaking.

Petitions for Exemption

Docket No.: FAA–2004–18751.

Petitioner: Vaughn College of Aeronautics & Technology.

Sections of 14 CFR Affected: 14 CFR 147, Appendix C

Description of Relief Sought: To allow the petitioner to teach certain welding, soldering, and brazing curriculum in the Airframe Structures section of Appendix C to Teaching level 1 instead of Teaching level 2.

[FR Doc. 04–25322 Filed 11–12–04; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF THE TREASURY

Fiscal Service

Surety Companies Acceptable on Federal Bonds; Roche Surety and Casualty Company, Inc.

AGENCY: Financial Management Service, Fiscal Service, Department of the Treasury.

ACTION: Notice.

SUMMARY: This is Supplement No. 3 to the Treasury Department Circular 570; 2004 Revision, published July 1, 2004, at 69 FR 40224.

FOR FURTHER INFORMATION CONTACT: Surety Bond Branch at (202) 874–1033.

SUPPLEMENTARY INFORMATION: A Certificate of Authority as an acceptable surety on Federal bonds is hereby issued to the following Company under 31 U.S.C. 9304 to 9308. Federal bond-approving officers should annotate their reference copies of the Treasury Circular 570, 2004 Revision, on page 40254 to reflect this addition.

Company Name: Roche Surety and Casualty Company, Inc.

Business Address: 1910 Orient Road, Tampa, Florida 33619.

Phone: (813) 623–5042.

UNDERWRITING LIMITATION b/: $450,000.

Surety Licenses c/: AR, FL, GA, IN, KS, LA, MD, MO, NE, NV, NJ, OK, SC, TN, TX. Incorporated in: Florida.

Certificates of Authority expire on June 30 each year, unless revoked prior

to that date. The Certificates are subject to subsequent annual renewal as long as the companies remain qualified (31 CFR Part 223). A list of qualified companies is published annually as of July 1 in Treasury Department Circular 570, with details as to underwriting limitations, areas in which licensed to transact surety business and other information.

The Circular may be viewed and downloaded through the Internet at *http://www.fms.treas.gov/c570.* A hard copy may be purchased from the Government Printing Office (GPO) Subscription Service, Washington, DC, Telephone (202) 512–1800. When ordering the Circular from GPO, use the following stock number: 769–004–04926–1.

Questions concerning this Notice may be directed to the U.S. Department of the Treasury, Financial Management Service, Financial Accounting and Services Division, Surety Bond Branch, 3700 East-West Highway, Room 6F07, Hyattsville, MD 20782.

Dated: November 4, 2004.

Vivian L. Cooper,

Director, Financial Accounting and Services Division, Financial Management Service.

[FR Doc. 04–25283 Filed 11–12–04; 8:45 am]

BILLING CODE 4810–35–M

Corrections

Federal Register
Vol. 69, No. 219
Monday, November 15, 2004

This section of the FEDERAL REGISTER contains editorial corrections of previously published Presidential, Rule, Proposed Rule, and Notice documents. These corrections are prepared by the Office of the Federal Register. Agency prepared corrections are issued as signed documents and appear in the appropriate document categories elsewhere in the issue.

DEPARTMENT OF THE TREASURY

Office of the Comptroller of the Currency

[Docket No. 04–22]

FEDERAL RESERVE SYSTEM

[Docket No. OP–1215]

FEDERAL DEPOSIT INSURANCE CORPORATION

DEPARTMENT OF THE TREASURY

Office of Thrift Supervision

[No. 2004–48]

Internal Ratings-Based Systems for Retail Credit Risk for Regulatory Capital

Correction

In notice document 04–23771 beginning on page 62748 in the issue of Wednesday, October 27, 2004 make the following correction:

On page 62774, after the heading *Example 3b: Portfolio Growth and the Timing of Default Measurements*, the table is corrected to read as set forth below.

Annual portfolio growth rate	Total portfolio accounts		Accounts defaulted by end of year	PD from start of year portfolio	PD from end of year portfolio
	Start of year	End of year			
−5%	1,000,000	950,000	20,000	2.0%	2.1%
−10%	1,000,000	900,000	20,000	2.0%	2.2%
5%	1,000,000	1,050,000	20,000	2.0%	1.9%
10%	1,000,000	1,100,000	20,000	2.0%	1.8%

Note: It is assumed that all 20,000 defaults that occurred during the year were accounts that were part of the portfolio on January 1. The Other Retail risk weight curve was used for this example, and LGD is assumed to be 90% in all four cases.

[FR Doc. C4–23771 Filed 11–12–04; 8:45 am]
BILLING CODE 1505–01–D

Federal Register

Monday,
November 15, 2004

Book 2 of 4 Books
Pages 65681–66234

Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Part 419

Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2005 Rates; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 419

[CMS–1427–FC]

RIN 0938–AM75

Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2005 Payment Rates

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule with comment period.

SUMMARY: This final rule with comment period revises the Medicare hospital outpatient prospective payment system to implement applicable statutory requirements and changes arising from our continuing experience with this system and to implement certain related provisions of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. In addition, the final rule with comment period describes final changes to the amounts and factors used to determine the payment rates for Medicare hospital outpatient services paid under the prospective payment system. These changes are applicable to services furnished on or after January 1, 2005.

In this final rule with comment period, we are responding to public comments received on the January 6, 2004 interim final rule with comment period relating to MMA provisions that were effective January 1, 2004, and finalizing those policies. Further, we are responding to public comments received on the November 7, 2003 final rule with comment period pertaining to the ambulatory payment classification assignment of Healthcare Common Procedure Coding System (HCPCS) codes identified in Addendum B of that rule with the new interim (NI) comment indicators (formerly referred to as condition codes).

DATES: *Effective Date:* This final rule with comment period is effective on January 1, 2005.

Comment Date: We will consider comments on the ambulatory payment classification assignments of HCPCS codes identified in Addendum B with new interim comment codes and other areas specified throughout this preamble, if we receive them at the appropriate address, as provided below no later than 5 p.m. on January 14, 2005.

ADDRESSES: In commenting, please refer to file code CMS–1427–FC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of three ways (no duplicates, please):

1. Electronically

You may submit electronic comments to *http://www.cms.hhs.gov/regulations/ecomments* (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word).

2. By Mail

You may mail written comments (one original and two copies) to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1427–FC, P.O. Box 8010, Baltimore, MD 21244–8018.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By Hand or Courier

If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members. Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or 7500 Security Boulevard, Baltimore, MD 21244–1850.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. After the close of the comment period, CMS posts all electronic comments received before the close of the comment period on its public website. Written comments received timely will be available for public inspection as they are received, generally beginning approximately 4 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone (410) 786–7195.

FOR FURTHER INFORMATION CONTACT: Dana Burley, (410) 786–0378, Outpatient prospective payment issues and Suzanne Asplen, (410) 786–4558, Partial hospitalization and community mental health center issues.

SUPPLEMENTARY INFORMATION:

Availability of Copies and Electronic Access

Copies: To order copies of the **Federal Register** containing this document, send your request to: New Orders, Superintendent of Documents, PO Box 371954, Pittsburgh, PA 15250–7954. Specify the date of the issue requested and enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or Master Card number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 512–1800 (or toll-free at 1–888–293–6498) or by faxing to (202) 512–2250. The cost for each copy is $10. As an alternative, you can view and photocopy the **Federal Register** document at most libraries designated as Federal Depository Libraries and at many other public and academic libraries throughout the country that receive the **Federal Register**.

This **Federal Register** document is also available from the **Federal Register** online database through *GPO Access,* a service of the U.S. Government Printing Office. The Web site address is: *http://www.gpoaccess.gov/fr/index.html.*

Alphabetical List of Acronyms Appearing in the Final Rule With Comment Period

ACEP—American College of Emergency Physicians
AHA—American Hospital Association
AHIMA—American Health Information Management Association
AMA—American Medical Association
APC—Ambulatory payment classification
AMP—Average manufacturer price
ASP—Average sales price
ASC—Ambulatory surgical center
AWP—Average wholesale price
BBA—Balanced Budget Act of 1997, Public Law 105–33
BIPA—Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Public Law 106–554
BBRA—Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Public Law 106–113
CAH—Critical access hospital
CCR—(Cost center specific) cost-to-charge ratio
CMHC—Community mental health center

CMS—Centers for Medicare & Medicaid Services (formerly known as the Health Care Financing Administration)
CORF—Comprehensive outpatient rehabilitation facility
CPT—[Physicians'] Current Procedural Terminology, Fourth Edition, 2004, copyrighted by the American Medical Association
CRNA—Certified registered nurse anesthetist
CY—Calendar year
DMEPOS—Durable medical equipment, prosthetics, orthotics, and supplies
DMERC—Durable medical equipment regional carrier
DRG—Diagnosis-related group
DSH—Disproportionate share hospital
EACH—Essential Access Community Hospital
E/M—Evaluation and management
EPO—Erythropoietin
ESRD—End-stage renal disease
FACA—Federal Advisory Committee Act, Public Law 92–463
FDA—Food and Drug Administration
FI—Fiscal intermediary
FSS—Federal Supply Schedule
FY—Federal fiscal year
HCPCS—Healthcare Common Procedure Coding System
HCRIS—Hospital Cost Report Information System
HHA—Home health agency
HIPAA—Health Insurance Portability and Accountability Act of 1996, Public Law 104–191
ICD–9–CM—International Classification of Diseases, Ninth Edition, Clinical Modification
IME—Indirect medical education
IPPS—(Hospital) inpatient prospective payment system
IVIG—Intravenous immune globulin
LTC—Long-term care
MedPAC—Medicare Payment Advisory Commission
MDH—Medicare-dependent hospital
MMA—Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108–173
MSA—Metropolitan Statistical Area
NCCI—National Correct Coding Initiative
NCD—National Coverage Determination
OCE—Outpatient code editor
OMB—Office of Management and Budget
OPD—(Hospital) outpatient department
OPPS—(Hospital) outpatient prospective payment system
PET—Positron Emission Tomography
PHP—Partial hospitalization program
PM—Program memorandum
PPI—Producer Price Index
PPS—Prospective payment system
PPV—Pneumococcal pneumonia (virus)
PRA—Paperwork Reduction Act
QIO—Quality Improvement Organization
RFA—Regulatory Flexibility Act
RRC—Rural referral center
SBA—Small Business Administration
SCH—Sole community hospital
SDP—Single drug pricer
SI—Status indicator
TEFRA—Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97–248
TOPS—Transitional outpatient payments
USPDI—United States Pharmacopoeia Drug Information

To assist readers in referencing sections contained in this document, we are providing the following outline of contents:

Outline of Contents

I. Background

A. Legislative and Regulatory Authority for the Outpatient Prospective Payment System

When the Medicare statute was originally enacted, Medicare payment for hospital outpatient services was based on hospital-specific costs. In an effort to ensure that Medicare and its beneficiaries pay appropriately for services and to encourage more efficient delivery of care, the Congress mandated replacement of the cost-based payment methodology with a prospective payment system (PPS). The Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33), enacted on August 5, 1997, added section 1833(t) to the Social Security Act (the Act) authorizing implementation of a PPS for hospital outpatient services. The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113), enacted on November 29, 1999, made major changes that affected the hospital outpatient PPS (OPPS). The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106–554), enacted on December 21, 2000, made further changes in the OPPS. Section 1833(t) of the Act was also recently amended by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Public Law 108–173, enacted on December 8, 2003 (these amendments are discussed later under section I.E. of this final rule with comment period). The OPPS was first

implemented for services furnished on or after August 1, 2000. Implementing regulations for the OPPS are located at 42 CFR Part 419.

Under the OPPS, we pay for hospital outpatient services on a rate-per-service basis that varies according to the ambulatory payment classification (APC) group to which the service is assigned. We use Healthcare Common Procedure Coding System (HCPCS) codes (which include certain Current Procedural Terminology (CPT) codes) and descriptors to identify and group the services within each APC group. The OPPS includes payment for most hospital outpatient services, except those identified in section I.B. of this final rule with comment period. Section 1833(t)(1)(B)(ii) of the Act provides for Medicare payment under the OPPS for certain services designated by the Secretary that are furnished to inpatients who have exhausted their Part A benefits or who are otherwise not in a covered Part A stay. In addition, the OPPS includes payment for partial hospitalization services furnished by community mental health centers (CMHCs).

The OPPS rate is an unadjusted national payment amount that includes the Medicare payment and the beneficiary copayment. This rate is divided into a labor-related amount and a nonlabor-related amount. The labor-related amount is adjusted for area wage differences using the inpatient hospital wage index value for the locality in which the hospital or CMHC is located.

All services and items within an APC group are comparable clinically and with respect to resource use (section 1833(t)(2)(B) of the Act). In accordance with section 1833(t)(2) of the Act, subject to certain exceptions, services and items within an APC group cannot be considered comparable with respect to the use of resources if the highest median (or mean cost, if elected by the Secretary) for an item or service in the APC group is more than 2 times greater than the lowest median cost for an item or service within the same APC group (referred to as the ''2 times rule''). In implementing this provision, we use the median cost of the item or service assigned to an APC group.

Special payments under the OPPS may be made for new technology items and services in one of two ways. Section 1833(t)(6) of the Act provides for temporary additional payments or ''transitional pass-through payments'' for certain drugs, biological agents, brachytherapy devices used for the treatment of cancer, and categories of medical devices for at least 2 but not more than 3 years. For new technology services that are not eligible for pass-through payments and for which we lack sufficient data to appropriately assign them to a clinical APC group, we have established special APC groups based on costs, which we refer to as APC cost bands. These cost bands allow us to price these new procedures more appropriately and consistently. Similar to pass-through payments, these special payments for new technology services are also temporary; that is, we retain a service within a new technology APC group until we acquire adequate data to assign it to a clinically appropriate APC group.

B. Excluded OPPS Services and Hospitals

Section 1833(t)(1)(B)(i) of the Act authorizes the Secretary to designate the hospital outpatient services that are paid under the OPPS. While most hospital outpatient services are payable under the OPPS, section 1833(t)(1)(B)(iv) of the Act excluded payment for ambulance, physical and occupational therapy, and speech-language pathology services, for which payment is made under a fee schedule. The Secretary exercised the broad authority granted under the statute to exclude from the OPPS those services that are paid under fee schedules or other payment systems. Such excluded services include, for example, the professional services of physicians and nonphysician practitioners paid under the Medicare Physician Fee Schedule; laboratory services paid under the clinical diagnostic laboratory fee schedule; services for beneficiaries with end-stage renal disease (ESRD) that are paid under the ESRD composite rate; and services and procedures that require an inpatient stay that are paid under the hospital inpatient prospective payment system (IPPS). We set forth the services that are excluded from payment under the OPPS in § 419.22 of the regulations.

Under § 419.20 of the regulations, we specify the types of hospitals and entities that are excluded from payment under the OPPS. These excluded entities include Maryland hospitals, but only for services that are paid under a cost containment waiver in accordance with section 1814(b)(3) of the Act; critical access hospitals (CAHs); hospitals located outside of the 50 States, the District of Columbia, and Puerto Rico; and Indian Health Service hospitals.

C. Prior Rulemaking

On April 7, 2000, we published in the **Federal Register** a final rule with comment period (65 FR 18434) to implement a prospective payment system for hospital outpatient services. The hospital OPPS was first implemented for services furnished on or after August 1, 2000. Section 1833(t)(9) of the Act requires the Secretary to review certain components of the OPPS not less often than annually and to revise the groups, relative payment weights, and other adjustments to take into account changes in medical practice, changes in technology, and the addition of new services, new cost data, and other relevant information and factors. Since implementing the OPPS, we have published final rules in the **Federal Register** annually to implement statutory requirements and changes arising from our experience with this system. For a full discussion of the changes to the OPPS, we refer readers to these **Federal Register** final rules.[1]

On November 7, 2003, we published a final rule with comment period in the **Federal Register** (68 FR 63398) that revised the OPPS to update the payment weights and conversion factor for services payable under the calendar year (CY) 2004 OPPS on the basis of claims data from April 1, 2002 through December 31, 2002. In this final rule with comment period, we are finalizing the APC assignments and addressing public comments received pertaining to the new interim HCPCS codes listed in Addendum B of the November 7, 2003 final rule with comment period identified by new interim (NI) comment indicators (formerly referred to as condition codes). Subsequent to publishing the November 7, 2003 final rule with comment period, we published a correction of the final rule with comment period on December 31, 2003 (68 FR 75442). That December 31, 2003 document corrected technical errors in the November 7, 2003 final rule with comment period and included responses to a number of public comments that were inadvertently omitted from the November 2003 final rule with comment period.

On January 6, 2004, we published in the **Federal Register** an interim final rule with comment period (69 FR 820) that implemented provisions of Public Law 108–173 that affected payments made under the OPPS, effective January 1, 2004. We are finalizing this interim

[1] Interim final rule with comment period, August 3, 2000 (65 FR 47670); interim final rule with comment period, November 13, 2000 (65 FR 67798); final rule and interim final rule with comment period, November 2, 2001 (66 FR 55850 and 55857); final rule, November 30, 2001 (66 FR 59856); final rule, December 31, 2001 (66 FR 67494); final rule, March 1, 2002 (67 FR 9556); final rule, November 1, 2002 (67 FR 66718); final rule with comment period, November 7, 2003 (68 FR 63398); and interim final rule with comment period, January 6, 2004 (69 FR 820).

final rule and addressing public comments associated with that rule in this final rule with comment period.

D. APC Advisory Panel

1. Authority of the APC Panel

Section 1833(t)(9)(A) of the Act, as amended by section 201(h) of the BBRA of 1999, requires that we consult with an outside panel of experts to review the clinical integrity of the payment groups and weights under the OPPS. The Advisory Panel on APC Groups (the APC Panel), discussed under section I.D.2. of this preamble, fulfills this requirement. The Act further specifies that the Panel will act in an advisory capacity. This expert panel, which is to be composed of 15 representatives of providers subject to the OPPS (currently employed full-time, not consultants, in their respective areas of expertise), reviews and advises us about the clinical integrity of the APC groups and their weights. The APC Panel is not restricted to using our data and may use data collected or developed by organizations outside the Department in conducting its review.

2. Establishment of the APC Panel

On November 21, 2000, the Secretary signed the charter establishing the Advisory Panel on APC Groups. The APC Panel is technical in nature and is governed by the provisions of the Federal Advisory Committee Act (FACA), as amended (Public Law 92–463). On November 1, 2002, the Secretary renewed the charter. The renewed charter indicates that the APC Panel continues to be technical in nature, is governed by the provisions of the FACA, may convene up to three meetings per year, and is chaired by a Federal official.

Originally, in establishing the APC Panel, we solicited members in a notice published in the **Federal Register** on December 5, 2000 (65 FR 75943). We received applications from more than 115 individuals who nominated either colleagues or themselves. After carefully reviewing the applications, we chose 15 highly qualified individuals to serve on the APC Panel. Because of the loss of four APC Panel members due to the expiration of terms of office on March 31, 2004, we published a **Federal Register** notice on January 23, 2004 (69 FR 3370) that solicited nominations for APC Panel membership. From the 24 nominations that we received, we chose four new members. The entire APC Panel membership is identified on the CMS Web site at *http://www.cms.hhs.gov/faca/apc/apcmem.asp.*

3. APC Panel Meetings and Organizational Structure

The APC Panel first met on February 27, February 28, and March 1, 2001. Since that initial meeting, the APC Panel has held five subsequent meetings, with the last meeting taking place on September 1, 2, and 3, 2004. Prior to each of these biennial meetings, we published a notice in the **Federal Register** to announce each meeting and, when necessary, to solicit nominations for APC Panel membership. For a more detailed discussion about these announcements, refer to the following **Federal Register** notices: December 5, 2000 (65 FR 75943), December 14, 2001 (66 FR 64838), December 27, 2002 (67 FR 79107), July 25, 2003 (68 FR 44089), and December 24, 2003 (68 FR 74621), and August 5, 2004 (69 FR 47446).

During these meetings, the APC Panel established its operational structure that, in part, includes the use of three subcommittees to facilitate its required APC review process. Currently, the three subcommittees are the Data Subcommittee, the Observation Subcommittee, and the Packaging Subcommittee. The Data Subcommittee is responsible for studying the data issues confronting the APC Panel and for recommending viable options for resolving them. This subcommittee was initially established on April 23, 2001, as the Research Subcommittee and reestablished as the Data Subcommittee on April 13, 2004. The Observation Subcommittee, which was established on June 24, 2003, and reestablished with new members on March 8, 2004, reviews and makes recommendations to the APC Panel on all issues pertaining to observation services paid under the OPPS, such as coding and operational issues. The Packaging Subcommittee, which was established on March 8, 2004, studies and makes recommendations on issues pertaining to services that are not separately payable under the OPPS but are bundled or packaged APC payments. Each of these subcommittees was established by a majority vote of the APC Panel during a scheduled APC Panel meeting. All subcommittee recommendations are discussed and voted upon by the full APC Panel.

For a detailed discussion of the APC Panel meetings, refer to the hospital OPPS final rules cited in section I.C. of this preamble. Full discussions of the APC Panel's February 2004 and September 2004 meetings and the resulting recommendations are included in sections II., III., IV., V., and VI. of this preamble under the appropriate subject headings.

E. Provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003

On December 8, 2003, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Public Law 108–173, was enacted. Public Law 108–173 made changes to the Act relating to the Medicare OPPS. In a January 6, 2004 interim final rule with comment period, we implemented provisions of Public Law 108–173 relating to the OPPS that were effective for CY 2004. In this final rule with comment period, we are responding to public comments received on the January 6, 2004 interim final rule and finalizing that rule. In addition, in this final rule with comment period, we are implementing the following sections of Public Law 108–173 that are effective for CY 2005:

- Section 611, which provides for Medicare coverage of an initial preventive physical examination under Part B, subject to the applicable deductible and coinsurance, as an outpatient department (OPD) service payable under the OPPS. The provisions of section 611 apply to services furnished on or after January 1, 2005, but only for individuals whose coverage period under Medicare Part B begins on or after that date.
- Section 614, which provides that screening mammography and diagnostic mammography services are excluded from payment under the OPPS. This amendment applies to screening mammography services furnished on or after the date of enactment of Public Law 108–173 (that is, December 8, 2003), and in the case of diagnostic mammography, to services furnished on or after January 1, 2005.
- Section 621(a)(1), which requires special classification of certain separately paid radiopharmaceutical agents and drugs or biologicals, and specifies the pass-through payment percentages, effective for services furnished on or after January 1, 2005, for the three categories of ''specified covered OPD drugs'' defined in the statute: sole source drug; innovator multiple source drug; and noninnovator multiple source drug. In addition, payment for these drugs for CYs 2004 and 2005 does not have to be made in a budget neutral manner.
- Section 621(a)(2), which specifies the reduced threshold for the establishment of separate APCs with respect to drugs or biologicals from $150 to $50 per administration for drugs and biologicals furnished in CYs 2005 and 2006.

• Section 621(a)(3), which excludes separate drug APCs from outlier payments. Specifically, no additional payment will be made in the case of APC groups established separately for drugs and biologicals.

• Section 621(b), which requires that all devices of brachytherapy consisting of a seed or seeds (or radioactive source) furnished on or after January 1, 2004, and before January 1, 2007, be paid based on the hospital's charges for each device, adjusted to cost. This provision also requires that these brachytherapy services be excluded from outlier payments.

F. Summary of the Provisions of the August 16, 2004 Proposed Rule

On August 16, 2004, we published a proposed rule in the **Federal Register** (69 FR 50447) that set forth proposed changes to the Medicare hospital OPPS and to implement provisions of Public Law 108–173 specified in section I.E. of this preamble that would be effective for services furnished on or after January 1, 2005. The following is a summary of the major changes that we proposed to make:

1. Changes to the APC Groups

As required by section 1833(t)(9)(A) of the Act, we proposed the annual update of the APC groups and the relative payment weights. This section also requires that we consult with an outside panel of experts, the Advisory Panel on APC Groups, to review the clinical integrity of the groups and weights under the OPPS. Based on analyses of Medicare claims data and recommendations of the APC Panel, we proposed to establish a number of new APCs and to make changes to the assignment of HCPCS codes under a number of existing APCs.

We also discussed the application of the 2 times rule and proposed exceptions to it; coding for stereotactic radiosurgery services; the proposed movement of procedures from the new technology APCs; the proposed changes to the list of procedures that will be paid as inpatient services; and the proposed addition of new procedure codes to the APCs.

2. Recalibrations of APC Relative Payment Weights

In the proposed rule, we discussed the methodology used to recalibrate the proposed APC relative payment weights and set forth the proposed recalibration of the relative weights for CY 2005.

3. Payment Changes for Devices

In the proposed rule, we discussed proposed changes to the pass-through payment for devices and the methodology used to reduce, if applicable, transitional pass-through payments to offset costs packaged into APC groups.

4. Payment Changes for Drugs, Biologicals, Radiopharmaceutical Agents, and Blood and Blood Products

In the proposed rule, we discussed our proposed payment changes for drugs, biologicals, radiopharmaceutical agents, and blood and blood products.

5. Estimated Transitional Pass-Through Spending in CY 2005 for Drugs, Biologicals, and Devices

In the proposed rule, we discussed the proposed methodology for measuring whether there should be an estimated pro rata reduction for transitional pass-through drugs, biologicals, and devices for CY 2005.

6. Other Policy Decisions and Proposed Policy Changes

In the proposed rule, we presented our proposals for CY 2005 regarding the following:

• Update of statewide default cost-to-charge ratios (CCRs).

• A conforming change to the regulation relating to the use of the first available cost reporting period ending after 1996 and before 2001 for determining a provider's payment-to-cost ratio to calculate transitional corridor payments for hospitals paid under the OPPS that did not have a 1996 cost report.

• Changes in the status indicators and comment indicators assigned to APCs for CY 2005.

• Elimination of the diagnostic tests criteria as a requirement for hospitals to qualify for separate payment of observation services under APC 0339 (Observation) and changes to the guidelines to hospitals for counting patients' time spent in observation care.

• Payment under the OPPS for certain procedures currently assigned to the inpatient list.

• Strategy for giving the public notice of new implementation guidelines for new evaluation and management codes.

• Addition of three new HCPCS codes and descriptors for brachytherapy sources that would be paid separately, pursuant to Public Law 108–173.

• Modification of the HCPCS code descriptors for brachytherapy source descriptors for which units of payment are not already delineated.

• Payment for services furnished emergently to an outpatient who dies before admission to a hospital as an inpatient.

7. Conversion Factor Update for CY 2005

As required by section 1833(5)(3)(C)(ii) of the Act, in the proposed rule, we proposed to update the conversion factor used to determine payment rates under the OPPS for CY 2005.

8. Wage Index Changes for CY 2005

In the proposed rule, we discussed the proposed retention of our current policy to apply the IPPS wage indices to wage adjust the APC median costs in determining the OPPS payment rate and the copayment standardized amount. These indices reflect major changes for CY 2005 relating to hospital labor market areas as a result of OMB revised definitions of geographical statistical areas; hospital reclassifications and redesignations, including the one-time reclassifications under section 508 of Public Law 108–173; and the wage index adjustment based on commuting patterns of hospital employees under section 505 of Public Law 108–173.

9. Determination of Payment Rates and Outlier Payments for CY 2005

In the proposed rule, we discussed how APC payment rates are calculated and how the payment rates are adjusted to reflect geographic differences in labor-related costs. We also discussed proposed changes in the way we would calculate outlier payments for CY 2005.

10. Regulatory Impact Analysis

In the proposed rule, we set forth our analysis of the impact that the proposed changes would have on affected hospitals and CMHCs.

G. Public Comments Received on the August 16, 2004 Proposed Rule

We received over 550 timely pieces of correspondence containing multiple comments on the August 16, 2004 proposed rule. Summaries of the public comments and our responses to those comments are set forth in the various sections of this preamble under the appropriate heading.

We received a number of general public comments on our proposed changes to the OPPS for CY 2005.

Comment: Some commenters were concerned about the extent to which OPPS payment rates have fluctuated from year to year. Because Medicare payment is a very significant portion of income for most hospitals, they stated that the instability in the OPPS payment rates makes it difficult for hospitals to plan and budget. They indicated that there is a tremendous degree of variation across APCs in terms of payment to cost ratios and that they

would expect that after three years of operating the OPPS, the payment to cost ratios would be much more stable. One commenter offered to share analysis of payment to cost ratios with CMS. Commenters stated that such variation in payments compared to costs puts full-service hospitals and their communities at risk because limited-service, or ''niche'' providers can easily identify and redirect patients with more lucrative APCs to their facilities, leaving full-service hospitals with a disproportionate share of patients who receive services that are assigned to the underpaid APCs.

Response: We recognize hospitals' need for stability in payments for hospital outpatient services. We would appreciate receiving studies of the extent to which there is variation across APCS in terms of payment to cost ratios across the multiple years of the OPPS to aid us in assessing factors that might contribute to instability in the payment rates.

Comment: One commenter indicated that the entire OPPS is underfunded, as it pays only 87 cents of every dollar of hospital outpatient care provided to Medicare beneficiaries. The commenter stated that it will continue to work with Congress to address inadequate payment rates and updates in order to ensure access to hospital-based outpatient services for Medicare beneficiaries.

Response: Our early analyses indicated that the OPPS was, in its inception, based on payment that was less than cost due to statutory reductions in payment for hospital outpatient costs prior to the enactment of the Balanced Budget Act of 1997, which authorized the current OPPS. We agree that the commenter will need to work with Congress to change certain fundamental features of the OPPS. For example, the base amounts upon which the OPPS was established, the rules concerning budget neutrality, and subsequent out-year adjustments such as annual reductions in coinsurance and adjustments to outlier and pass-through payment allocations are established in statute and, as such, would require legislation to amend.

Comment: One commenter objected to the use of the display date to start the 60-day comment period for the proposed rule. The commenter stated that the display copy did not contain all of the information included in the proposed rule, such as the comment due date, and did not satisfy the statute's requirement that the notice of proposed rulemaking be published in the **Federal Register**, with provision for a 60-day comment period. The commenter indicated that the use of the display date to start the comment period gives reviewers too short a period of time to comment properly and also, in this case, gives CMS an inadequate period of time to review the comments and prepare the final rule. The commenter urged CMS to publish a proposed rule no later than late July to provide more time for CMS to consider public comments.

Response: While the law requires that we provide a 60-day public comment period and that the notice of proposed rulemaking be published in the **Federal Register**, it does not require that the date of **Federal Register** publication be the first day of the comment period. The two requirements are independent. We post the proposed rule on the CMS Web site on the date of display of the proposed rule at the **Federal Register**, thereby making the proposed rule far more easily available to the public than was the case when the only public dissemination was publication in the **Federal Register**, and satisfying the requirement for a 60-day comment period. By making the proposed rule available on the CMS Web site (as well as at the **Federal Register**), we provided the public with access to not only the proposed rule but also to all of the supporting files and documents cited in the proposed rule in a manner that can be used for analysis. We note that the computer files posted on the Web site can be manipulated for independent analysis. Therefore, we believe that beginning the comment period for the proposed rule with the display date at the **Federal Register**, and posting the proposed rule and data files on the CMS Web site on the display date, fully complies with the statute and provides a far better opportunity for the public to have meaningful input than the past practice under which the comment period began with the publication date in the **Federal Register** a week or longer after the display date and no other data in any other form was furnished.

With respect to the publication date of the proposed rule, we publish the proposed rule as soon as it is practicable for us to do so. Our process for development of the proposed rule begins with a winter meeting of the APC Panel based on the earliest possible data analysis for the forthcoming year. We then pull claims for the period ending December of the data year and also pull cost report data for development of CCRs to apply to the claims data. This step cannot be started until approximately March 1 of the year and the development of the proposed rule data takes considerable time as there are many analyses to be performed and decisions to be made before each stage of data development can be undertaken. We have to balance the need to improve the process and to deal with each year's special issues with the need to issue a proposed rule in sufficient time to permit the public to comment and to permit us sufficient time to review the comments and develop the final rule. Each year we review the timeline and process to determine how we can best achieve that balance, while ensuring that we issue the best possible proposed rule for public comment.

H. Public Comments Received on the January 6, 2004 Interim Final Rule With Comment Period

We received approximately 40 timely pieces of correspondence containing multiple comments on the MMA provisions relating to payment for drugs and brachytherapy under the OPPS that were included in the January 6, 2004 interim final rule with comment period. Summaries of the public comments and our responses to those comments are set forth in sections V. and VII.G. of this preamble under the appropriate heading.

I. Public Comments Received on the November 7, 2003 Final Rule With Comment Period

We received 25 timely pieces of correspondence on the November 7, 2003 final rule with comment period, some of which contained multiple comments on the APC assignment of HCPCS codes identified with the new interim condition indicators (now referred to as condition codes) in Addendum B of that final rule with comment period. Summaries of the public comments and our responses to those comments are set forth in various sections of this preamble under the appropriate subject areas.

II. Changes Related to Ambulatory Payment Classifications (APCs)

Section 1833(t)(2)(A) of the Act requires the Secretary to develop a classification system for covered hospital outpatient services. Section 1833(t)(2)(B) provides that this classification system may be composed of groups of services, so that services within each group are comparable clinically and with respect to the use of resources. In accordance with these provisions, we developed a grouping classification system, referred to as the Ambulatory Payment Classification Groups (or APCs), as set forth in § 419.31 of the regulations. We use Level I and Level II Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group the services within each APC. The APCs are organized such that each

group is homogeneous both clinically and in terms of resource use. (However, new technology APCs that are temporary groups for certain approved services are structured based on cost rather than clinical homogeneity.) Using this classification system, we have established distinct groups of surgical, diagnostic, and partial hospitalization services, and medical visits. Because of the transitional pass-through provisions, we also have developed separate APC groups for certain medical devices, drugs, biologicals, radiopharmaceuticals, and devices of brachytherapy.

We have packaged into each procedure or service within an APC group the cost associated with those items or services that are directly related and integral to performing a procedure or furnishing a service. Therefore, we would not make separate payment for packaged items or services. For example, packaged items and services include: Use of an operating, treatment, or procedure room; use of a recovery room; use of an observation bed; anesthesia; medical/surgical supplies; pharmaceuticals (other than those for which separate payment may be allowed under the provisions discussed in section V. of this preamble); and incidental services such as venipuncture. Our packaging methodology is discussed in section IV.B.3. of this final rule with comment period.

A. APC Changes: General

Under the OPPS, we pay for hospital outpatient services on a rate-per-service basis that varies according to the APC group to which the service is assigned. Each APC weight represents the median hospital cost of the services included in that APC relative to the median hospital cost of the services included in APC 0601, Mid-Level Clinic Visits. The APC weights are scaled to APC 0601 because a mid-level clinic visit is one of the most frequently performed services in the outpatient setting.

Section 1833(t)(9)(A) of the Act requires the Secretary to review the components of the OPPS not less than annually and to revise the groups and relative payment weights and make other adjustments to take into account changes in medical practice, changes in technology, and the addition of new services, new cost data, and other relevant information and factors. Section 1833(t)(9)(A) of the Act, as amended by section 201(h) of the BBRA of 1999, also requires the Secretary, beginning in CY 2001, to consult with an outside panel of experts to review the APC groups and the relative payment weights.

Finally, section 1833(t)(2) of the Act provides that, subject to certain exceptions, the items and services within an APC group cannot be considered comparable with respect to the use of resources if the highest median (or mean cost, if elected by the Secretary) for an item or service in the group is more than 2 times greater than the lowest median cost for an item or service within the same group (referred to as the ''2 times rule''). We use the median cost of the item or service in implementing this provision. The statute authorizes the Secretary to make exceptions to the 2 times rule in unusual cases, such as low volume items and services.

Section 419.31 of the regulations sets forth the requirements for the APC system and the determination of the payment weights. In this section, we discuss the changes that we proposed to the APC groups; the APC Panel's review and recommendations from the February 2004 meeting and our proposals in response to those recommendations; the application of the 2 times rule and proposed exceptions to it; coding for stereotactic radiosurgery services; the proposed movement of procedures from the new technology APCs; the proposed changes to the inpatient list; and the proposed additions of new procedures codes to the APCs. In addition, in this section under the appropriate subject heading, we present the APC Panel's review and recommendations of items discussed at the September 1, 2, and 3, 2004 meeting held after publication of the proposed rule and our final decisions on these recommendations. We then present our final policies that are effective for CY 2005.

B. APC Panel Review and Recommendations

1. February 2004 Panel Meeting

As stated above, the APC Panel held its first 2004 meeting on February 18, 19, and 20, 2004, to discuss the revised APCs for the CY 2005 OPPS. In preparation for that meeting, we published a notice in the **Federal Register** on December 24, 2003 (68 FR 74621), to announce the location, date, and time of the meeting; the agenda items; and the fact that the meeting was open to the public. In that notice, we solicited public comment specifically on the items included on the agenda for that meeting. We also provided information about the APC Panel meeting on the CMS Web site: *http://www.cms.hhs.gov/faca/apc/panel.*

Oral presentations and written comments submitted for the February 2004 APC Panel meeting met, at a minimum, the adopted guidelines for presentations set forth in the **Federal Register** document (68 FR 74621). In conducting its APC review, the APC Panel heard testimony and received evidence in support of the testimonies from a number of interested parties. For the February 2004 deliberations, the APC Panel used hospital outpatient claims data for the period January 1, 2003, through September 30, 2003, that provided, at a minimum, median costs for the APC structure in place in CY 2004 and that was based on CCRs used for setting the CY 2004 payment rates. The data set presented to the APC Panel represented 9 months of the CY 2003 data that we proposed to use to recalibrate the APC relative weights and to calculate the proposed APC payment rates for CY 2005. In sections II.B.4. through 7. and sections II.C. through I. of this preamble, we summarize the APC issues discussed during the APC Panel's February 2004 meeting, the Panel's recommendations, the proposals that we included in the August 16, 2004 proposed rule, our proposals with respect to those recommendations, and the policies that we are finalizing for CY 2005 in this final rule with comment period.

2. September 2004 Panel Meeting

As stated earlier, the APC Panel held its second 2004 meeting on September 1–3, 2004. In preparation for that meeting, we published a notice in the **Federal Register** on August 5, 2004 (69 FR 47446) to announce the location, date, and time of the meeting, the agenda items, and the fact that the meeting was open to the public. In that notice, we solicited public comments specifically on the items included on the agenda for that meeting. During the September 2004 APC Panel meeting, the APC Panel heard testimony on a number of the proposed changes in APCs included in the August 16, 2004 proposed rule. We are summarizing the topics that were discussed at the September 2004 Panel meeting and the APC Panel's recommendations on each topic in the chart below. We have included references to the appropriate section of this preamble for the more detailed discussion of each recommendation.

For the September 2004 deliberations, the APC Panel used the hospital outpatient claims data that we used in developing the proposed rule; that is, data for the period of January 1, 2003,

through December 31, 2003, including updated CCRs.

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Summary of APC Panel Recommendations from September 2004 Meeting

Recommendation	For Discussion, see Preamble Section
The APC Panel recommended that CMS should--	Section II.B.6
1. Continue its exploration of ways to increase the number of multiple procedure claims that can be used for OPPS ratesetting.	Section III.A.1
2. Post the crosswalk of revenue codes to cost centers on the OPPS website.	Section V.H
3. Assign a modifier to CPT codes 36540, 36600, 51701, and 97602 to facilitate identification of claims on which any of those is the only payable code on the date of service.	Section II.B.7
4. Not change the status indicator for CPT code 76937.	Section II.B.7
5. Allow separate payment for observation services even when cardiac catheterization is performed on the same day.	Section VII.D
6. Expand the list of diagnoses eligible for observation services.	Section VII. D
7. Solicit input on the inpatient list from professional organizations.	Section II.G
8. Maintain payment for low-volume blood products for CY 2005 at the CY 2004 level.	Section V.I
9. Use external data as a basis for setting payment rates for low-volume blood products.	Section V.I
10. Evaluate whether or not current statutes allow the extension of pass-through status for embolization protective system (HCPCS code C1884).	Section IV.A.2
11. Require that C-codes be reported for all devices associated with a C-code.	Section III.C.4
12. Retain the CY 2004 configuration of APCs 0385 and 0386.	Section III.C.1
13. Except for APCs 0418 and 0425, make adjustments to the medians for the device-dependent APCs listed in Table 19 of the August 16, 2004 proposed rule that increase or decrease by 5 percent for CY 2005 compared to CY 2004.	Section III.C.4
14. Assign CPT code 58563 and HCPCS code 0009T to APC 0387.	Section II.C.13
15. Evaluate the APC assignments for CPT codes 36555 through 36597 for discussion at the first CY 2005 (winter) meeting of the APC Panel.	Section II.C.13
16. Maintain CPT codes 77523 and 77525 in the new technology APC for CY 2005.	Section II. F.3
17. Assign status indicator K to HCPCS code J2790	Section V.B.2

3. Contents of This Section of the Preamble

The discussion in this section II.B. of this final rule with comment period is limited to APC changes regarding APCs other than those that violate the 2 times rule and those that represent drugs, biologicals, and transitional pass-through devices, or those that are new technology APCs. The specific APC Panel review and recommendations applicable to those APCs are discussed in sections II.C., IV., III., and II.F., respectively, of the preamble to this final rule with comment period.

4. APC 0018: Biopsy of Skin/Puncture of Lesion

During the February 2004 APC Panel meeting, one presenter recommended moving CPT tracking codes 0046T (Catheter lavage, mammary duct(s)) and 0047T (Each additional duct) from APC 0018 and placing them in an APC that more accurately reflects each of the procedures. The APC Panel recommended that we reassign CPT codes 0046T and 0047T to APC 0021, Level III Excision/Biopsy.

In the August 16, 2004 proposed rule, we proposed to accept the APC Panel's recommendation. We did not receive any public comments on our proposal. Therefore, we are adopting as final, without modification, our proposal to reassign CPT codes 0046T and 0047T to APC 0021.

5. Level I and II Arthroscopy

APC 0041: Level I Arthroscopy

APC 0042: Level II Arthroscopy

We testified before the APC Panel at its February 2004 meeting regarding a comment that we received in 2003 requesting that we reassign CPT code 29827 (Arthroscopy, shoulder with rotator cuff repair) from APC 0041 to APC 0042, based on its similarity to CPT 29826 (Arthroscopy, shoulder decompression of subacromial space with partial acromioplasty without coracoacromial release). Our clinical staff considered the request and determined that APCs 0041 and 0042 should be reconfigured to improve clinical homogeneity. An APC Panel presenter provided evidence to support moving CPT code 29827 to an APC that would more accurately recognize the complexity of that procedure. We requested the APC Panel's recommendation regarding a total revision of these two APCs.

The APC Panel recommended that we reevaluate the codes in APCs 0041 and 0042 and propose restructuring that would improve the clinical homogeneity in the two APCs.

In the August 16, 2004 proposed rule, we proposed to accept the APC Panel's recommendation and to revise APCs 0041 and 0042 as presented in Tables 1 and 2 of that proposed rule. We received one public comment on our proposed restructuring.

Comment: One commenter requested that we move code 0014T from APC 0041 to APC 0042. The commenter provided information in support of its belief that the procedure more accurately matches the clinical work and resource inputs of APC 0042 than of APC 0041.

Response: We agree with the commenter and are assigning the procedure to APC 0042. The tracking code 0014T is being retired and the successor code is CPT code 29868 (Arthroscopy, knee, surgical, osteochondral autograft(s) meniscal transplantation (including arthrotomy for meniscal insertion, medial or lateral). Placement of this code in APC 0042 is subject to comment in response to this final rule with comment period because the code is a new code for CY 2005.

Accordingly, restructured APCs 0041 and 0042 for CY 2005, as modified based on the public comment received, are shown in Tables 1 and 2 below.

Table 1.--Reconstructed APC 0041: Level I Arthroscopy

CPT/HCPCS Code	Description
29850	Knee arthroscopy/surgery
29870	Knee arthroscopy/diagnostic
29871	Knee arthroscopy/drainage
29873	Knee arthroscopy/surgery
29874	Knee arthroscopy/surgery
29875	Knee arthroscopy/surgery
29876	Knee arthroscopy/surgery
29877	Knee arthroscopy/surgery
29879	Knee arthroscopy/surgery
29880	Knee arthroscopy/surgery
29881	Knee arthroscopy/surgery
29882	Knee arthroscopy/surgery
29883	Knee arthroscopy/surgery
29884	Knee arthroscopy/surgery
29886	Knee arthroscopy/surgery
29805	Shoulder arthroscopy/diagnostic
29819	Shoulder arthroscopy/surgery
29820	Shoulder arthroscopy/surgery
29821	Shoulder arthroscopy/surgery
29822	Shoulder arthroscopy/surgery
29823	Shoulder arthroscopy/surgery
29825	Shoulder arthroscopy/surgery
29834	Elbow arthroscopy/surgery
29835	Elbow arthroscopy/surgery
29836	Elbow arthroscopy/surgery
29837	Elbow arthroscopy/surgery
29838	Elbow arthroscopy/surgery
29840	Wrist arthroscopy
29843	Wrist arthroscopy/surgery
29844	Wrist arthroscopy/surgery
29845	Wrist arthroscopy/surgery
29846	Wrist arthroscopy/surgery
29848	Wrist arthroscopy/surgery
29891	Wrist endoscopy/surgery
29892	Ankle arthroscopy/surgery
29894	Ankle arthroscopy/surgery
29895	Ankle arthroscopy/surgery
29897	Ankle arthroscopy/surgery
29898	Ankle arthroscopy/surgery
29804	Jaw arthroscopy/surgery
29999	Arthroscopy of joint
0012T	Osteochondral knee autograft
29830	Elbow arthroscopy
29860	Hip arthroscopy, dx
29887	Knee arthroscopy/surgery

Table 2.--Reconstructed APC 0042: Level II Arthroscopy

CPT/HCPCS Code	Description
29851	Knee arthroscopy/surgery
29885	Knee arthroscopy/surgery
29888	Knee arthroscopy/surgery
29889	Knee arthroscopy/surgery
29806	Shoulder arthroscopy/surgery
29807	Shoulder arthroscopy/surgery
29824	Shoulder arthroscopy/surgery
29826	Shoulder arthroscopy/surgery
29827	Arthroscopic rotator cuff repair
29847	Wrist arthroscopy/surgery
29855	Tibial arthroscopy/surgery
29856	Tibial arthroscopy/surgery
29899	Ankle arthroscopy/surgery
29800	Jaw arthroscopy/surgery
0013T	Osteochondral knee allograft
29861	Hip arthroscopy/surgery
29862	Hip arthroscopy/surgery
29863	Hip arthroscopy/surgery
29868	Meniscal transplantation, knee

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6. Angiography and Venography Except Extremity

APC 0279: Level II Angiography and Venography Except Extremity

APC 0280: Level III Angiography and Venography Except Extremity

APC 0668: Level I Angiography and Venography Except Extremity

a. February 2004 Panel Meeting

As requested by the APC Panel, at the February 2004 Panel meeting, we presented our proposal for reconfiguring APCs 0279, 0280, and 0668 that reflected changes based on prior input with outside clinical experts. The APC Panel had previously reviewed these APCs during its January 2003 meeting and had recommended that we not restructure these three APCs until we received input from clinical experts in the field. When we updated the APC groups in CY 2003, we accepted the APC Panel's recommendation and made no changes to APCs 0279, 0280, and 0668.

A review of these APCs was prompted by a commenter who requested that we move CPT code 75978 (Repair venous blockage) from APC 0668 to APC 0280 and that we move CPT code 75774 (Artery x-ray, each vessel) from APC 0668 to APC 0279. The commenter submitted evidence in support of these requests and testified before the APC Panel regarding the common use of CPT code 75978 for treating dialysis patients and the often required multiple intraoperative attempts to succeed with this procedure for such patients.

After receiving input from the clinical experts, we determined that these three APCs should be revised to improve their clinical homogeneity. At the February 2004 meeting, we presented our proposed restructuring of APCs 0279, 0280, and 0668 to the APC Panel. The APC Panel concurred with our proposal.

In addition, subsequent to the APC Panel meeting, we discovered several procedures in these APCs that were more appropriately placed in other APCs in order to remedy any 2 times rule violations. We included those modifications in our proposed restructured APCs published in Table 3 in the August 16, 2004 proposed rule.

b. Public Comments Received

Comment: Several commenters requested that CMS postpone or cancel the proposed plans for moving angiography codes 75960 (Transcatheter introduction of intravascular stent(s), (non-coronary vessel) percutaneous and/or open, radiological supervision and interpretation, each vessel), 75962 (Transluminal balloon angioplasty, peripheral artery, radiological supervision and interpretation), 75964 (Transluminal balloon angioplasty, each additional peripheral artery, radiological supervision and interpretation), 75966 (Transluminal balloon angioplasty, renal or other visceral artery, radiological supervision and interpretation), and 75968 (Transluminal balloon angioplasty, each additional visceral artery, radiological supervision and interpretation), which are integral to a number of angioplasty and stent placement procedures, from APC 0280 to APC 0668. One commenter indicated that the proposed decreases in payments for these services that would result from their APC reassignment were inconsistent with CMS' proposal to limit payment decreases for device-dependent APCs. Another commenter was particularly concerned that code 75962, which is used for angioplasty of arterial blockages, may have a wide range of associated procedure costs. The commenters stated that aggregate payment for all services billed for many high volume procedures such as peripheral transluminal angioplasty and single stent placement will decrease by 16 to 21 percent, in large part due to the reassignment of codes 75960, 75962, 75964, 75966, and 75968 to the lower level APC 0668 in the angiography and venography except extremity series and

to their placement on the bypass list. Two commenters were concerned that supervision and interpretation services as part of peripheral atherectomy procedures were assigned to higher paying APC 0279, potentially providing hospitals with an incentive to perform atherectomy instead of angioplasty or stent procedures, or both. Further, the commenters suggested that the lower payment for the supervision and interpretation services moved to APC 0668 for CY 2005 provides an incentive for hospitals to treat patients on an inpatient basis or may limit beneficiaries' access to the outpatient procedures. One commenter indicated that the cost and complexity of performing angiographic procedures for angioplasty are similar, if not more complex, than those of performing angiographic procedures for atheretomy.

The commenters did not understand why CMS reassigned the supervision and interpretation codes from a Level III to a Level I APC and believed that CMS did not take into account the higher level of hospital resources and staffing required for certain therapeutic radiology supervision and interpretation services. Further, they questioned the assumptions CMS adopted in the creation of the bypass list to develop ''pseudo''single claims. They suggested that there might be significant differences between the multiple procedure claims that CMS converts to ''pseudo'' single claims and those that CMS is unable to use. Thus, the commenters questioned the reliability of the claims data and encouraged CMS to use external data as the basis for the decisionmaking. One commenter noted that, of a large number of claims for APC 0668, 79 percent accounted for device costs and 81 percent accounted for room charges, but CMS' single claim methodology had only 4 percent of claims accounting for device costs or room charges.

Finally, one commenter, a group of providers, stated that they expected substantial payment decreases to result from the proposed restructuring of APCs 0279, 0280, and 0668. The commenter suggested that CMS should establish a mechanism (such as dampening) to offset large payment swings similar to those anticipated as a result of the CMS proposal.

Response: Our analyses of claims data used for the CY 2004 OPPS and several past comments led us to recognize the need to restructure APCs 0279, 0280, and 0668 for the CY 2005 OPPS. There were only two services in APC 0668 for CY 2004, APC 0279 was excepted from the 2 times rule in CY 2004, and the median costs for individual services in APCs 0668, 0279, and 0280 showed significant overlap. The APC Panel also acknowledged the need to reconfigure these APCs. In our proposed rule, we presented the restructured APCs in which the procedures within each APC demonstrated both clinical and resource homogeneity, and our final data confirmed the appropriate assignment of the services. For instance, the peripheral atherectomy supervision and interpretation codes (75992 through 75996) assigned to the Level II APC (0279) consistently had higher median costs than the supervision and interpretation codes for intravascular stent placement or peripheral or visceral artery balloon angioplasty, which are assigned to the Level I APC (0668). For CY 2005, the median costs for the supervision and interpretation codes for stent placement and angioplasty were much lower than the median cost of their prior APC 0280 ($1,181) and were within the range of median costs ($239–$444) for other procedures assigned to APC 0668. As APCs 0668, 0279, and 0280 are not device-dependent APCs because we expect the devices to be reported with the interventional procedures provided (that are in device-dependent APCs), it would be inappropriate to apply the device-dependent APC policy to APCs 0668, 0279, and 0280. In addition, there were no violations of the 2 times rule in the restructured APCs 0668, 0279, or 0280 based on full year 2003 hospital claims data.

The supervision and interpretation codes 75960, 75962, 75964, 75966, and 75968, along with peripheral atherectomy supervision and interpretation CPT codes, were proposed for the bypass list for CY 2005. As the commenters noted, we recognized that angiography and venography services generally involve multiple procedure claims, and less than 10 percent of bills for APCs 0668, 0279, and 0280 were available for ratesetting for CY 2004. We proposed to place a number of radiological supervision and interpretation codes on the bypass list for CY 2005 because we believed that these codes should have little packaging associated with them and we recognized that their addition to the bypass list might enable us to use significantly more data from multiple procedure claims for APCs 0668, 0279, 0280, and others. We did not expect that devices and room charges would generally be packaged with the supervision and interpretation services, but rather would be packaged with the interventional procedures they accompanied. This accounts for the low percentage of device and room costs on the single bills in APC 0668 used for the median calculation. None of the commenters provided any information about why it would be inappropriate to include these codes on the bypass list, other than to point out the decline in proposed payment rates for the services. If packaging appropriately attributable to the supervision and interpretation services through the bypass procedure had been assigned to the interventional procedures that the supervision and interpretation services accompanied (such as angioplasty or stent placement), there should have been increases in the median costs for the interventional procedures. We did not see any such significant increases, and believe that our data do not indicate any specific packaging allocation problems with respect to the supervision and interpretation services. We have no evidence of underreporting of costs used to calculate the median costs for APC 0668.

For CY 2005, we had a significantly greater number of single claims available for use in median calculation for APCs 0668, 0279, and 0280. For example, for CY 2005, the median costs for the two supervision and interpretation codes with the highest volume that were of concern to the commenters (codes 75960 and 75962) were based on 20 percent of claims in contrast to only 1 percent used last year. While it is possible, as suggested by the commenters, that there may be differences between the packaging in multiple procedure claims that we were able to convert to ''pseudo'' single claims and those that we were unable to use, we have no reason to believe that these issues are unique to these APCs or especially problematic for these supervision and interpretation services. Our goal continues to be to use as much of our historical hospital claims data to set payment rates as possible. As we have consistently stated, we are pursuing strategies to improve our ability to utilize multiple procedure claims for median calculation, including discussions with the APC Panel Data Subcommittee.

With regard to the commenter's suggestion that we establish a mechanism to offset payment changes from one year to the next, we understand the commenter's desire for a stable system. However, while we are not convinced that an overall dampening policy is required, we continue to work toward improving the hospital claims data through education, data management, and data analyses. We believe that we have achieved significant improvements so far.

c. Final Policy for CY 2005

After consideration of the APC Panel's recommendations and the public comments we received on the August 16, 2004 proposal, we are finalizing our proposal for the restructuring of APCs 0668, 0279, and 0280.

Tables 3, 4, and 5 reflect the final restructuring of APCs 0668, 0279, and 0280.

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Table 3.—Restructured APC 0668: Level I Angiography and Venography Except Extremity

CPT/HCPCS Code	Description	CY 2004 APC	CY 2005 APC
75660	Artery x-rays, head and neck	0279	0668
75705	Artery x-rays, spine	0279	0668
75733	Artery x-rays, adrenals	0280	0668
75960	Transcatheter introduction, stent	0280	0668
75961	Retrieval, broken catheter	0280	0668
75962	Repair arterial blockage, peripheral artery	0280	0668
75964	Repair artery blockage, each	0280	0668
75966	Repair arterial blockage, renal or other visceral	0280	0668
75968	Repair arterial blockage, each		
	additional visceral	0280	0668
75970	Vascular biopsy	0280	0668
75978	Repair venous blockage	0668	0668

Table 4.—Restructured APC 0279: Level II Angiography and Venography Except Extremity

CPT/HCPCS Code	Description	CY 2004 APC	CY 2005 APC
75658	Artery x-rays, arm	0280	0279
75741	Artery x-rays, lung	0279	0279
75746	Artery x-rays, lung	0279	0279
75756	Artery x-rays, chest	0279	0279
75774	Artery x-rays, each vessel	0668	0279
75810	Vein x-ray, spleen/liver	0279	0279
75825	Vein x-ray, trunk	0279	0279
75827	Vein x-ray, chest	0279	0279
75833	Vein x-rays, kidneys	0279	0279
75887	Vein x-ray, liver	0280	0279
75891	Vein x-ray, liver	0279	0279
75992	Atherectomy, x-ray exam	0280	0279
75993	Atherectomy, x-ray exam	0280	0279
75994	Atherectomy, x-ray exam	0280	0279
75995	Atherectomy, x-ray exam	0280	0279
75996	Atherectomy, x-ray exam	0280	0279

Table 5. —Restructured APC 0280: Level III Angiography and Venography Except Extremity

CPT/HCPCS Code	Description	CY 2004 APC	CY 2005 APC
75600	Contrast x-ray exam of aorta	0280	0280
75605	Contrast x-ray exam of aorta	0280	0280
75625	Contrast x-ray exam of aorta	0280	0280
75630	X-ray aorta, leg arteries	0280	0280
75650	Artery x-rays, head and neck	0280	0280
75662	Artery x-rays, head and neck	0279	0280
75665	Artery x-rays, head and neck	0280	0280
75671	Artery x-rays, head and neck	0280	0280
75676	Artery x-rays, neck	0280	0280
75680	Artery x-rays, neck	0280	0280
75685	Artery x-rays, spine	0279	0280
75710	Artery x-rays, arm/leg	0280	0280
75716	Artery x-rays, arms/legs	0280	0280
75722	Artery x-rays, kidney	0280	0280
75724	Artery x-rays, kidneys	0280	0280
75726	Artery x-rays, abdomen	0280	0280
75731	Artery x-rays, adrenal gland	0280	0280
75736	Artery x-rays, pelvis	0280	0280
75743	Artery x-rays, lungs	0280	0280
75885	Vein x-ray, liver	0279	0280
75889	Vein x-ray, liver	0279	0280

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7. Packaged Codes in APCs

As a result of requests from the public, the Packaging Subcommittee of the APC Panel was established to review all the CPT codes with a status indicator of ''N.'' Status indicator ''N'' indicates that payment for packaged codes is bundled into the payment that providers receive for separately payable codes for items or services provided on the same day. Providers have often suggested that many codes could be billed alone, without any separately payable service on the claim, and requested that these codes not be assigned status indicator ''N.'' The Packaging Subcommittee identified areas for change of some packaged CPT codes for items or services that could be provided as the sole service on a given date. During the September 2004 meeting, the APC Panel accepted the report of the Packaging Subcommittee and made the following recommendations:

- The Panel recommended that the Packaging Subcommittee review packaged codes individually instead of making a global decision for all packaged codes.
- The Panel recommended that CMS assign a modifier to CPT codes 36540 (Collect blood venous device), 36600 (Withdrawal of arterial blood), 51701 (Insert bladder catheter), and 97602 (Wound[s] care, non-selective) to be used when these codes are the only code on that particular claim for the same date of service. The APC Panel indicated that it would revise this subset of codes once data become available.
- The Panel recommended that CMS educate providers and intermediaries on the correct billing procedures for the packaged CPT codes 36540, 36600, 51701, and 97602.
- The Panel recommended that CMS not change the status indicator for CPT 76397 (Ultrasound guidance for vascular access). The Panel indicated that it would review the data on this code as they become available.
- The Panel recommended that the Packaging Subcommittee continue to meet throughout the year to discuss other problematic packaged codes.

CMS is considering the recommendation that a modifier be used when certain codes are the only codes on a particular claim for the same date of service. We note that code 97602 is assigned a status indicator of ''A'' in this final rule with comment period, and is no longer payable under OPPS. Therefore, a modifier, if applicable, would not be assigned for this code.

Comment: One commenter asked CMS to review all the packaged codes to determine which codes should become separately payable. Several commenters also requested that codes 36540 (Collect blood venous device), 36600 (Withdrawal of arterial blood), and 97602 (Wound[s] care, nonselective) become separately payable because they are often the only procedure on a bill. In cases where there is no separately payable code on a claim, providers do not receive payment for these packaged services.

Response: We appreciate the commenters' suggestions. As stated above, the APC Panel Packaging Subcommittee recently reviewed all the packaged codes. We are currently

considering whether to create a modifier to be used for CPT codes 36540, 36600, and 51701 when these codes appear on a claim without any separately payable code on the same date of service. As stated above, code 97602 will not be payable under OPPS for CY 2005 and, therefore, is excluded from this discussion. Additional detailed suggestions for the Packaging Subcommittee should be submitted to *APCPanel@cms.hhs.gov* with ''Packaging Subcommittee'' in the subject line.

Comment: Two commenters requested that code 76937 (Ultrasound guidance for vascular access) be assigned to APC 0268 (Ultrasound Guidance Procedures), with status indicator ''S'' instead of the proposed status indicator ''N.''

Response: We are accepting the APC Panel's recommendations that code 76937 remain packaged for CY 2005. We are concerned that there will be unnecessary utilization of this procedure if it is separately payable. In addition, because code 76937 only became effective on January 1, 2004, there are currently no claims data for this code. When we review the CY 2004 claims data for the CY 2006 payment rates, we will reexamine the status of code 76937. We also note that the APC Panel Packaging Subcommittee remains active, and additional issues and new data concerning the packaging status of codes will be shared for their consideration as information becomes available.

Comment: Several commenters requested that the following CPT codes become unpackaged: 42550 (Injection for salivary x-ray) and other x-ray injection codes; 75998 (Fluoroscopic guidance for central venous access device placement); 74328 (Endoscopic catheterization of the biliary ductal system, S&I); 74329 (Endoscopic catheterization of the pancreatic ductal system, S&I); 74330 (Combined endoscopic catheterization of the biliary and pancreatic ductal systems, S&I); 36500 (Insert of catheter, vein); 75893 (venous sampling by catheter); 75989 (abscess drainage under x-ray); 76001 (Fluoroscope exam); 76003 (Needle localization by x-ray); 76005 (Fluoroguide for spine inject); 90471 and 90472 (Immunization administration); 94760, 94761, and 94762 (Pulse oximetry); and G0269 (Occlusive device in vein art). The commenters were concerned that the OPPS has denied hospitals reimbursement for these services.

Response: Hospitals include charges for packaged services on their claims, and the costs associated with these packaged services are then bundled into the costs for separately payable procedures on the claims. Hospitals may use CPT codes to report any packaged services that were performed, consistent with CPT coding guidelines. Because these imaging codes are packaged, their presence on a claim that includes a code for another separately payable service does not necessarily result in the claim being a multiprocedure claim. Payment for these imaging services is packaged in this way into payment for the separately payable services with which the imaging services are billed.

The Packaging Subcommittee reviewed every code that was packaged in CY 2004. The Committee narrowed the list of packaged codes to a list of potentially problematic codes and subsequently reviewed utilization and median cost data for these codes. One of the main criteria evaluated by the Packaging Subcommittee to determine whether a code should become unpackaged was how likely it was for the code to be billed without any other code for separately payable services on the claim. We encourage submission of clinical scenarios involving currently packaged codes to the Packaging Subcommittee for review at future meetings. Submissions should be sent to the *APCPanel@cms.hhs.gov* with ''Packaging Subcommittee'' in the subject line.

We will continue to package CPT codes 42550 and other x-ray injection codes, 75998, 73428, 74329, 74330, 36500, 75893, 75989, 76001, 76003, 76005, 90471, 94472, 94760, 94761, 94762, and G0269 for CY 2005 and will discuss these codes with the APC Panel Packaging Subcommittee.

Comment: One commenter requested that the status indicator for code G0102 (Prostate cancer screening; digital rectal examination) be changed from packaged to separately payable. The commenter indicated that the screening is administered as part of the initial preventive physical examination. The commenter stated, ''The payment for G0102 will be zero because it is identified with status indicator 'N' which means it is packaged and not paid for separately.''

Response: Currently, under the OPPS, we do not make separate payment for code G0102. Its costs are bundled into the costs of other separately payable services furnished by the hospital on the same day. For example, a digital rectal examination is usually furnished as part of an evaluation and management service, so its payment would generally be bundled into payment for the evaluation and management service when a covered evaluation and management service is furnished on the same day as the digital rectal examination. It is a relatively quick and simple procedure. Likewise, when the examination is performed during the same visit as the initial preventive examination, we would expect that costs associated with the examination would be bundled into the costs for the initial preventive examination. Accordingly, we are continuing to package code G0102.

Comment: One commenter requested that we map code G0168 (Wound closure by adhesive) to an APC instead of assigning status indicator ''N'' to the code. The commenter was concerned that access to wound adhesives would be reduced if this code is not separately payable.

Response: Wound adhesives are considered supplies used to repair lacerations and surgical incisions. These products are used instead of sutures to close wounds. We do not make separate payments for sutures under the OPPS. Providers are paid when they use wound adhesives in the same manner as they are paid for other ''packaged'' procedures. The charges for code G0168 should be packaged into whichever procedure(s) is billed on the same date of service. Payment to the provider reflects the cost of performing the procedure and the related supplies.

C. Limits on Variations Within APCs: Application of the 2 Times Rule

Section 1833(t)(2) of the Act provides that the items and services within an APC group cannot be considered comparable with respect to the use of resources if the median (or mean) of the highest cost item or service within an APC group is more than 2 times greater than the median of the lowest cost item or service within that same group. However, the statute authorizes the Secretary to make exceptions to this limit on the variation of costs within each APC group in unusual cases such as low volume items and services. No exception may be made in the case of a drug or biological that has been designated as an orphan drug under section 526 of the Federal Food, Drug, and Cosmetic Act. We implemented this statutory provision in § 419.31 of the regulations. Under this regulation, we elected to use the highest median cost and lowest median cost to determine comparability.

During the APC Panel's February 2004 meeting, we presented data and information concerning a number of APCs that violate the 2 times rule and asked the APC Panel for its recommendation. We discuss below the APC Panel's recommendations specific to each of these APCs, our proposals in

response to the APC Panel's recommendations that were discussed in the August 2004 proposed rule, and our final policies.

1. Cardiac and Ambulatory Blood Pressure Monitoring

APC 0097: Cardiac and Ambulatory Blood Pressure Monitoring

We expressed concern to the APC Panel that APC 0097 appears to violate the 2 times rule. We sought the APC Panel's recommendation on revising the APC to address the violation. Based on clinical homogeneity considerations, the APC Panel recommended that we not restructure APC 0097 for CY 2005.

We proposed to accept the APC Panel's recommendation that we make no changes to APC 0097 for CY 2005. We did not receive any public comments on our proposal. Accordingly, in this final rule, we are not making any changes to APC 0097 for CY 2005.

2. Electrocardiograms

APC 0099: Electrocardiograms

We expressed concern to the APC Panel at its February 2004 meeting that APC 0099 appears to violate the 2 times rule. We asked the APC Panel to recommend options for resolving this violation. Based on clinical homogeneity considerations, the APC Panel recommended that we not alter the structure of APC 0099 for CY 2005.

We proposed to accept the APC Panel's recommendation that we make no changes to APC 0099 for CY 2005. We did not receive any public comments on our proposal. Accordingly, in this final rule with comment period, we are not making any changes to APC 0099 for CY 2005.

3. Excision/Biopsy

APC 0019: Level I Excision/Biopsy

APC 0020: Level II Excision/Biopsy

APC 0021: Level III Excision/Biopsy

We expressed concern to the APC Panel at its February 2004 meeting that APC 0019 appears to violate the 2 times rule. We advised the APC Panel that this violation was not evident in CY 2004 because the CY 2002 median cost data used in calculating the CY 2004 APC updates supported moving CPT codes 11404 (Removal of skin lesion) and 11623 (Removal of skin lesion) from APC 0020 and APC 0021. However, based on the CY 2003 data reviewed by the APC Panel, APC 0019 would violate the 2 times rule. Therefore, we asked the APC Panel to recommend an approach to resolve the violation. We asked the APC Panel if we should leave this APC as is; divide APC 0019 into two separate APCs; or move some codes in APC 0019 to higher level excision/biopsy APCs. In making its recommendation, the APC Panel noted that the 2 times violation in APC 0019 was minor, and recommended that we not modify APC 0019.

We proposed to accept the APC Panel's recommendation to not make any modifications to APC 0019 for CY 2005. We did not receive any public comments on our proposal. Accordingly, in this final rule with comment period, we are not making any changes to APC 0019 for CY 2005.

4. Posterior Segment Eye Procedures

APC 0235: Level I Posterior Segment Eye Procedures

We expressed concern to the APC Panel at its February 2004 meeting that APC 0235 appears to violate the 2 times rule. At the August 2003 APC Panel meeting, the APC Panel recommended that we monitor the data for APC 0235 for review at its February 2004 meeting. In order to address the apparent violation, we asked the APC Panel to consider moving a few CPT codes from APC 0235 into a higher level posterior segment eye procedure APC. The APC Panel noted that the 2 times violation in APC 0235 was minor, and recommended that we not change APC 0235.

We proposed to accept the APC Panel's recommendation that we make no changes to the structure of APC 0235 for CY 2005. We receive one public comment regarding this proposal.

Comment: One commenter urged CMS not to finalize the proposal to keep the CY 2004 structure of APC 0235 for CY 2005. The commenter asked CMS to consider moving codes 67220 (Treatment of choroids lesion), 67221 (Ocular photodynamic therapy), 67225 (Eye photodynamic therapy, add-on), 67101 (Repair detached retina), and 67141 (Treatment of retina) to a higher level Posterior Segment Eye Procedure APC.

Response: After further analysis, we continue to believe that the resources and clinical characteristics of these codes are most compatible and homogeneous with those services in Level I Posterior Segment Eye Procedures, APC 0235. We plan to discuss the possible restructuring of APCs 0235, 0236, and 0237 (Level I, Level II, and Level III Posterior Segment Eye Procedures, respectively) at the next APC Panel meeting. We invite comments on these APCs.

In this final rule with comment period, we are adopting as final the proposal not to make any changes to APC 0235 for CY 2005.

5. Laparoscopy

APC 0130: Level I Laparoscopy

APC 0131: Level II Laparoscopy

We expressed concern to the APC Panel at its February 2004 meeting that APC 0130 appears to violate the 2 times rule. We suggested moving CPT code 44970 (Laparoscopy, appendectomy) from APC 0130 to APC 0131. The APC Panel recommended that we make this change.

We proposed to accept the APC Panel's recommendation to move CPT code 44970 from APC 0130 to APC 0131. We did not receive any public comments on our proposal. Accordingly, in this final rule with comment period, we are adopting as final without modification our proposal to move CPT code 44970 from APC 0130 to APC 0131.

6. Anal/Rectal Procedures

APC 0148: Level I Anal/Rectal Procedure

APC 0155: Level II Anal/Rectal Procedure

APC 0149: Level III Anal/Rectal Procedure

APC 0150: Level IV Anal/Rectal Procedure

We expressed concern to the APC Panel at its February 2004 meeting that APC 0148 appears to violate the 2 times rule. We suggested moving CPT code 46020 (Placement of seton) from APC 0148 to a higher level anal/rectal procedure APC. The APC Panel reviewed the four anal/rectal APCs (APC 0148, 0149, 0150, and 0155) and recommended moving CPT codes 46020 and 46706 (Repair of anal fistula with glue) from APC 0148 to APC 0150. The APC Panel also recommended moving CPT codes 45005 (Drainage of rectal abscess) and 45020 (Drainage of rectal abscess) from APC 0148 to APC 0155.

We proposed to accept the APC Panel's recommendations specific to APC 0148. We received one favorable public comment on our proposal. Accordingly, in this final rule with comment period, we are adopting as final without modification our proposal and are moving CPT codes from APC 0148 to APCs 0150 and 0155 as shown in the Table 6 below.

Table 6.—Movement of Anal/Rectal Procedures from APC 0148 to APC 0150 and APC 0155

CPT/HCPCS	Description	CY 2004 APC	CY 2005 APC
46020	Placement of seton	0148	0150
46706	Repair anal fistula with glue	0148	0150
45005	Drainage of rectal abscess	0148	0155
45020	Drainage of rectal abscess	0148	0155

7. Nerve Injections

APC 0204: Level I Nerve Injections

APC 0206: Level II Nerve Injections

APC 0207: Level III Nerve Injections

APC 0203: Level IV Nerve Injections

We expressed concern to the APC Panel that APC 0203 and APC 0207 appear to violate the 2 times rule. After careful consideration of new data presented during the February 2004 meeting, the APC Panel recommended moving CPTs 64420 (Nerve block injection, intercostal nerve), 64630 (Injection treatment of nerve), 64640 (Injection treatment of nerve), and 62280 (Treatment of a spinal cord lesion) from APC 0207 to APC 0206. The APC Panel also recommended moving CPT code 62282 (Treatment of a spinal canal lesion) from APC 0207 to APC 0203.

After reviewing more recent, complete calendar year data that was not available in February 2004, we proposed to accept only the APC Panel's recommendation to move CPTs 64630 and 64640 from APC 0207 to APC 0206 and to make some other changes that we believed were appropriate to improve the nerve injection APCs' clinical and resource homogeneity, as shown in Tables 7, 8, and 9 of the proposed rule.

We received two comments regarding our proposed reassignment of four CPT codes from APC 0203 to APC 0207 to address an apparent violation of the 2 times rule.

Comment: Commenters urged CMS not to finalize the proposed changes to CPT codes 64620 (Injection treatment of nerve), 64680 (Injection treatment of nerve), 62263 (Lysis epidural adhesions) and 62264 (Epidural lysis on single day), which we proposed to move from APC 0203 to APC 0207. The commenters stated that the proposed payment for these services was well below the cost of the resources required to provide the services at an acceptable standard of care. The commenters requested that we not move these four codes from APC 0203.

Response: After further analysis, we agree with the commenters that CPT codes 64620, 62263, and 62264 should remain in APC 0203 based on clinical and resource homogeneity with the services in APC 0203. Therefore, in this final rule with comment period, we are not moving these three codes from APC 0203, as displayed in Table 9B below.

However, based on our final CY 2003 hospital data for CPT code 64680, utilizing over half of the several hundred total bills for this service for calculation of median hospital costs, we continue to believe that the resources and clinical characteristics of destruction of the celiac plexus by neurolytic nerve agent are most compatible and homogeneous with those services in Level III Nerve Injections, APC 0207. Therefore, in this final rule with comment period, we are adopting as final the proposed movement of CPT code 64680 from APC 0203 to APC 0207, as displayed in Table 9B below.

Accordingly, all of the final APC reassignments of nerve injections codes in this final rule with comment period are displayed below in Tables 7, 8, 9A, and 9B.

Table 7.—Movement of Level III: Nerve Injections CPT Codes from APC 0207 to APC 0204 and APC 0206

CPT/HCPCS	Description	CY 2004 APC	CY 2005 APC
64420	Nerve block injection, intercostal nerve	0207	0204
64421	Nerve block injection, intercostals, multiple	0207	0206
64472	Injection paravertebral cervical/thoracic, add-on	0207	0206
64476	Injection paravertebral lumbosacral, add-on	0207	0206
64630	Injection treatment of nerve	0207	0206
64640	Injection treatment of nerve	0207	0206

Table 8.—Movement of Level I: Nerve Injections CPT Codes from APC 0204 to APC 0206

CPT/HCPCS	Description	CY 2004 APC	CY 2005 APC
61791	Treatment of a trigeminal tract	0204	0206
64410	Nerve block injection, phrenic	0204	0206
64412	Nerve block injection, spinal accessory	0204	0206
64446	Nerve block injection, sciatic, continuous infusion	0204	0206
G0260	Injection for sacroiliac joint anesthesia	0204	0206

Table 9A.—Movement of Level II: Nerve Injections CPT Codes from APC 0206 to APC 0204 and APC 0207

CPT/HCPCS	Description	CY 2004 APC	CY 2005 APC
62270	Spinal fluid tap, diagnostic	0206	0204
62272	Drainage of cerebrospinal fluid	0206	0204
62310	Injection of spine cervical/thoracic	0206	0207
62311	Injection of spine lumbar/sacral (cd)	0206	0207
62318	Injection of spine with catheter, cervical/thoracic	0206	0207
62319	Injection of spine with catheter Lumbar/sacral (cd)	0206	0207

Table 9B.—Movement of Level III and Level IV Nerve Injections CPT Codes Between APC 0203 and APC 0207

CPT/HCPCS	Description	CY 2004 APC	CY 2005 Proposed APC	CY 2005 Final APC
62263	Lysis epidural adhesions	0203	0207	0203
62264	Epidural lysis on single day	0203	0207	0203
64620	Injection treatment of nerve	0203	0207	0203
64680	Injection treatment of nerve	0203	0207	0207

8. Anterior Segment Eye Procedures

APC 0232: Level I Anterior Segment Eye Procedures

APC 0233: Level II Anterior Segment Eye Procedures

We expressed concern to the APC Panel at its February 2004 meeting that APC 0233 appears to violate the 2 times rule. We suggested moving CPT codes 65286 (Repair of eye wound), 66030 (Injection treatment of eye), and 66625 (Removal of iris) from APC 0233 to APC 0232. The APC Panel agreed and recommended that we move CPT codes 65286, 66030, and 66625 from APC 0233 to APC 0232.

We proposed to accept the APC Panel's recommendation and to reassign these three codes. We received one public comment on our proposal.

Comment: One commenter asserted that the costs for performing the procedures under CPT codes 65286 and 66625 are similar to the costs for performing procedures in APC 0233 and requested that these codes not be moved to APC 0232.

Response: After further analysis, we continue to believe that the resources and clinical characteristics of codes 62586 and 66625 are most compatible and homogeneous with those services in Level I Anterior Segment Eye Procedures, APC 0232.

Therefore, in this final rule with comment period, we are adopting as final without modification our proposal and are moving CPT codes 65286, 66030, and 66625 from APC 0233 to APC 0232 as shown in the Table 10 below.

Table 10.--Reassignment of Anterior Segment Eye Procedures Codes From APC 0233 to APC 0232

CPT/HCPCS	Description	CY 2004 APC	CY 2005 APC
65286	Repair of eye wound	0233	0232
66030	Injection treatment of eye	0233	0232
66625	Removal of iris	0233	0232

9. Pathology

APC 0343: Level II Pathology

APC 0344: Level III Pathology

We expressed concern to the APC Panel at its February 2004 meeting that APC 0343 appears to violate the 2 times rule. We suggested moving CPT code 88346 (Immunoflourescent study) from APC 0343 to APC 0344. The APC Panel concurred with our proposal.

We proposed to accept the APC Panel's recommendation and to move CPT code 88346 from APC 0343 to APC 0344. We received one public comment on our proposal.

Comment: One commenter requested that CMS split APC 0344 into two APCs to create another level for the pathology procedures. The commenter stated that creation of another level would lead to more economically homogenous APCs to provide payment that more closely covers the costs of the procedures. The commenter pointed out that APC 0344, as currently configured, violates the 2 times rule and recommended that CMS split APC 0344 into two APCs and that CMS should assign them to a newly created APC rather than finalize its proposal to assign the new computer-assisted image analysis procedures to APC 0344.

Response: We believe that our proposed reassignment of CPT code 88346 from APC 0343 to 0344, as recommended by the APC Panel, will improve the resource and clinical homogeneity of the APCs. We are reluctant to make further reassignments without hospital cost data to support changes. Several of the codes that the commenter is concerned about, including APC codes 88360 (Morphometric analysis, tumor immunohistochemistry, quantitative or semiquantitative, each antibody; manual), 88368 (Morphometric analysis, in situ hybridization, each probe; manual), and 88367 (Morphometric analysis, in situ hybridization, each probe; using computer assisted technology) were new in CY 2004 and CY 2005 and, as such, we do not have available claims data for analysis.

Given the new codes mentioned by the commenter and the 2 times rule violations in APC 0342 and 0344, we expect that we will want to solicit the advice of the APC Panel regarding the configuration of all the pathology APCs: 0342, 0343, 0344, and 0661, at their next meeting. We will reexamine the APCs for future updates to the OPPS, but will not make other changes to the APCs at this time.

In this final rule with comment period, we are adopting as final without modification our proposal and are moving CPT code 88346 from APC 0343 to APC 0344.

10. Immunizations

APC 0355: Level III Immunizations (for CY 2005: Level I Immunizations)

APC 0356: Level IV Immunizations (for CY 2005: Level II Immunizations)

We expressed concern to the APC Panel at its February meeting that APCs 0355 and 0356 appear to violate the 2 times rule. In order to eliminate this violation, we suggested moving CPT 90636 (Hepatitis A/Hepatitis B vaccine, adult dose, intramuscular use) from APC 0355 to APC 0356. We also suggested moving CPT codes 90375 (Rabies immune globulin, intramuscular or subcutaneous), 90740 (Hepatitis B vaccine, dialysis or immunosuppressed patient, intramuscular), 90723 (Diphtheria-pertussis-tetanus, Hepatitis B, Polio vaccine, intramuscular), and 90693 (Typhoid vaccine, AKD, subcutaneous) from APC 0356 to APC 0355.

The APC Panel recommended moving CPT 90636 from APC 0355 to APC 0356 and CPT codes 90740, 90723, and 90693 from APC 0356 to APC 0355. The APC Panel delayed making a recommendation on CPT 90375 and requested that we collect additional cost data on this procedure for discussion at the next scheduled APC Panel meeting.

In the August 16, 2004 proposed rule, we proposed to accept the APC Panel's recommended changes to move CPT code 90740 from APC 0356 to 0355, and to move CPT code 90636 from 0355 to 0356. Based on our review of more recent claims data than were available to the APC Panel, we also determined that the medians for CPT codes 90693 and 90375 are below the $50 drug packaging threshold. Therefore, we also proposed to package both CPT codes 90693 and 90375 and to change the status indicator for CPT code 90723 to ''E'' because it is not payable by Medicare.

We received one public comment relating to CPT code 90740.

Comment: One commenter requested that CMS not reassign CPT code 90740 Recombivax 40mcg/mL (a brand name for Hepatitis B vaccine), from APC 0356 (Level II Immunizations) to APC 0355 (Level I Immunizations), as proposed. The commenter stated that the CMS median cost of $5.55 is erroneous and that the lowest published price for Recombivax 40mcg/mL in the Federal Supply Schedule is $79.33. Therefore, the commenter believed that code 90740 does not violate the 2 times rule when assigned to APC 0356.

Response: We are using the CY 2003 hospital claims as the basis for payment and we believe we have adequate claims on which to base payment for CPT code 90740 for CY 2005. We were able to use 99 percent of the claims for CPT code 90740 for median calculation and believe that our assignment of CPT code 90740 for CY 2005 is appropriate.

In this final rule with comment period, we are adopting as final without modification our proposal and are moving CPT code 90740 from APC 0356 to APC 0355 and CPT code 90636 from APC 0355 to APC 0356, as shown in Table 11, and packaging both CPT codes 90693 and 90375.

Table 11.—Movement of Immunization CPT Codes Between APC 0355 and APC 0356

CPT/HCPCS	Description	CY 2004 APC	CY 2005 APC
90636	Hepatitis A/Hepatitis B vaccine, adult dose, intramuscular use	0355	0356
90740	Hepatitis B vaccine, dialysis or immunosuppressed patient	0356	0355

11. Pulmonary Tests

APC 0367: Level I Pulmonary Tests

APC 0368: Level II Pulmonary Tests

APC 0369: Level III Pulmonary Tests

We expressed concern to the APC Panel at its February 2004 meeting that APC 0369 appears to violate the 2 times rule. We suggested moving CPT code 94015 (Patient recorded spirometry) from APC 0369 to APC 0367. The APC Panel concurred with our proposal.

In the August 16, 2004 proposed rule, we proposed to accept the APC Panel's recommendation and to move CPT code 94015 from APC 0369 to APC 0367. In addition, during our analysis of more recent claims data following the APC Panel meeting, we noted that APC 0367 violated the 2 times rule. Therefore, we proposed to reassign CPT codes 94375, 94750, 94450, 94014, 94690, and 93740 to APC 0368.

We did not receive any public comments on our proposal. Accordingly, in this final rule with comment period, we are adopting as final without modification our proposal and are moving CPT code 94015 from APC 0369 to APC 0367 and reassigning CPT codes 93740, 94014, 94375, 94450, 94690, and 94750 to APC 0368, as shown in Table 12A.

Table 12A.—Reassignment of Certain CPT Codes Among APCs 0367, 0368 and 0369

HCPCS	Description	CY 2004 APC	CY 2005 APC
93740	Temperature gradient studies	0367	0368
94014	Patient recorded spirometry	0367	0368
94015	Patient recorded spirometry	0369	0367
94375	Respiratory flow volume loop	0367	0368
94450	Hypoxia response curve	0367	0368
94690	Exhaled air analysis	0367	0368
94750	Pulmonary compliance study	0367	0368

12. Clinic Visits

APC 0600: Low Level Clinic Visits

We expressed concern to the APC Panel at its February 2004 meeting that APC 0600 appears to violate the 2 times rule. We suggested moving HCPS code G0264 (Assessment other than CHF, chest pain, asthma) to a higher level clinic visit. The APC Panel recommended that we not make any changes to APC 0600.

We proposed to accept this recommendation and not make any changes to APC 0600 for CY 2005. We received one public comment on our proposal from a provider group.

Comment: One comment recommended that CMS investigate further the apparent two times violation in APC 0600. The commenter believed that, although the APC Panel did not recommend reassignment of HCPCS code G0264 (Initial nursing assessment of patient directly admitted to observation with diagnosis other than CHF, chest pain or asthma or patient directly admitted to observation with diagnosis of CHF, chest pain or asthma when the observation stay does not qualify for G0244), in order to remedy the apparent violation, CMS should make the reassignment of G0264 to a much higher level clinic visit (APC 0602, High Level Clinic Visit) due to the resources involved in directly admitting a patient to observation. The commenter provided examples of services that the commenter believed are part of the initial observation nursing assessment provided by a hospital, including patient registration, comprehensive nursing clinical admission assessment, initiation of physician orders, coordination and scheduling of ancillary services, administration of medications, and assessment of discharge planning needs.

Response: We do not agree with the commenter's assertion that the services coded using G0264 are necessarily more resource intensive than a low-level clinic visit. The beneficiary whose observation stay would be coded using G0264 presents to the hospital following a physician visit. The beneficiary has already been assessed by the physician who, as a result of the assessment, has decided that observation care is warranted. We are concerned that hospitals may be attributing costs to the initial nursing assessment that are more appropriately attributable to observation services themselves, such as administration of medications, scheduling of tests to be conducted during the period of observation, and discharge planning. It is not apparent why the services provided in the hospital associated with admission to observation care (including some of those listed by the commenter) should require the resources of a High Level Clinic Visit (APC 0602) as the commenter suggested. Thus, we agree with the APC Panel's recommendation to leave G0264 in APC 0600.

Accordingly, in this final rule with comment period, we are adopting as final our proposal not to make any changes to APC 0600 for CY 2005.

13. Other APC Assignment Issues

We received a number of comments about specific APC assignments and payment amounts that were generated by our proposed rates or proposed changes to HCPCS code APC assignments resulting from our revisions to address violations of the 2 times rule. Those changes were not all specifically discussed in the proposed rule, but were open to comment. We respond to these comments in this section of the final rule.

a. Catheters for Brachytherapy Services

Comment: One commenter asked that CMS consider carefully in which APCs to place new CPT codes 19296, 19297, and 19298 (for placement of catheters into the breast for brachytherapy) because the services have, heretofore, been coded under unlisted code 19499, which is assigned to APC 0028 (Level I Breast Surgery) and with a proposed payment amount of $1,081 for CY 2005. The commenter believed that this

proposed amount is too low to appropriately reflect the costs of these services.

Response: We have assigned new CPT codes 19296 and 19298 in New Technology APC 1524 (New Technology-Level XIV ($3,000–$3,500)) with a payment amount of $3,250 and CPT code 19297 in APC 1523 (New Technology-Level XXIII ($2,500–$3,000)) with a payment amount of $2,750 for CY 2005 OPPS. These are new codes and the APC assignments were not included in the proposed rule. Therefore, the APC assignments are subject to comment.

b. Peripherally Inserted Central Catheters (PICC)

We received one comment regarding our proposed APC reassignment of CPT codes 36568 (Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; under 5 years of age) and 36569 (Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; age 5 years or older to APC 0187 (Miscellaneous placement/repositioning). We made the proposal based on a recommendation by the APC Panel during its February 2004 meeting.

Comment: One commenter requested that we not reassign CPT codes 36568 and 36569 from APC 0032 to APC 0187 as proposed.

Response: We proposed to reassign the PICC lines to APC 0187 based on our agreement with the APC Panel that there are significant differences in the clinical complexity and resource use associated with the procedures assigned to APC 0032 compared to PICC line insertion. We will reevaluate the APC assignment of the PICC line insertion once we have sufficient data to evaluate the assignment.

c. External Fixation Devices

Comment: One commenter indicated that APC 0046 (Open/Percutaneous Treatment Fracture) contains violations of the two times rules and should be broken into multiple APCs so that CPT codes 20690 (Apply bone fixation device) and 20692 (Apply bone fixation device), which are for application of external fixation devices, could be paid appropriate amounts. Other commenters asked that CMS require that claims for these codes must contain codes for the devices and asked that we revise the definition of C1713 (Anchor/screw for opposing bone to bone or soft tissue to bone (implantable)) to also apply to external fixation devices and to remove the requirement that the device be implantable. One commenter also asked that we instruct providers to bill code 20690 or 20692 when external fixation is provided with the reduction of a fracture and asked that we create a new APC to contain CPT codes 20690 and 20692.

Response: CPT codes 20690 and 20692 are currently in APC 0050 and no changes were proposed for 2005 OPPS. There are no 2 times violations in the APC in which they are located and each of these codes represents approximately one percent of the volume in the APC. Therefore we see no reason to create a new APC for these codes. The CPT codes for treatment of a fracture often include with or without fixation in the definition of the code. Where fixation is included in the definition of the code, it would be miscoding to also report 20690 or 20692; these codes should be reported if, and only if, fixation is not included in the definition of the CPT code for treatment of the fracture. Providers should review the CPT instructions and look to the AMA's guidance on coding if they have questions about when these codes should be reported.

d. Apheresis

Comment: Two commenters disagreed with our proposed reassignment of CPT code 36515 (Apheresis, adsorp/reinfuse) to APC 0111 (Blood Product Exchange) and recommended that the code be reassigned to APC 0112 (Apheresis, Photopheresis and Plasmapheresis). One of the commenters, a medical specialty society, indicated that the procedure involves an expensive disposable supply item that costs more than the proposed payment rate for APC 0111. In addition, this commenter stated that the proposed payment rate would be significantly less than the physician's office payment, which the commenter concluded indicated that the charge data used to establish the median cost of the procedure may be incorrect.

Response: APC assignments are based on clinical homogeneity and comparable resource utilization for all CPT and HCPCS codes within an APC. After careful review, we disagree with the commenters that CPT code 36515 should be reassigned to APC 0112. We believe that the resources required for CPT code 36515 are more similar to the other CPT codes in APC 0111. Thus, for CY 2005, we are adopting as final our proposal to assign CPT code 36515 to APC 0111, effective January 1, 2005.

e. Imaging for Intravenous Cholangiogram (IVC) Filter Placement and Breast Biopsy

Comment: One commenter requested that we move CPT code 75940 (Percutaneous placement of IVC filter, radiological supervision and interpretation) from APC 0187 (Miscellaneous Placement/Repositioning) to APC 0280 (Level III Angiography and Venography Except Extremity) and CPT code 76095 (Stereotactic localization guidance for breast biopsy or needle placement, each lesion, radiological supervision and interpretation) from APC 0187 (Miscellaneous Placement/Repositioning) to APC 0289 (Needle Localization for Breast Biopsy). The commenter believed that imaging for IVC filter placement and breast biopsy are entirely unrelated services to the central venous access surgical procedures comprising the majority of the codes in APC 0187.

Response: We understand the commenter's concern regarding the clinical inconsistency between the services described by CPT codes 75940 and 76095, which are assigned to APC 0187, and the central venous access (CVA) procedures that are also assigned to APC 0187. However, we disagree with the commenter's recommendation that CPT codes 75940 and 76095 be reassigned. First, if we were to accept the commenter's recommendation to reassign CPT code 75940 to APC 0280 and CPT code 76095 to APC 0289, the resource homogeneity of those two APCs would be compromised, and we would be significantly overpaying CPT code 75940 and underpaying CPT code 76095 based on the median costs of those two codes relative to the median costs of the procedures currently assigned to APCs 0280 and 0289, respectively. Further, we lack data for a number of the CVA codes in APC 0187 because they are new codes that were established in CY 2004. We believe that these new CVA codes are clinically similar to the codes that comprise APC 0187, and we estimate that they are also similar in terms of resource costs, which is why we assigned them to APC 0187. Once we have accumulated data for these new codes, we will review the configuration of APC 0187, and make whatever changes are appropriate in future updates. Therefore, we are maintaining CPT codes 75940 and 76095 in APC 0187 for CY 2005.

f. Hysteroscopic Endometrial Ablation Procedures

Comment: Some commenters opposed the APC Panel recommendation that both CPT codes 0009T (Endometrial cryoablation) and 58563 (Hysteroscopic endometrial ablation) be assigned to APC 0387 (Level II Hysteroscopy) in CY 2005. The commenters were concerned that adding endometrial cryoablation

(CPT 0009T) to APC 0387 would seriously weaken the clinical homogeneity of APC 0387 because CPT 0009T (Endometrial ablation with ultrasonic guidance) does not use hysteroscopy, and it requires an ultrasound machine and a separate capital unit, or compressor console, to provide cryotherapeutic energy. Instead, the commenters urged CMS not to keep CPT code 58563 in APC 0387, but rather, to assign it to APC 0202, in addition to assigning code 0009T to APC 0202, as we had proposed. One commenter argued that the clinical homogeneity of APC 0202 would be enhanced by grouping the two endometrial ablation procedures that use visualization to monitor and confirm the destruction of the endometrium in the same APC. Moreover, moving both CPT codes 58563 and 0009T to APC 0202 would highlight APC 0202's clinical homogeneity as a more device-intensive family of new technology procedures while better organizing APC 0387 as the group of non-device hysteroscopic procedures involving surgical removal or resection of intrauterine tissue for reasons other than abnormal uterine bleeding (AUB). The same commenter also believed that assigning both codes to APC 0202 would negate any inappropriate incentives to use either treatment because of payment. Other commenters asked that CMS create a new APC for endometrial cryoablation and place that APC on the device-dependent list as it did for cryoablation of the prostate because they have found that the device is 70 percent of the total cost of endometrial cryoablation. The commenters asked that the new APC be paid at least $3,448 to appropriately reflect the hospital's cost of the service.

Response: After careful consideration of the comments, we have decided to make final for CY 2005 our proposal to retain hysteroscopic endometrial ablation (CPT code 58563) in APC 0387. In addition, we are making final for CY 2005 our proposal to assign endometrial cryoablation with ultrasonic guidance to APC 0202. (We note that CPT code 0009T for endometrial cryoablation with ultrasonic guidance is replaced by new CPT code 58356 for CY 2005.). We believe that the need for a hysteroscope to perform hysteroscopic endometrial ablation makes it similar to the other services in APC 0387. On the other hand, Endometrial cryoablation uses a device but not a hysteroscope and, therefore, is more clinically compatible with APC 0202, which contains other resource intensive gynecologic services that also use a device but not a hysteroscope. Moreover, APC 0202 is a device-dependent APC and, therefore, a more appropriate placement for a procedure that uses a device.

g. Hysteroscopic Female Sterilization

Comment: One commenter indicated that the AMA intended create a new CPT level III tracking code for hysteroscopic female sterilization for CY 2005 and urged CMS to assign it to APC 0202. The commenter indicated that this new service places implants through a hysteroscope to occlude the fallopian tubes and that, therefore, it should be assigned to APC 0202, which would provide appropriate payment for this new service for which the implants cost $1,000 to $1,500.

Response: This service is represented by new CPT code 58565 (Hysteroscopic fallopian tube cannulation and micro insert placement), which was created after the issuance of the proposed rule. We are placing this new code to APC 0202 for CY 2005 for the OPPS. The placements of new codes in APCs, such as this code, are subject to comment during the comment period of this final rule with comment period.

h. Urinary Bladder Residual Study

Comment: One commenter asked us to keep CPT code 78730 (Urinary bladder residual study) in APC 0404 (Renal and Genitourinary Studies Level I) instead of moving it to APC 0340 (Minor Ancillary Procedures). The commenter noted that this code is being misused to report other than urinary bladder residual imaging.

Response: CPT code 78730 was created and originally valued for the Medicare Physician Fee Schedule as a procedure that required the services of a nuclear medicine technician. Subsequently, the use of the code has changed so that it is now used primarily by urologists. We do not believe that urologists perform services requiring nuclear medicine technicians and so, as the commenter pointed out, it appears that the code may now be utilized for coding a service that is different from that for which it was created.

However, we are not reassigning the code at this time, as requested by the commenter, pending further review. To that end, we would appreciate submission of resource data from other physician specialties that use CPT code 78730 for us to review in the context of our hospital data so that we can examine this issue further.

i. Intracranial Studies, Electrodiagnostic Testing, Autonomic Testing, and EEG

We received one comment relating to the APC assignments for several electrodiagnostic testing, autonomic testing, and EEG codes.

Comment: One commenter requested that CPT code 93888 (Intracranial study) be moved from APC 0266 (Level II Diagnostic Ultrasound Except Vascular) and assigned to APC 0267 (Level III Diagnostic Ultrasound Except Vascular) as it was in CY 2002; that CPT codes 95870 (Muscle test, nonparaspinal), 95900 (Motor nerve conduction test), and 95904 (Sensory NCV) be assigned to APC 0218 (Level II Nerve Muscle Tests); that CPT codes 95921, 95922, and 95923 (Autonomic nerve function tests) be assigned to APC 216 (Level III Nerve and Muscle Tests); and that CPT codes 95953 and 95956 (EEG monitoring) be assigned to APC 209 (Extended EEG Studies and Sleep Studies, Level II).

Response: Based on our final CY 2003 hospital data for CPT codes 93888, 95870, 95900, 95904, 95921, and 95922, we continue to believe that the resources and clinical characteristics of those codes are most compatible with other services in the APCs to which they are assigned. We made no proposal to change any of those APC assignments. Therefore, in this final rule with comment period, we are finalizing our continued placement of CPT code 93888 in APC 0266; CPT codes 95870, 95900, and 95904 in APC 0215; and CPT codes 95921 and 95922 in APC 0218. We are moving CPT code 95923 from APC 0215 to APC 0218 because the resources for this code are most compatible and homogenous with those services in Level II Nerve and Muscle Tests.

Based on our further review of CPT codes 95953 and 95956, we are moving these two CPT codes, as well as code 95950, to APC 0209 (Extended EEG Studies and Sleep Studies, Level II). Based on our review of clinical and resource use characteristics of these CPT codes, we discovered that 95953, 95956 and 95950 all are more homogenous with procedures assigned to APC 0209 than in their current APCs. Although we did not propose to make these reassignments in the proposed rule, based in part on the comment received and our further review, we are making these reassignments in this final rule with comment period in the interest of clinical and resource use homogeneity.

Accordingly, we are reassigning the CPT codes relating to intracranial studies, electrodiagnostics testing, autonomic testing, and EEG to APCs, as displayed below in Table 12B.

Table 12B.—Reassignment of CPT Codes Relating to Intracranial Studies, Electrodiagnostic Testing, Autonomic Testing, and EEG

CPT/HCPCS	Description	CY 2004 Final APC	CY 2005 Final APC
95923	Autonomic nerve function test	0215	0218
95950	Ambulatory EEG monitoring	0213	0209
95953	EEG monitoring/computer	0209	0209
95956	EEG monitoring, cable/radio	0214	0209

j. Therapeutic Radiation Treatment

Comment: Some commenters objected to the proposed movement of CPT code 77370 (Radiation physics consult) from APC 0305 (Level II Therapeutic Radiation Treatment Preparation) to APC 0304 (Level I Therapeutic Radiation Treatment Preparation), with a proposed reduction in the payment rate by 51 percent from the CY 2004 payment rate of $200.60. The commenters indicated that the current CY 2004 payment rate is already inadequate. The commenters expressed concern that the proposed payment of $98.27 would not compensate for the costs incurred to deliver this service and urged that CPT code 77370 remain in APC 0305.

Response: The median of $134.22 for CPT code 77370 was based on 95 percent of the total CY 2003 claims (33,070 single procedure claims out of 34,792 total claims). Based on these claims data, we believe that the movement of CPT code 77370 from APC 0305 (with a proposed median of $229.92) to APC 0304 (with a proposed median of $99.92) is appropriate. Therefore, we are finalizing our movement of CPT code 77370 from APC 0305 to APC 0304 for CY 2005.

k. Hyperthermia Procedures

Comment: One commenter expressed concern about the 9-percent decrease in the proposed payment rate for hyperthermia procedures (CPT codes 77600 through 77605) assigned to APC 0314 (Hyperthermic Therapies). The commenter asserted that the hospital charges do not reflect the tremendous capital costs associated with hyperthermia procedures. The commenter suspected that the questionably high utilization for these procedures may be a result of miscoding. The commenter requested that CMS consider the hyperthermia practice expense data submitted through the Practice Expense Advisory Council (PEAC) and Medicare Physician Fee Schedule (MPFS) processes. The commenter urged CMS to maintain the CY 2004 payment rates for hyperthermia through CY 2005 to allow additional time for the commenter to educate providers on the proper coding and cost reporting for hyperthermia.

Response: We believe the data do not support the commenter's concern that a high utilization for these codes is indicative of miscoding, as we do not consider 552 total claims to reflect a high utilization that gives rise to question. The payment rate for APC 0314 for CY 2005 noted in the proposed rule was set using 86 percent of the total claims (that is, 452 single procedure claims out of 522 total claims), which we consider to be sufficiently robust for ratesetting purposes. Therefore, we will not consider practice expense data submitted through the PEAC or MPFS processes.

l. Physician Blood Bank Services

Comment: One commenter asked that CMS place CPT codes 86077, 86078 and 86079 (Physician blood bank services) into an APC and make payment for them under the OPPS. The commenter indicated that the current assignment of status indicator ''A'' is assigned to HCPCS codes that are paid under another fee schedule but that these services are not paid under any other fee schedule or payment system and, therefore, the hospital is not being paid for these services. The commenter noted that the services had status indicator ''X'' for minor services and had APC assignments in the CY 2003 OPPS.

Response: We agree and have assigned these CPT codes to APC 343 with status indicator ''X.'' These services consist mainly of physician professional services, which are paid through the Medicare Physician Fee Schedule, but we expect there may also be some hospital resources utilized. We have given these codes a condition code of ''NI'' (new interim) in this interim final rule with comment because they were not paid under the OPPS in CY 2004 and because we were not able to use the data for these codes in the calculation of the median cost for APC 343.

m. Caloric Vestibular Test

Comment: One commenter requested an explanation for the proposed movement of CPT code 92543 (Caloric vestibular test) from APC 0363 (Level I Otorhinolaryngologic Function Tests) to APC 0660 (Level 2 Otohinplaryngologic Function Tests), and CPT codes 92553 (Audiometry, air and bone) and 92575 (Sensorineural acuity test) from APC 0365 (Level II Audiometry) to APC 0364 ((Level I Audiometry).

Response: We regularly review CPT codes to ensure that they are in appropriate clinical APCs, based on resource use and clinical homogeneity. Upon review, we have found that code 92543 fits more appropriately in a higher-paying APC in the same family of otorhinolaryngologic function test APCs, while codes 92553 and 92575 fit in a lower-paying APC in the same family of audiometry APCs.

n. APC 0365—Level II Audiometry

Comment: One commenter stated that the services in APC 0365 (Level II Audiometry) are not clinically homogeneous and also violate the 2 times rule, sometimes by a spread of 300 percent. The commenter asked that CMS split the APC into two APCs: one containing CPT codes 92604, 92602, 92603, 92601 and 92561 and a second new APC containing CPT codes 92577, 92579, 92582, 92557.

Response: We agree that revision of this APC would result in improved clinical homogeneity and better grouping of services with similar resources. Therefore, we are establishing a new APC 0366 (Level III Audiometry), and are placing in the new APC those

services that are specific to aural rehabilitation after cochlear implantation: CPT codes 92601, 92602, 92603, and 92604.

o. Noncoronary Intravascular Ultrasound (IVUS)

Comment: One commenter requested that CMS keep CPT code 37250 (Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; initial vessel) in APC 0670 (Level II Intravascular and Intracardiac Ultrasound and Flow Reserve) and to use only those claims that capture intravascular ultrasound (IVUS) device-related costs to calculate the median cost for this procedure.

Response: We assigned CPT 37250 to APC 0416 (Level I Intravascular and Intracardiac Ultrasound and Flow Reserve) in the proposed rule. We created two levels for IVUS by creating APC 0416 in order to recognize both the clinical and resource use differences between the coronary and noncoronary vessel procedures, as well as the initial vessel and each additional vessel procedures. Prior to creation of APC 0416, all IVUS procedures, coronary and noncoronary, as well as initial vessel and each additional vessel, were assigned to APC 0670. Based on analysis of our CY 2003 hospital claims data, we concluded that the services in APC 0670 had widely varying median costs, with lower median costs for both the each additional vessel (noncoronary and coronary) and initial noncoronary vessel services in APC 0670, as compared with the initial coronary vessel IVUS. We recognized that the additional vessel services would not require a second costly device in most cases. We also noted that the initial vessel coronary IVUS code, CPT 92978, includes imaging supervision and the interpretation and report, while the initial vessel noncoronary IVUS code, CPT 37250, does not include the radiological supervision and interpretation, which is billed using another CPT code. Thus, we believe that the hospital resources utilized to perform initial vessel noncoronary and coronary IVUS are likely to be different because the service elements in the CPT codes vary. Based on this review, we believe CPT 37250, a noncoronary vessel procedure with a median cost of $361, is appropriately assigned to APC 0416 and would be significantly overpaid if assigned to APC 0670.

For CY 2005, we did not have the ''C'' coded claims to use to identify device-related costs with the level of specificity that was possible for CY 2004. However, we had significantly more claims available for CPT 37250 for ratesetting this year than for CY 2004. We believe that the data on which the assignment to APC 0416 was based were reflective of hospital claims data regarding the resources utilized for the service. As we note elsewhere in this preamble, we will be requiring the use of device codes to report all devices utilized, beginning January 1, 2005.

Accordingly, in this final rule we are finalizing the assignment of CPT 37250 to APC 0416 for CY 2005.

p. Electronic Analysis of Neurostimulator Pulse Generators

Comment: One commenter stated that the services in APC 0692 (Electronic Analysis of Neurostimulator Pulse Generators) are not clinically homogeneous and also violate the 2 times rule. The commenter asked that CMS split the APC into two APCs: one containing CPT codes 95972 and 95975, and a second new APC containing CPT codes 95970, 95971, and 95974.

Response: We recognize that there is a violation of the two times rule in APC 0692. Therefore, we are moving CPT code 95970 to APC 0218 (Level II Nerve and Muscle Tests), which places it in a clinical APC that is suitable in terms of resource use for the service and results in APC 0692 conforming to the 2 times rule.

q. Endoscopic Ultrasound Services

Comment: One commenter asked that CMS create a separate APC for endoscopic ultrasound services because the commenter believed that there are unique costs associated with them. The commenter also believed that ultrasound costs were not packaged into the median for endoscopic ultrasound services because of correct coding edits that define endoscopic ultrasound services as including ultrasound.

Response: We have no reason to believe that the costs for endoscopic ultrasound services do not contain the costs for the ultrasound component of the service. Ultrasound services are included in the definition of the endoscopy CPT codes, and the hospital would include charges for the ultrasound in the charge for endoscopy that uses ultrasound services. We believe that the current APC placement of the codes for endoscopic ultrasound services in APC 0141 (Level I Upper GI Procedures) is valid, both with regard to clinical homogeneity and resource use.

r. External Counterpulsation (ECP)

Comment: Several commenters requested that G0166 (External Counterpulsation) in APC 0678 (External Counterpulsation) be assigned status indicator ''S'' rather than ''T'' and that CMS maintain the payment rate for external counterpulsation at the CY 2004 level. The commenters asserted that external counterpulsation is a stand-alone procedure and that assigning it a status indicator ''T'' has contributed to declining and inadequate payment rates for the services. The commenters argued that the proposed payment rate for CY 2005 is not reflective of the costs of the service and that the rate should be consistent with other cardiovascular equipment trends such as echocardiography. They contended that the claims data CMS used are erroneous and pointed out that the payment rate has decreased every year since CY 2000, from $112.72 in CY 2004 to a proposed rate of $105.38 for CY 2005. The commenter also speculated that ''batching'' or ''misreporting'' of claims also may be contributing to the rate decline trend for external counterpulsation.

Response: We do not believe that the rate decrease for these procedures has anything to do with the ''T'' status indicator. The rate for external counterpulsation proposed in the August 16, 2004 proposed rule was based on virtually all (35,764) of the 37,565 hospital claims submitted and the APC is comprised of only this one procedure. We are confident that the claims data are representative of actual costs and as such, that the proposed decreased rate is appropriate.

The status indicator only affects the payment rate when external counterpulsation is billed with another procedure that has a status indicator ''T.'' There are few multiple procedure claims for this procedure in the CY 2003 claims data and, thus, only a very small effect of multiple procedure discounting was possible.

In the absence of supporting information from the commenters, it is not clear what the commenters mean by considering the batching of claims as contributing to the payment decrease. It is also not clear whether or not the commenters' belief that misreporting may be contributing to the rate decline trend for external counterpulsation is justified. However, we encourage hospitals to code accurately.

D. Exceptions to the 2 Times Rule

As discussed earlier, the Secretary is authorized to make exceptions to the 2 times limit on the variation of costs within each APC group in unusual cases such as low volume items and services.

Taking into account the APC changes that we proposed for CY 2005 based on the APC Panel recommendations discussed in section II.C. of this

preamble and the use of CY 2003 claims data to calculate the median cost of procedures classified in the APCs in the August 16, 2004 proposed rule, we discussed our review of all the APCs to determine which APCs would not meet the 2 times limit. We used the following criteria to decide whether to propose exceptions to the 2 times rule for affected APCs:

- Resource homogeneity.
- Clinical homogeneity.
- Hospital concentration.
- Frequency of service (volume).
- Opportunity for upcoding and code fragments.

For a detailed discussion of these criteria, refer to the April 7, 2000 OPPS final rule with comment period (65 FR 18457).

In the August 16, 2004 proposed rule, we proposed to exempt 54 APCs from the 2 times rule based on the criteria cited above. In cases in which a recommendation of the APC Panel appeared to result in or allow a violation of the 2 times rule, we generally accepted the APC Panel's recommendation because these recommendations were based on explicit consideration of resource use, clinical homogeneity, hospital specialization, and the quality of the data used to determine the APC payment rates that we proposed for CY 2005. The median cost for hospital outpatient services for these and all other APCs can be found at Web site: *http//www.cms.hhs.gov.*

We received one public comment on our proposal.

Comment: One commenter recommended that we use statistical methods to determine variations in the medians of services mapped to an APC. Specifically, the commenter suggested the cost data for an APC should include the standard deviation and the coefficient of variation using the geometric mean as the basis for the measure of dispersion. The commenter recommended that very few APCs be allowed to violate the 2 times rule.

Response: We appreciate the commenter's recommendations. We will consider these recommendations for future recalibrations. We do currently review the range of standard descriptive statistics for all APCs, including, but not limited to, the standard deviation and coefficient of variation. As we stated in the proposed rule, we used multiple criteria to assess whether to propose exceptions to the 2 times rule for affected APCs, including resource and clinical homogeneity, hospital concentration, frequency of services, and opportunities for upcoding and code fragments. Despite an increase in the number of clinical APCs in the OPPS over the last several years, the number of APCs excepted from the 2 times rule has remained relatively stable.

The proposed rule listed exceptions from the 2 times rule based on data from January 1, 2004 through September 30, 2004. For this final rule with comment period, we used data from January 1, 2003 through December 31, 2003. As a result of the additional data, the list of APCs that we are excepting from the 2 times rule has been updated. In this final rule with comment period, we are adopting 57 APCs as excepted from the 2 times rule, as shown in Table 13 below.

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Table 13.--APCs Exceptions to the 2 Times Rule

APC	APC Description
0019	Level I Excision/ Biopsy
0024	Level I Skin Repair
0025	Level II Skin Repair
0032	Insertion of Central Venous/Arterial Catheter
0043	Closed Treatment Fracture Finger/Toe/Trunk
0046	Open/Percutaneous Treatment Fracture or Dislocation
0060	Manipulation Therapy
0080	Diagnostic Cardiac Catheterization
0081	Non-Coronary Angioplasty or Atherectomy
0087	Cardiac Electrophysiologic Recording/Mapping
0093	Vascular Reconstruction/Fistula Repair without Device
0099	Electrocardiograms
0105	Revision/Removal of Pacemakers, AICD, or Vascular
0121	Level I Tube changes and Repositioning
0122	Level II Tube changes and Repositioning
0140	Esophageal Dilation without Endoscopy
0146	Level I Sigmoidoscopy
0147	Level II Sigmoidoscopy
0148	Level I Anal/Rectal Procedure
0164	Level I Urinary and Anal Procedures
0183	Testes/Epididymis Procedures
0187	Miscellaneous Placement/Repositioning
0193	Level V Female Reproductive Proc
0203	Level IV Nerve Injections
0204	Level I Nerve Injections
0209	Extended EEG Studies and Sleep Studies, Level II
0213	Extended EEG Studies and Sleep Studies, Level I
0214	Electroencephalogram
0235	Level I Posterior Segment Eye Procedures
0236	Level II Posterior Segment Eye Procedures
0252	Level II ENT Procedures
0262	Plain Film of Teeth
0268	Ultrasound Guidance Procedures
0274	Myelography
0281	Venography of Extremity
0285	Myocardial Positron Emission Tomography (PET)
0297	Level II Therapeutic Radiologic Procedures
0303	Treatment Device Construction
0314	Hyperthermic Therapies
0322	Brief Individual Psychotherapy
0335	Magnetic Resonance Imaging, Miscellaneous
0340	Minor Ancillary Procedures
0341	Skin Tests
0342	Level I Pathology
0344	Level III Pathology
0355	Level I Immunizations
0356	Level II Immunizations
0364	Level I Audiometry
0370	Allergy Tests
0373	Neuropsychological Testing
0389	Non-imaging Nuclear Medicine
0397	Vascular Imaging
0409	Red Blood Cell Tests
0422	Level II Upper GI Procedures
0600	Low Level Clinic Visits
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver
0699	Level IV Eye Tests & Treatments

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E. Coding for Stereotactic Radiosurgery Services

1. Background

In the November 7, 2003 final rule with comment period (68 FR 63403), we discussed the APC Panel's consideration of HCPCS codes G0242 (Cobalt 60-based stereotactic radiosurgery plan) and G0243 (Cobalt 60-based stereotactic radiosurgery delivery). At its August 22, 2003 meeting, the APC Panel discussed combining the coding for these procedures under one code, with the payment for the new code derived by adding together the payments for HCPCS codes G0242 and G0243. The APC Panel recommended that we solicit additional input from professional societies representing neurosurgeons, radiation oncologists, and other experts in the field before recommending changes to the coding configuration for Cobalt 60-based stereotactic radiosurgery planning and delivery.

In a correction to the November 7, 2003 final rule with comment period, issued on December 31, 2003 (68 FR 75442), we considered a commenter's request to combine HCPCS codes G0242 and G0243 into a single procedure code in order to capture the costs of this treatment in a single procedure claim because the majority of patients receive the planning and delivery of this treatment on the same day. We responded to the commenter's request by explaining that several other commenters stated that HCPCS code G0242 was being misused to code for the planning phase of linear accelerator-based stereotactic radiosurgery planning. Because the claims data for HCPCS code G0242 represent costs for linear accelerator-based stereotactic radiosurgery planning (due to misuse of the code), in addition to Cobalt 60-based stereotactic radiosurgery planning, we were uncertain of how to combine these data with HCPCS code G0243 to determine an accurate payment rate for a combined code for planning and delivery of Cobalt 60-based stereotactic radiosurgery.

In consideration of the misuse of HCPCS code G0242 and the potential for causing greater confusion by combining HCPCS codes G0242 and G0243, we created a planning code for linear accelerator-based stereotactic radiosurgery (HCPCS code G0338) to distinguish this procedure from Cobalt 60-based stereotactic radiosurgery planning. We maintained both HCPCS codes G0242 and G0243 for the planning and delivery of Cobalt 60-based stereotactic radiosurgery treatment, consistent with the use of two G-codes for planning (HCPCS code G0338) and delivery (HCPCS codes G0173, G0251, G0339, G0340, as applicable) of each type of linear accelerator-based treatment. We indicated that we intend to maintain these new codes in their current new technology APCs until the payment rates could be set using medians from this expanded set of codes. We also stated that we would solicit input from the APC Panel at its February 2004 meeting.

During the February 2004 APC Panel meeting, several presenters discussed with the APC Panel their rationale for requesting that HCPCS codes G0242 and G0243 be combined into a single procedure code. One presenter explained that the request to combine the codes was made because certain fiscal intermediaries were rejecting claims in which HCPCS codes G0242 and G0243 were reported with a surgery revenue code. Although we have not issued any national instructions to fiscal intermediaries to deny claims for these services if they are billed with a surgery revenue code, the presenter stated that we may have indirectly led some fiscal intermediaries to believe that Cobalt 60-based stereotactic radiosurgery should be reported with a radiation therapy revenue code because the procedure is separated into a planning code and a delivery code, which reflect the coding pattern of a radiation therapy procedure rather than a single code for a surgical procedure. The presenter stated that because of the way that CMS has coded this procedure, some fiscal intermediaries have established local edits to deny claims in which HCPCS codes G0242 and G0243 are reported on a claim with a surgery revenue code.

The APC Panel recommended that CMS work with the presenters to determine if any fiscal intermediaries have established local edits to reject claims in which HCPCS codes G0242 and G0243 are reported on a claim, and to determine specific reasons for any such local edits. The APC Panel also recommended that CMS take necessary action to ensure that any such claims are not being denied payment due to local edits. The APC Panel did not agree that the solution to ensuring payment was to combine HCPCS codes G0242 and G0243 into a single code, but rather recommended that CMS educate fiscal intermediaries as to the appropriate procedures for submission of these claims for Medicare payment.

2. Proposal for CY 2005

In the August 16, 2004 proposed rule, for CY 2005, we proposed to accept the APC Panel's recommendation to work with the presenters to ensure that claims in which HCPCS codes G0242 and G0243 are reported are not being inappropriately denied payment due to local edits established by fiscal intermediaries. In the meantime, for CY 2005, we proposed to maintain HCPCS code G0242 in New Technology APC 1516 (New Technology, Level XVI) at a payment rate of $1,450, and HCPCS code G0243 in New Technology APC 1528 (New Technology, Level XXVIII) at a payment rate of $5,250. These payment rates are the same as those established for CY 2004.

3. Public Comments Received and Departmental Responses

Comment: Numerous comments urged CMS to replace HCPCS codes G0242 (Cobalt 60-based multisource photon SRS, planning) and G0243 (Cobalt 60-based multisource photon SRS, delivery) with one surgical code (that is, CPT code 61793, Stereotactic radiosurgery, one or more lesions) for billing Cobalt 60-based multisource photon stereotactic radiosurgery. These commenters explained that Cobalt 60-based multisource photon SRS is considered to be a one session, neurosurgical procedure and is not separated into planning and delivery sessions. One commenter contended that this procedure is managed and performed exclusively by neurosurgeons.

In response to the OPPS final rule with comment period published on November 7, 2003, one commenter suggested that a combined surgical code representing Cobalt 60-based stereotactic radiosurgery could be appropriately assigned to APC 0222 (Implantation of Neurological Device), APC 0226 (Implantation of Drug Infusion Reservoir), or APC 0227 (Implantation of Drug Infusion Device) to reflect the device costs, the neurosurgical nature of the procedure, and the clinical homogeneity of the other CPT codes that currently reside in these APCs.

In response to the OPPS final rule with comment period published on November 7, 2003, and the OPPS proposed rule published on August 16, 2004, several commenters indicated that the current coding structure has resulted in a low volume of single procedure claims for these codes, reflecting the fact that single procedure claims are billed in error for this procedure due to the necessity of billing both HCPCS codes G0242 and G0243 to capture the planning and delivery costs of this procedure. These commenters explained that the concept of planning and delivery is representative of radiation

therapy and, therefore, does not accurately describe Cobalt 60-based multisource photon SRS. The commenters believed that the creation of HCPCS codes G0242 and G0243 has created an unnecessary burden on hospitals because commercial payors do not recognize these codes. One commenter described the burden of reporting the same service using two different coding systems as the costs associated with hiring and training additional staff, preparing individual negotiations with insurers, and addressing the rejection of claims and the delay of treatments.

In contrast, three commenters objected to the use of the term ''radiosurgery'' to describe Cobalt 60-based multisource photon SRS planning and delivery. One of these commenters indicated that Cobalt 60-based multisource photon SRS is a radiation therapy procedure. This commenter contended that the indirect costs of operating a radiation therapy department are considerably higher than that of a surgery department, when factoring in the cost of a radiation physicist and therapist. The commenter further indicated that the cost-to-charge ratio (CCR) for the radiation therapy cost center more accurately reflects the costs of providing this service relative to a surgical designation. Another commenter objected to our use of the term ''radiosurgery'' and asserted that this term is a misleading nomenclature because surgery is not involved, except for the placement of an externally attached coordinate reference frame. The commenter explained that this treatment usually consists of one or more high dose radiation treatments delivered by either a linear accelerator or a cobalt 60-based unit and, therefore, should be referred to as ''stereotactic radiation therapy.''

In response to the OPPS final rule with comment period published on November 7, 2003, one commenter urged that CMS not attempt to label stereotactic radiosurgery as either neurosurgery or external beam radiotherapy, and explained that stereotactic radiosurgery is a unique procedure that combines elements of both neurosurgery and external beam radiotherapy. This commenter recommended that we recognize CPT codes specifically designed for stereotactic radiosurgery.

Response: Considering the wide range of conflicting recommendations we received from commenters, we believe that appropriate coding for Cobalt 60-based multisource photon SRS remains a highly contentious and unsettled area of interest among hospitals, neurosurgeons, radiation oncologists, and non-Medicare payors. Based upon our reading of the comments and the observations of CMS staff, we do not believe that Cobalt 60-based multisource photon SRS can be easily classified as either a neurosurgical or radiation therapy procedure specifically. Rather, for the safe and effective delivery of Cobalt 60-based multisource photon SRS to typical patients with brain lesions, the contributions of hospital physician and nonphysician staff with expertise in neurosurgery and radiation therapy are essential for both the planning of the treatment and its delivery.

In the OPPS November 30, 2001 final rule in which we first established payment rates for stereotactic radiosurgery planning and treatment using G-codes in lieu of CPT codes, we noted that, for historical hospital claims for CPT code 61793 (Stereotactic radiosurgery), other combinations of codes from the radiation oncology CPT code section were billed most of the time as well. This confirmed our recognition of the multidisciplinary nature of the service. However, we note that the classification of stereotactic radiosurgery as either neurosurgery or radiation therapy is not relevant to payment for the service under the OPPS. Therefore, for purposes of the OPPS, we have not attributed the service to one specialty or the other.

While we consider the adoption of CPT codes that describe this service, we will continue to maintain HCPCS codes G0242 and G0243 as separate codes in their respective new technology APCs 1516 and 1528 for CY 2005. Although we recognize that the single claims data we collect from these codes may include aberrant claims due to the necessity of billing both HCPCS codes G0242 and G0243 on the same date of service for a correctly coded claim, the adoption of CPT code 61793 to replace HCPCS codes G0242 and G0243, as recommended by some commenters, would not resolve the multiple procedure claims dilemma due to the fact that typically hospitals would need to bill additional CPT codes along with CPT code 61793 to report the full range of services that are currently bundled into HCPCS codes G0242 and G0243. For example, in our November 30, 2001 final rule in which we described our determination of the total cost for stereotactic radiosurgery, to model costs for planning, we added the median costs of CPT codes 77295 (the most typical simulation code billed with CPT code 61793), 77300, 77370 (the most common physics consult billed with CPT code 61793), and 77315 (the most common dose plan billed with CPT code 61793). Furthermore, the descriptor for CPT code 61793 describes multiple forms of stereotactic radiosurgery (that is, stereotactic radiosurgery, one or more lesions; particle beam, gamma ray or linear accelerator), rather than Cobalt 60-based multisource photon SRS alone. The adoption of CPT code 61793 under the OPPS would have the effect of nullifying all of the stereotactic radiosurgery G–codes, which we are unwilling to do without cost data supporting an equal payment for all forms of stereotactic radiosurgery. In light of all the above-mentioned reasons, we believe that any stereotactic radiosurgery code changes for CY 2005 would be premature without cost data to support a code restructuring. In the meantime, we will continue to pay HCPCS codes G0242 and G0243 under their current respective new technology APCs 1516 and 1528 for CY 2005, as we continue to analyze new methods for resolving the issue of multiple procedure claims.

Comment: In response to the OPPS final rule with comment period published on November 7, 2003, and the OPPS proposed rule published on August 16, 2004, several commenters urged CMS to recognize the surgical nature of Cobalt 60-based multisource photon SRS by mapping the procedure to a surgical revenue code. The commenters claimed that some Medicare fiscal intermediaries continue to reject claims in which HCPCS codes G0242 and G0243 are reported with a surgery revenue code, and encouraged CMS to issue national instructions on the correct billing for stereotactic radiosurgery procedures. The commenters believed that revenue codes are established by the general APC in which the procedure resides. Another commenter stated that the placement of HCPCS codes G0242 and G0243 in new technology APCs labeled as radiation therapy has misled Medicare fiscal intermediaries to assume that a radiation revenue code must be reported with these claims. This commenter indicated that, as a result of providers reporting a radiation revenue code when billing HCPCS codes G0242 and G0243 and Medicare applying a radiation CCR ratio to these codes, the median costs for HCPCS codes G0242 and G0243 were understated, as the CCR for radiation is around 33 percent compared to a 45-percent to 55-percent CCR for surgery cost centers.

In response to the OPPS final rule with comment period published on November 7, 2003, and the OPPS proposed rule published on August 16, 2004, two commenters objected to the

assignment of HCPCS codes G0243 and G0173 to the same new technology APC 1528. The commenters argued that these two procedures should not be grouped into the same APC because they are clinically dissimilar and do not share the same level of resource intensity. The commenter believed that an APC grouping should be determined by the clinical nature of the procedure, its resource cost, the type of physician necessary to perform the procedure, the clinical setting in which the procedure is performed, and the clinical outcomes of the procedure. Another commenter indicated that the cost of Cobalt 60-based SRS multisource photon SRS delivery is 2.45 times the cost of linear accelerator-based SRS delivery, which the commenter believed to be an unacceptable violation of the 2 times rule. In contrast, one commenter reported that its facility has experienced no delays or claims rejections as a result of the current coding structure for stereotactic radiosurgery. The commenter urged CMS to maintain the current coding structure for Cobalt 60-based multi-source photon SRS planning and delivery, asserting that providers who carefully review the code descriptors should experience no delays or claims rejections.

Response: We believe the commenter's concerns regarding the clinical similarity and the application of the 2 times rule to a new technology APC reflect a misunderstanding of the purpose of the new technology APCS. We assign procedures to a new technology APC when we do not have adequate claims data upon which to determine the relative median cost of performing a procedure, and must rely on other sources of information (that is, external data that have been made publicly available) to determine its appropriate payment. New technology APCs do not carry clinical descriptors, such as radiation therapy; rather, the descriptor for each new technology APC represents a particular cost band (for example, $1,400 to $1,500). Payment for items assigned to a new technology APC is the mid-point of the band (for example, $1,450). As we stated in our proposed rule, we have worked together with some of the commenters to identify specific fiscal intermediaries who may be rejecting claims in which HCPCS codes G0242 and G0243 are reported. However, to date, we have been unable to identify any such local edits. Nor have we received examples of rejected claims from providers to enable us to determine why payment was not made for the claims. CMS will continue to work with providers and contractors to clarify coding and billing for all stereotactic radiosurgery procedures through program instructions, Medlearn Matters articles, and other outreach activities.

Comment: One commenter understood that the Advisory Panel on APC Groups is invested with the responsibility of providing correct coding for hospitals, and contended that the Panel should address in more detail the coding issues for stereotactic radiosurgery procedures. This commenter further indicated that the Panel is composed almost entirely of physicians rather than hospital financial personnel or hospital coders, to which the commenter objected as creating a direct conflict with hospital interests.

Response: We do not agree with the commenter's concerns regarding the Advisory Panel on APC Groups. The Panel is governed by the provisions of Pub. L. 92–463, which set forth standards for the formation and use of advisory panels (42 U.S.C. 13951 (t); section 1833(t) of the Act). According to the Charter, the function of the Panel is to review the APC groups and their associated weights and advise the Secretary of Health and Human Services and the Administrator of CMS concerning the clinical integrity of the APC groups and their weights. The subject-matter of the Panel includes to the following issues and related topics: addressing whether procedures are similar both clinically and in terms of resource use; assigning new CPT codes to APCs; reassigning codes to different APCs; and reconfiguring the APCs into new APCs. Responsibility for providing correct coding for hospitals does not fall within the purview of the Panel. Furthermore, we wish to reassure the commenter about the makeup of the Panel. The commenter's understanding that the Panel is almost entirely composed of physicians and lacks representation from hospital financial personnel or hospital coders is not accurate. As required by the Charter, all of the Panel members are currently employed in a full-time status by a hospital and serve as representatives of their hospital employer. Furthermore, only approximately half of the Panel members hold a medical degree, while the other half of the Panel members hold a hospital coding certification or nursing, pharmacy, or business degree(s), or both, or serve as hospital reimbursement officers, or both.

Comment: We received numerous comments suggesting various simplifications of the coding structure for SRS planning and delivery. Some commenters urged that CMS develop one uniform series of treatment codes for the various types of stereotactic radiation therapy, based on the process of care rather than a vendor-specific technology. One commenter suggested that CMS eliminate HCPCS codes G0338 (Linear accelerator-based SRS planning) and G0242 (Multi-source Cobalt 60-based photon SRS planning) and recognize existing CPT codes 77295 or 77301 to describe stereotactic radiation therapy planning, which the commenter believed would more accurately describe the process of care and reduce duplication in codes. Another commenter recommended that CMS eliminate HCPCS code G0242, and recognize HCPCS code G0338 for describing all forms of stereotactic radiosurgery planning by deleting the phrase that restricts the code to linear accelerator-based stereotactic radiosurgery planning.

In contrast, a commenter responding to the OPPS final rule with comment period published on November 7, 2003, suggested that CMS eliminate HCPCS code G0338, and recognize HCPCS code G0242 for all stereotactic radiosurgery planning by deleting the phrase that restricts the code to multisource Cobalt 60-based photon SRS planning. Other commenters recommended that CMS simplify the stereotactic radiosurgery delivery codes as well by eliminating HCPCS codes G0173 (SRS delivery, complete session) and G0251 (Linear accelerator-based SRS delivery, fractionated sessions), and recognizing HCPCS codes G0339 (Image guided, robotic linear accelerator-based SRS, complete or first session) and G0340 (Image guided, robotic linear accelerator-based SRS, second through fifth sessions) for all forms of stereotactic radiosurgery delivery by removing the word ''robotic'' from their descriptors. Another commenter suggested an alternative option for simplifying the stereotactic radiosurgery delivery codes by eliminating HCPCS codes G0339 and G0340, and recognizing HCPCS codes G0173 and G0251. This commenter recommended that CMS modify the descriptors for HCPCS codes G0173 and G0251 by deleting the linear accelerator specification so the codes apply to all forms of stereotactic radiosurgery delivery and deleting the maximum number of five sessions per course of treatment from the descriptor of HCPCS code G0251. One commenter suggested that CMS eliminate HCPCS codes G0173, G0251, G0339, and G0340 and recognize HCPCS code G0243 as including all stereostactic radiosurgery delivery procedures by deleting the phrase that restricts its use to

multisource Cobalt 60-based photon stereotactic radiosurgery delivery.

In response to the OPPS final rule with comment period published on November 7, 2003, one commenter indicated that HCPCS code G0340 (Image guided, robotic linear accelerator-based SRS, second through fifth sessions) should not be described by radiosurgery, contending that radiosurgery is defined by a single session treatment. The commenter recommended that the descriptor for HCPCS code G0340 be changed to ''image-guided, robotic, linear accelerator-based radiation therapy-hypofractionated delivery.'' One commenter responded to the OPPS proposed rule by applauding CMS for placing the first fraction of a multiple session treatment delivery of image-guided robotic linear accelerator-based stereotactic radiosurgery (described by HCPCS code G0339) in the same APC as a complete single session treatment delivery of image-guided robotic linear accelerator-based stereotactic radiosurgery, and stated that the resources consumed are identical, regardless of whether additional treatment sessions are delivered. This commenter agreed with CMS' placement of subsequent fractionated sessions in a lower paying APC to reflect the fewer resources consumed during the delivery of subsequent sessions.

In response to the OPPS final rule with comment period published November 7, 2003, several commenters supported CMS' decision to assign HCPCS codes G0338 (Linear accelerator-based stereotactic radiosurgery planning) and G0242 (Cobalt 60-based, multi-source photon stereotactic radiosurgery planning) to the same APC, and stated that the resource costs of both types of stereotactic radiosurgery planning are comparable. Another commenter applauded CMS' creation of HCPCS code G0338 to differentiate linear accelerator stereotactic radiosurgery planning from multisource photon stereotactic radiosurgery planning (HCPCS code G0242), due to the differences in their clinical uses and cost resources.

In response to the OPPS final rule with comment period published on November 7, 2003, one commenter supported the creation of HCPCS codes G0339 and G0340, as long as these codes are used exclusively for extracranial stereotactic radiosurgery treatments, such as those of the spine, lung, and pancreas. Due to limited cost data and clinical efficacy published on image-guided, robotic stereotactic radiosurgery used to treat extracranial indications, the commenter believed that the costs for this new and emerging technology would be more accurately captured by limiting the use of HCPCS codes G0339 and G0340 to extracranial stereotactic radiosurgery treatments.

Several commenters requested that CMS present their recommendations to the Advisory Panel on APC Groups during its next meeting in the event that the stereotactic radiosurgery code descriptors cannot be modified in time for the CY 2005 final rule.

Response: For reasons stated in a previous response, we believe that any stereotactic radiosurgery code changes for CY 2005 would be premature without cost data to support a code restructuring. For instance, in preparation of the CY 2006 OPPS Update, we intend to conduct data analysis for the first time for HCPCS codes G0338, G0339, and G0340, which were newly created G-codes for CY 2004. Therefore, until we have completed any such analysis, we will continue to maintain HCPCS codes G0173, G0251, G0338, G0339, G0242, and G0243 in their respective new technology APCs for CY 2005 as we consider the adoption of CPT codes to describe all stereotactic radiosurgery procedures for CY 2006, including the new CPT tracking codes 0082T (Stereotactic body radiation therapy, treatment delivery, one or more treatment areas, per day) and 0083T (Stereotactic body radiation therapy, treatment management, per day) that the AMA intends to make effective January 1, 2005. For CY 2005, we will assign a status indicator of ''E'' for CPT code 0082T to reflect the fact that the current G-codes for stereotactic radiosurgery treatment delivery include this service, and a status indicator of ''N'' for CPT code 0083T because we consider the treatment management per session bundled into the current stereotactic radiosurgery treatment delivery G-codes.

In reference to commenters' request that CMS present their recommendations for stereotactic radiosurgery code restructuring to the Advisory Panel on APC Groups, we refer the readers to the discussion above in an earlier response concerning the purview of the Panel's responsibilities. To the extent that the APC assignments for stereotactic radiosurgery codes are an issue, we may bring those to the attention of the Panel.

Comment: In response to the OPPS final rule with comment period published on November 7, 2003, several commenters expressed concern that the placement of HCPCS code G0340 (Image-guided robotic linear accelerator-based SRS delivery, fractionated treatment) in a higher paying new technology APC than G0251 (Non-robotic linear accelerator-based SRS delivery, fractionated treatment) creates a financial incentive to use robotic SRS technology over non-robotic stereotactic radiosurgery technology. The commenters urged that HCPCS codes G0251 and G0340 be placed in the same APC until clinical evidence supports an improved clinical outcome using robotic stereotactic radiosrugery as compared to non-robotic stereotactic radiosurgery and sound financial data supports payment differentiation. In addition to placing G0251 and G0340 in the same APC, one commenter urged that CMS remove the language ''or first session of fractionated treatment'' from the descriptor for G0339 and remove the language ''second through fifth sessions'' from the descriptor for G0340, so that placement of HCPCS codes G0251 and G0340 in the same APC will result in equal payments for the first session of fractionated therapy, regardless of the type of technology used to deliver fractionated stereotactic radiosurgery.

In response to the OPPS final rule with comment published on November 7, 2003, and the OPPS proposed rule published on August 16, 2004, several commenters asserted that the creation of HCPCS codes G0339 and G0340 was unnecessary, on the premise that all stereotactic radiosurgery and radiotherapy equipment is image guided and robotic. One commenter expressed concern that the creation of HCPCS codes G0339 and G0340, the limitation of HCPCS code G0340 to five fractionated sessions, and the placement of HCPCS code G0340 in a higher paying APC than other SRS modalities inadvertently amount to an endorsement by CMS of the CyberKnife technology. The commenter believed that the current payment rate for CyberKnife therapy results in excessive copayments for beneficiaries and unfairly advantages a technology that has provided insufficient clinical evidence of an improved outcome above existing stereotactic radiosurgery and radiotherapy modalities, and has provided CMS with no convincing cost data to support such an excessive return on investment. The commenter believed that if CMS had consulted the Medicare Coverage Advisory Committee (MCAC) or the Medical Technology Council (MTC), which advise CMS on whether specific medical treatments and technology should receive coverage, neither the MCAC nor the MTC would have recommended coverage for the CyberKnife technology. Other

commenters urged that CMS eliminate what they believe to be an unfair advantage given to HCPCS code G0339 by modifying the descriptor for HCPCS code G0173 (SRS delivery, complete session) to describe a complete session or first session of linear accelerator-based stereotactic radiosurgery delivery, and modifying the descriptor for HCPCS code G0251 to describe second through fifth sessions of linear accelerator-based stereotactic radiosurgery delivery, so that the first session of a multiple session treatment will be paid equal to that of a complete session, regardless of the type of stereotactic radiosurgery technology used.

Response: We disagree with commenters who believe that the creation of HCPCS codes G0339 and G0340, the limitation of HCPCS code G0340 to five fractionated sessions, and the placement of HCPCS code G0340 in a higher paying APC than other stereotactic radiosurgery modalities amount to an endorsement by CMS of a particular technology. We also note that the code descriptors for HCPCS codes G0339 and G0340 do not limit themselves to the CyberKnife technology. As other commenters indicated, the term ''image-guided robotic'' applies to other types of stereotactic radiosurgery besides CyberKnife. The OPPS payment system establishes payment rates for services based on relative resources utilized by hospitals to provide such services, based primarily on historical claims data if data are available. If hospital claims data are unavailable, we may consider external data to assist us. From 2000 through 2002, the manufacturer of one type of image-guided robotic stereotactic radiosurgery technology (that is, CyberKnife), along with several hospitals, provided CMS with cost data indicating the level of resources utilized in the provision of this form of stereotactic radiosurgery. We believe these data support the current placement of HCPCS codes G0339 and G0340 in their respective new technology APCs 1528 and 1525 for CY 2005.

To date, we have not received such cost data on non-robotic linear accelerator-based stereotactic radoisurgery (that is, on HCPCS codes G0173 and G0251) to aid us in determining if the current payment differentiation is appropriate. Therefore, we will maintain HCPCS codes G0339 and G0340 in APCs 1528 and 1525, respectively, and make no changes to their descriptors for CY 2005. In reference to CMS consulting a medical technology council for advice on new technology coverage, we refer the readers to section II.F.4.,''Public Comments Received Relating to Other New Technology APC Issues,'' of this final rule with comment period for a discussion of the recently established Council on Technology and Innovation.

Comment: A number of commenters, mostly providers of radiation oncology centers or departments, pointed out that stereoscopic kV x-ray guidance using infrared and/or camera technology is a new and important technology that allows for improved precision in radiation therapy targeting. These commenters indicated that kV x-ray guidance is not described by any current HCPCS or CPT code and requested that CMS create a new HCPCS G-code for payment under the OPPS. In addition, one commenter requested that CMS establish a new HCPCS code necessary for target localization in conjunction with intensity modulated radiation therapy, stereotactic radiotherapy, and stereotactic radiosurgery.

Response: The kV x-ray guidance using infrared technology came to our attention by means of an application to be considered for assignment to a new technology APC. We have recently concluded that the kV x-ray guidance should receive a temporary ''C'' code for OPPS payment under certain circumstances described below, and that it should be placed into a new technology APC. Therefore, we are creating the following HCPCS code to describe kV x-ray guidance using infrared technology:

HCPCS code C9722 (Stereoscopic kV x-ray imaging with infrared tracking for localization of target volume)

We are assigning the new HCPCS code C9722 to New Technology APC 1502 at a payment of $75, effective on January 1, 2005.

While we are assigning a C-code and payment for hospital costs, we are not assigning a G-code because we believe that the interested party should seek a CPT code from the AMA. We believe that the CPT Editorial Panel needs to assess the need for a code for the service, and, if a code is granted, evaluate the resources necessary to provide this service. This technology has been available for more than 2 years. We consider this time period to be sufficient for the interested party to request a CPT code from the AMA.

In addition, in our definition and payment instructions for this service, we are limiting additional payment for this service to occasions when kV x-ray is not billed with stereotactic radiosurgery delivery G-codes. As all stereotactic radiosurgery delivery services require guidance, the current payments for the stereotactic radiosurgery delivery G-codes (HCPCS codes G0173, G0243, G0251, G0339, and G0340) bundle payment for guidance services with stereotactic radiosurgery delivery.

4. Final Policy for CY 2005

We are adopting our proposal to maintain HCPCS codes G0173, G0242, G0243, G0251, G0338, and G0339 in their respective new technology APCs for CY 2005. We will consider the adoption of CPT codes to describe all stereotactic radiosurgery procedures in the future.

F. Movement of Procedures From New Technology APCs to Clinically Appropriate APCs

1. Background

In the November 30, 2001 final rule (66 FR 59903), we made final our proposal to change the period of time during which a service may be paid under a new technology APC. Beginning in CY 2002, we retained services within new technology APC groups until we acquired adequate data to enable us to assign the service to a clinically appropriate APC. This policy allows us to move a service from a new technology APC in less than 2 years if sufficient data are available. It also allows us to retain a service in a new technology APC for more than 3 years if sufficient data upon which to base a decision for reassignment have not been collected.

In the November 7, 2003 final rule with comment period, we implemented a comprehensive restructuring of the new technology APCs to make the payment levels more consistent (68 FR 63416). We established payment levels in $50, $100, and $500 intervals and expanded the number of new technology payment levels.

2. APC Panel Review and Recommendation

During the APC Panel's February 2004 meeting, the APC Panel heard testimony from several interested parties who requested specific modifications to the APCs for the radiation oncology APC. They asked the APC Panel to make several recommendations: (1) That we move CPT code 77418 (Radiation treatment delivery, Intensity-modulated radiation therapy (IMRT)) from APC 0412 (IMR Treatment Delivery) back into a new technology APC; (2) that we dampen, or limit, any possible payment reductions to APC 0301 (Level II Radiation Therapy); (3) that we accept more external data to evaluate costs; and (4) that we identify more claims that are useful for ratesetting.

In response to the testimony presented, the APC Panel recommended that we reassign CPT code 77418 to the new technology APC 1510 for CY 2005 and that we explain to providers any steps we take to limit payment reductions to APC 0301 so that they can better plan for future years during which we may decide not to apply a dampening, or payment reduction limitation, to the rates for APC 0301.

In the August 16, 2004 proposed rule, we did not propose to accept the APC Panel's recommendations because we believe that we have ample claims data for use in determining an appropriate APC payment rate for CPT code 77418. Moreover, we believe that the development of median cost for CPT code 77418 based on those data is representative of hospital bills.

We have over 255,000 claims for this service, and over 95 percent were single claims that we could use for ratesetting. Moreover, the APC medians have been stable for the last 2 years of data. As indicated by our claims data, returning code 77418 to new technology APC 1510 would result in a payment for the service that is significantly higher than the resources utilized to provide it.

We refer the readers to section II.F.4., ''Public Comments Received Relating to Other New Technology APC Issues,'' of this final rule with comment period for a discussion of the public comments and our final policy regarding the APC placement of CPT code 77418 for CY 2005.

Comment: Several commenters objected to the proposed assignment of CPT code 77418 to APC 0412 at a payment rate of $307.78. These commenters disagreed with CMS' conclusion that the significant volume of single claims used to set the payment rate accurately reflects the costs hospitals incur to provide this service, and argued that hospitals are inaccurately coding this service and submitting insufficient charges for delivering this therapy. One commenter raised concerns that some providers are incorrectly billing procedures other than IMRT under CPT code 77418. Commenters urged CMS to accept the recommendation of the Advisory Panel on APC Groups to return CPT code 77418 to a new technology APC with a payment rate comparable to the CY 2003 payment rate of $400.

Response: As we noted previously, we do not accept the Panel's recommendation to move CPT code 77418 back to a new technology APC. We believe the 2 years (that is, CYs 2002 and 2003) that CPT code 77418 was in new technology APC 0710 allowed ample opportunity for providers to receive proper instruction on correctly coding and billing for this service. The proposed payment rate of $307.78 for CY 2005 was set using 96 percent of the total claims (that is, 246,045 single procedure claims out of 255,020 total claims) for CPT code 77418, which deeply supports its current placement in clinical APC 0412. Therefore, we will maintain CPT code 77418 in APC 0412 for CY 2005.

Comment: Several commenters objected to the proposed movement of CPT code 77301 (Radiotherapy dose plan, IMRT) from new technology APC 1510 (New Technology, Level X) with a payment rate of $850 to clinical APC 0310 (Radiation treatment preparation, Level III) with a payment rate of $811.91. The commenters indicated that this procedure is relatively new and that hospitals appear to be inaccurately reporting the costs of providing this service. The commenters recommended that, until more data can be collected and analyzed, CMS retain CPT code 77301 in new technology APC 1510 at a payment rate of $850.

Response: We move a procedure from a new technology APC to a clinical APC when we have adequate claims data for ratesetting. We believe that the proposed movement of CPT code 77301 from new technology APC 1510 to clinical APC 0310 is appropriate, considering that 88 percent of the total claims (66,076 single procedure claims out of 74,911 total claims) were used to set the payment rate of $811.91 for APC 0301. Furthermore, CPT code 77301 has been placed in a new technology APC for the past 3 years (that is, CY 2002 through CY 2004), which we believe to be ample time for providers to receive proper instruction on correctly coding and billing for CPT code 77301. Therefore, as proposed, we are moving CPT code 77301 from new technology APC 1510 to clinical APC 0310 for CY 2005.

Comment: One commenter requested that new CPT 0073T (Compensator-based beam modulation treatment delivery of inverse planned treatment using three or more high resolution (milled or cast) compensator convergent beam modulated fields, per treatment session) be assigned to APC 0412 with an ''S'' status indicator. The commenter believed that the assignment of 0073T should be the same as that for CPT 77418.

Response: We agree with the commenter and are assigning CPT 0073T to APC 0412 with status indicator ''S'' for CY 2005.

3. Proposed and Final Policy for CY 2005

There are 24 procedures currently assigned to new technology APCs for which we have data adequate to support assignment into clinical APCs. Therefore, in the August 16, 2004 proposed rule, we proposed to reassign these procedures to clinically appropriate APCs. We proposed to assign 24 of the procedures that were listed in Table 14 of the proposed rule to clinically appropriate APCs using CY 2003 claims data to set medians on which payments would be based.

As we did in the proposed rule, we present below a further explanation to provide a fuller understanding of the payment rates for several of the procedures that we proposed to move out of new technology APCs and into clinical APCs.

a. Photodynamic Therapy of the Skin

For CPT code 96567 (Photodynamic therapy of the skin), the impact of the payment decrease between CY 2004 and CY 2005 is actually low, as the CY 2004 payment included the topically applied drug required to perform this procedure and the CY 2005 payment does not. We will now pay separately for the drug billed under HCPCS code J7308 in CY 2005. We have adequate claims data on which to base payment for that procedure in a clinically appropriate APC. Payment based on those data in addition to removal of the drug for separate payment resulted in a lower median cost for the APC.

Comment: Several commenters objected to the proposed movement of CPT code 96567 (Photodynamic therapy of the skin) from New Technology APC 1540 (New Technology, Level III) with a payment rate of $150 to clinical APC 0013 (Level II Debridement and Destruction) with a proposed payment rate of $66.15. The commenters recognized that the drug (that is, HCPCS code J7308) used with this procedure is no longer bundled into the payment for CPT code 96567, and agreed that some payment reduction is appropriate. However, the commenters indicated that the proposed payment rate for APC 0013 would not cover the costs of providing this service even after excluding the costs of the drug.

Response: We believe that the resources and the clinical nature of CPT code 96567 are consistent with other codes that are placed in APC 0013. Therefore, in this final rule with comment period, we are finalizing our proposal to move CPT code 96567 from New Technology APC 1540 to clinical APC 0013 for CY 2005.

Comment: One commenter brought to our attention that CPT code 96571 (Photodynamic therapy, additional 15 minutes) may have been moved mistakenly from New Technology APC 1541 to clinical APC 0012 (Level I Debridement and Destruction). The commenter suggested that CPT code 96571 be placed in the same clinical APC 0013 (Level II Debridement and Destruction) as CPT code 96570 (Photodynamic therapy, 30 minutes).

Response: We agree with the commenter that CPT code 96571 was mistakenly moved to APC 0012 in the proposed rule. Because CPT code 96571 is an add-on code for an additional 15 minutes of photodynamic therapy, reported in addition to CPT code 96570, which describes the first 30 minutes of therapy, we believe that both codes, with status indicator ''T,'' should be placed in APC 0015 (Level III Debridement and Destruction). Therefore, in this final rule with comment period, we are moving CPT code 96571 from New Technology APC 1541 to clinical APC 0015 for CY 2005.

b. Left Ventricular Pacing, Lead and Connection

Based on a comparison of payment rates for CY 2004 and CY 2005, it appears that there is a large increase in payment that results from reassigning CPT code 33224 (Insertion of left ventricular pacing, lead and connection) from its new technology APC to a clinical APC. The difference is due to the fact that the CY 2005 APC payment includes the cost of the left ventricular lead that was not included in the CY 2004 new technology APC payment. The left ventricular lead was paid as a pass-through device under HCPCS code C1900 in CY 2004, but is not eligible for pass-through payments in CY 2005, and, as such, is now included in the APC for the procedure.

Similarly, the CY 2005 payment rate for CPT code 33225 (Left ventricular pacing lead add-on) includes the cost of the ventricular lead. However, for code 33225, the data are still somewhat unstable. Therefore, in the proposed rule, we maintained CPT code 33225 in a new technology APC, but at a higher payment level, to reflect the additional cost of the lead.

We received no comments and, therefore, we are reassigning CPT code 33224 to a clinical APC for CY 2005.

c. Positron Emission Tomography (PET) Scans

PET–FDG (Nonmyocardial)

In the proposed rule, we noted that a number of positron emission tomography (PET) scans currently are classified into APC 1516. We recognized that PET is an important technology in many instances and want to ensure that the technology remains available to Medicare beneficiaries when medically necessary. We believe that we have sufficient data to assign PET scans to a clinically appropriate APC. However, we have been told that if the effect of doing so is to reduce payment significantly for the procedure, it may hinder access to this technology. Therefore, as indicated in the August 16, 2004 proposed rule, we considered three options as the proposed payment for these procedures in CY 2005, based on our review of the 2003 claims data for the PET procedures. We specifically invited comments on each of these options.

Option 1: Continue in CY 2005 the current assignment of the scans to New Technology APC 1516 prior to assigning to a clinical APC.

Option 2: Assign the PET scans to a clinically appropriate APC priced according to the median cost of the scans based on CY 2003 claims data. Under this option, we would assign PET scans to APC 0420 (PET Imaging).

Option 3: Transition assignment to a clinical APC in CY 2006 by setting payment in CY 2005 based on a transition payment of a 50–50 blend of the median cost and a New Technology APC payment for CY 2004. We would assign the scans to New Technology APC 1513 for the blended transition payment.

We included the proposed rates for these options in Addendum B of the proposed rule.

Comment: Many commenters supported maintaining a number of PET scans in New Technology APC 1516 for CY 2005, as presented under option 1 of the proposed rule. These commenters expressed concern that options 2 and 3 set forth in the proposed rule would greatly impede patient access to PET technology. They stated that options 2 and 3 fail to account for the significant degree of variation in hospital mark-up practices and capital depreciation methods associated with PET procedures and, therefore, underestimate hospitals' costs for performing PET scans. These commenters further explained that the majority of hospitals report PET procedures under an overall diagnostic radiology revenue code rather than distinguishing PET procedures under a diagnostic nuclear medicine revenue code. The commenters expressed concern that PET claims data, when adjusted using a cost to charge ratio not specific to PET, underestimate the relative costs associated with PET imaging procedures.

Another commenter commissioned a time-and-motion study at nine PET facilities in geographically diverse regions of the United States to estimate hospitals' actual costs for providing PET scans. According to the commenter, this cost study concluded that many hospitals could not afford to provide PET scans at a payment rate below $1,450. In addition, the commenter indicated that the cost study suggested that hospitals need to perform three or more scans per day in order to break even at the current payment rate of $1,450 per scan. The commenter pointed out that using a marketing share-weighted average, the cost study found that PET facilities across the United States are performing an average of 2.63 PET scans per day, translating into a loss of $165.18 per scan for most PET providers at the current payment rate of $1,450 per scan. However, the commenter did not clarify whether this national average of performing 2.63 PET scans per day reflects utilization by both hospitals and freestanding PET centers. The commenter urged that PET remain in new technology APC 1516 for CY 2005, and noted that any reductions in payment, including the proposed blended payment rate of $1,150, would significantly impede patient access to this technology, especially in rural settings where the volume of PET scans tends to be lower. Another commenter that provides FDG to 300 PET imaging centers in geographically diverse regions of the United States reviewed their May, June, and July 2004 data for these PET centers and reported an average number of 1.88 PET scans provided per day and a median of 1.3 PET scans provided per day across the 300 PET centers. Again, the commenter did not clarify whether this national average of performing 1.88 PET scans per day reflects utilization by both hospitals and freestanding PET centers. This commenter expressed concern that any reduction in payment for PET scans, with or without a reduction in payment for FDG, may drive many PET centers into an operating deficit and reduce the availability of PET scans for Medicare beneficiaries.

Response: We appreciate the many comments we received on this topic and the efforts undertaken by several of the commenters to provide us with additional data concerning the costs of providing the scans. We acknowledge variations in hospital markup practices, capital depreciation and other cost allocation methods, although we note that the CCRs in the various reported cost centers (that is, Nuclear Medicine,

Imaging Department, Radiology) for PET procedures are fairly consistent. The median hospital CCR for these cost centers ranges from 0.3118 to 0.3172, and does not vary greatly from the median overall hospital CCR of 0.33. We believe that the robust number of claims (that is, 55,838 single procedure claims out of 61,492 total claims, representing 91 percent of the total claims) provides sufficient data to assign PET scans to a clinically appropriate APC. However, we received numerous comments indicating that any reduction in payment for PET scans would hinder access by Medicare beneficiaries to this technology. Based on our review of the comments, we are setting the CY 2005 payment for PET scans based on a 50–50 blend of the median cost and the CY 2004 new technology APC payment rate, as presented under option 3 in the proposed rule. PET scans will be assigned to new technology APC 1513 for a blended payment rate of $1,150 for CY 2005.

Comment: One commenter pointed out that the CY 2003 hospital claims data may not account for the current shift to PET/CT technology, which the commenter stated has virtually doubled the cost of launching a viable PET operation, from an average cost of $1,200,000 for a dedicated PET scanner to an average cost of $2,400,000 for a PET/CT scanner. The commenter estimated that approximately 90 percent of the PET systems currently being sold are PET/CT scanners and predicted that the current installed base of approximately 35 percent PET/CT and 65 percent dedicated PET will shift to an overwhelming majority of PET/CT scanners within the next 5 years. The commenter argued that investment in a PET/CT scanner is important to be competitive in the marketplace, due to better capability for detecting malignancies. The commenter stated that the higher capital costs of a PET/CT operation require a patient volume of between four and five patients per day to break even compared to a patient volume of between two and three patients for a dedicated PET operation. According to the commenter, the number of claims for PET remains relatively low compared to MRI and CT scans, comprising less than 1 percent of all imaging procedures performed in the United States. Therefore, the commenter argued that providers would be unlikely to recover significant losses through increased patient volume.

Several commenters indicated that the American Medical Association will be creating three new CPT codes 78814, 78815, and 78816 to describe PET with concurrent CT for anatomical localization for CY 2005. One commenter recommended that CMS assign these new CPT codes for PET/CT scans to three different new technology APCs, while another commenter recommended that CMS place these new CPT codes in new technology APC 1516 at a payment rate of $1,450.

Response: The current G code descriptors do not describe PET/CT scan technology, and should not be reported to reflect the costs of a PET/CT scan. At present, we have decided not to recognize the CPT codes for PET/CT scans that the AMA intends to make effective January 1, 2005, because we believe the existing codes for billing a PET scan along with an appropriate CT scan, when provided, preserve the scope of coverage intent of the PET G-codes as well as allow for the continued tracking of the utilization of PET scans for various indications. We plan to issue billing guidance through program instructions and provider education articles for hospitals to use when they provide both a PET and CT scan to patients in their outpatient department. While we acknowledge that PET/CT scanners may be more costly to purchase than dedicated PET scanners, a PET/CT scanner is versatile and may also be used to perform individual CT scans, thereby potentially expanding its use if PET/CT scan demand is limited.

Comment: One commenter supported assigning PET procedures to new technology APC 1513 at a payment rate of $1,150, based on a 50–50 blend of the median cost and the CY 2004 new technology payment, as presented under option 3 of the proposed rule. This commenter stated that option 3 provides the best balance between ensuring continued beneficiary access to this valuable technology and the need for CMS to consistently apply its ratesetting methodology to determine payment rates. Another commenter supported the assignment of PET procedures into a clinically appropriate APC that pays at least $1,200. This commenter believed that a payment of at least $1,200 would compensate adequately for the technology and necessary staffing.

Response: We agree with the commenters that a balance must be reached between ensuring continued beneficiary access to PET scans and the necessity for CMS to apply consistently its rate-setting methodology. Balancing the concern regarding possible adverse effects on patient access that might result from a substantial precipitous reduction in payment with information from thousands of hospital claims and the cost data we received from commenters, we are setting the CY 2005 payment for PET scans based on a 50–50 blend of the median cost and the CY 2004 new technology APC payment rate, as presented under option three in the proposed rule. We believe we have reached this balance for CY 2005 by assigning PET scans to new technology APC 1513 for a blended payment rate of $1,150.

Comment: Another commenter addressed the issue of three new CPT codes 78811, 78812, and 78813 for tumor PET imaging to replace CPT code 78810 (Tumor imaging, positron emission tomography, metabolic evaluation) for CY 2005. The commenter recommended that CMS adopt these new CPT codes in place of the existing G-codes and place them in new clinical APCs, which would result in one level for brain PET scans, two levels for cardiac PET scans, and three levels for tumor PET scans.

Response: At present, we believe that the existing G-codes for PET scans adequately serve the purpose of tracking utilization of PET scans for various indications. Therefore, CMS will continue to recognize the existing G-codes for PET scans.

Comment: One commenter requested that CMS provide the number of single procedure claims that support assigning FDG-PET scans to a clinically appropriate APC according to the median cost of the scans, as presented under option 2 in the proposed rule.

Response: The number of single procedure claims used to create the median of $898.64 discussed in the proposed rule under option 2 for APC 0420 (PET imaging) totaled 55,838 single procedure claims out of 61,492 total claims.

PET (Myocardial)

Comment: One commenter brought to our attention that CPT code 78459 (myocardial imaging, PET, metabolic evaluation) and HCPCS code G0230 (PET imaging; metabolic assessment for myocardial viability following inconclusive SPECT study) are both currently paid under OPPS and describe nearly the same procedure, with the exception that HCPCS code G0230 has a more narrow description. The commenter understood that CMS had intended to replace HCPCS code G0230 with CPT code 78459, but was confused by the payable status indicator for both codes. Two commenters recommended that CMS clarify the proper use of these codes and move CPT code 78459 from APC 0285 (Myocardial Positron Emission Tomography), with a payment rate of $690.61 to APC 1516 with a payment rate of $1,450.

Response: We appreciate the commenter bringing to our attention the

duplication of codes for myocardial PET imaging for metabolic assessment. At present, we will change the status indicator for CPT code 78459 (Myocardial imaging, PET, metabolic evaluation) to ''B,'' not payable under the OPPS, and move HCPCS code G0230 (PET imaging; metabolic assessment for myocardial viability following inconclusive SPECT study), along with the other PET codes currently assigned to APC 1516, from APC 1516 to APC 1513 for CY 2005. We will seek advice on the APC placement of HCPCS code G0230 from the Advisory Panel on APC Groups during their next meeting.

Comment: Several commenters indicated that the resources, other than the radiopharmaceuticals, required to perform the PET myocardial perfusion imaging studies assigned to APC 0285 (Myocardial Positron Emission Tomography) do not differ significantly from many of the PET tumor imaging procedures contained in new technology APC 1516. These commenters requested an explanation for the payment rate decrease from $1,058.87 in the proposed rule for the CY 2004 update to $772.08 in the final rule for the CY 2004 update, and the further decrease to $690.61 in the proposed rule for the CY 2005 update. The commenters objected to CMS creating an exception to the 2 times rule for APC 0285. The commenters believed that the small volume of these procedures and the complexity of multiple G-codes to describe both single and multiple imaging sessions preclude reasonable conclusions about the cost of providing these services. The commenters recommended that CMS move the 18 G-codes from APC 0285 paying $690.61 to APC 1516 with a payment rate of $1,450. The commenters further recommended that we reduce the complexity of billing for these procedures by collapsing these eighteen G-codes into two CPT codes based on resources for single and multiple studies, replacing HCPCS codes G0030–G0047 with CPT code 78491 (Myocardial imaging, PET, perfusion; single study at rest or stress) and CPT code 78492 (Myocardial imaging, PET, perfusion; multiple studies at rest or stress).

Response: The steady decline of the payment rate for APC 0285 since the CY 2004 proposed rule is attributable to the 153-percent increase in the number of single procedure claims used to set the payment rate for APC 0285, which gave rise to better data to more accurately set the payment rate. In the CY 2004 proposed rule, we used 613 single procedure claims out of 1,584 total claims (39 percent of total claims) to set the CY 2004 proposed payment rate of $1,058.87. In the CY 2004 final rule, we used 1,089 single procedure claims out of 1,778 total claims (61 percent of total claims) to set the CY 2004 final payment rate of $772.08. In the CY 2005 proposed rule, we used 1,451 single procedure claims out of 1,946 total claims (75 percent of total claims) to set the CY 2005 proposed payment rate of $690.61. At present, composition of APC 0285 will be maintained for CY 2005 while we collect claims data on HCPCS codes G0030 through G0047. Based on our CY 2003 data for the specific G-codes, we cannot identify a predictable pattern of increased hospital costs associated with multiple studies as compared with single studies. We will present before the Advisory Panel on APC Groups during their next meeting the commenters' recommendation to recognize CPT codes 78491 and 78492 as representing single and multiple myocardial PET studies and movement of these codes from APC 0285 to APC 1516. We note that we will be moving the PET scans currently in APC 1516 to APC 1513 for CY 2005, and will bring that to the Panel's attention as they consider potential APC movement of the myocardial PET studies.

d. Bard Endoscopic Suturing System

For CY 2005, we proposed to create APC 0422 for Level II Upper GI Procedures and to assign HCPCS code C9703 (the Bard Endoscopic Suturing System), as well as other procedures to APC 0422 based on clinical and resource homogeneity. Currently, HCPCS code C9703 is assigned to New Technology APC 1555, with a payment of $1,650. Our examination of CY 2003 claims data for HCPCS code C9703 revealed that 137 of the 171 single claims were from a single institution with an extremely low and consistent cost per claim. We do not believe that those 137 claims represent the service described by HCPCS code C9703, which includes an upper gastrointestinal endoscopy along with suturing of the esophagogastric junction. Therefore, in establishing the median for APC 0422, we did not use the 137 claims, which we believe were incorrectly coded.

Comment: Several commenters opposed the movement of HCPCS code C9703 (Bard Endoscopic Suturing System) from New Technology APC 1555 with a payment rate of $1,650 to clinical APC 0422 (Level II Upper GI Procedures) with a proposed payment rate of $1,274. The commenters indicated that the proposed payment under APC 0422 is inadequate to cover even the equipment costs alone. The commenters contended that the claims data are insufficient to support movement of this procedure out of its new technology APC and into a clinical APC, and urged CMS to maintain HCPCS code C9703 in New Technology APC 1555 with a payment rate of $1,650.

Response: As we stated in the proposed rule, our examination of the CY 2003 claims data for APC 0422 revealed that 137 of the 171 single claims for HCPCS code C9703 were incorrectly coded. Therefore, the remaining single claims were used in establishing the median for APC 0422. Considering that HCPCS code C9703 has remained in a new technology APC for 2 years with a relatively modest volume, we are not convinced that maintaining HCPCS code C9703 in a new technology APC will necessarily result in a high volume for future ratesetting. Furthermore, the median cost as calculated for HCPCS code C9703, using the subset of single claims, has been relatively stable over the past 2 years and consistent with the median for APC 0422. In addition, in keeping with our practice to use CPT codes, if possible, we will discontinue HCPCS code C9703 and instruct providers to report service with this technology under CPT code 0008T (Upper gastrointestinal endoscopy with suture), which will be payable under the OPPS for CY 2005. In this final rule with comment period, we are finalizing our proposal to move HCPCS code C9703, which will be replaced with CPT code 0008T, from New Technology APC 1555 to clinical APC 0422 for CY 2005. Code 0008T is assigned status indicator ''NI'' and, as such, is open for public comment during the 60-day comment period associated with this final rule with comment period.

e. Stretta System

Comment: Several commenters objected to the movement of HCPCS code C9701 (Stretta system) from New Technology APC 1557 with a payment rate of $1,850 to clinical APC 0422 (Level II Upper GI Procedures) with a proposed payment rate of $1,274. The commenters indicated that the proposed payment is inadequate to cover even the equipment costs alone, and urged CMS to maintain HCPCS code C9701 in New Technology APC 1557 with a payment rate of $1,850.

Response: The single claims volume for HCPCS code C9701 has remained modest for the past 2 years of its placement in a new technology APC. Therefore, we do not believe that maintaining HCPCS code C9701 in a new technology APC will necessarily result in a high volume for future

ratesetting. Furthermore, the median cost for HCPCS code C9701 has been stable over the past 2 years and consistent with the median for APC 0422. Moreover, we can now discontinue HCPCS code C9701 and will instruct providers to report service with this technology under CPT code 43257 (Upper gastrointestinal endoscopy with delivery of thermal energy), a new CPT code that will be payable under OPPS for CY 2005. We are finalizing our proposal to move HCPCS code C9701, which will be replaced with CPT code 43257, from New Technology APC 1557 to clinical APC 0422 for CY 2005.

f. Gastrointestinal Tract (GI) Capsule Endoscopy

Comment: Several comments opposed our proposal to move CPT code 91110 (GI Capsule Endoscopy) from New Technology APC 1508 with a payment rate of $650 to clinical APC 0141 (Level I Upper GI Procedures) with a proposed payment rate of $464.52 for CY 2005. (CPT code 91110 (Capsule Endoscopy) replaced HCPCS code G0262 in CY 2004. HCPCS code G0262 was mapped to New Technology APC 1508 in CY 2004.) The commenters explained that the cost data for CPT code 91110 are unreliable due to multiple coding changes over the last 3 years and, therefore, believed that the data should not be used to set the payment rate. The commenters indicated that the device costs are $450, and under the proposed payment rate, only $14 would be available to cover the service portion of the procedure. The commenters expressed concern that patient access to care would be hindered by moving the service into clinical APC 0141. The commenters also contended that the proposed assignment of this procedure to APC 0141 is inappropriate because none of the other services that reside in APC 0141 require a device of significant cost and the codes are not clinically homogeneous with CPT code 91110. The commenters urged CMS to maintain CPT code 91110 in New Technology APC 1508 with a payment rate of $650. One commenter suggested that CMS assign a C code to the capsule and instruct providers to bill this C-code along with HCPCS code G0262. One commenter requested that, if CMS does not maintain CPT code 91110 in new technology APC 1508, CMS consider two additional options: (1) Limiting the rate reduction for CY 2005 to 5 percent of the CY 2004 rate; or (2) assign CPT code 91110 to APC 0142 (Small Intestine Endoscopy), which the commenter stated would be a compromise because the payment of $503.20 would still ''underpay'' the hospital for the costs of providing the procedure.

Response: Generally, we do not establish C-codes for devices outside of the pass-through process, so we will not assign a C-code to the capsule. We remind providers that they should include the charges for device costs associated with this capsule within the charges reported for CPT code 91110. We agree with the commenters that CPT code 91110 may not belong in APC 0141 based on clinical homogeneity and resource consumption. We had almost 4,000 single claims, about 90 percent of all CY 2003 claims for capsule endoscopy, available for use in calculating the median cost of the service. We have confidence that our median reflects hospital resources needed to perform the service. As one commenter recommended, we believe that the resource costs and clinical nature of CPT code 91110 are more consistent with other codes that reside in APC 0142. Therefore, in this final rule with comment period, we are moving CPT code 91110 from New Technology APC 1508 to clinical APC 0142 for CY 2005, as the commenter suggested.

g. Proton Beam Therapy

Comment: Several commenters urged CMS to maintain intermediate (CPT code 77523) and complex (CPT code 77525) proton beam therapies in New Technology APC 1511 at a payment rate of $950 for CY 2005. The commenters indicated that the proposed payment rate of $678.31 for CY 2005 does not capture the significant difference in resource consumption and complexity between the simple and the intermediate/complex procedures. These commenters expressed concern that the low volume of claims submitted by only two facilities provides volatile and insufficient data for movement into the proposed clinical APC 0419 (Proton Beam Radiation Therapy) at a payment rate of $678.31. They pointed out that more than four additional centers are currently under construction or in the planning phases in response to the high demand for this technology. The commenters explained that the extraordinary capital expense of between $70–$125 million and high operating costs of a proton beam necessitate adequate payment for this service to protect the financial viability of this emerging technology. They feared that a payment reduction would halt diffusion of this technology and negatively impact patient access to this cancer treatment.

Two commenters explained that the CY 2005 proposed payment rates for CPT codes 77523 (intermediate proton beam treatment) and 77525 (complex proton beam treatment) were based on costs derived by applying CCRs from the most recent Medicare cost reports to charges reported on CY 2003 claims submitted by two hospitals, which were the only two proton therapy centers in operation in the United States at the time. The commenters further indicated that these two hospitals, from which all of the intermediate and complex proton therapies claims were derived, reported the costs and charges of proton therapy along with the costs and charges for all other radiation therapy services on the radiation therapy department line. One commenter calculated an overall radiation therapy department CCR of 0.2442 using CY 2003 data from one of these hospitals. This commenter then calculated a proton beam therapy CCR of 0.4175 by isolating the costs and charges for proton beam therapy from the costs and charges for the overall radiation therapy department. The commenter applied this proton beam therapy CCR of 0.4175 to calculate the costs based on average CY 2003 charges for intermediate and complex proton beam treatments and reported a cost of $1,105.96 for intermediate proton beam treatment and a cost of $1,216.60 for complex proton beam treatment, significantly above Medicare's proposed payment rate of $678.31 for CY 2005.

Commenters believed that this understatement of costs in the Medicare cost reports from these two hospitals is largely responsible for the inadequacy of the proposed payment rates for intermediate and complex proton beam treatments. The commenters requested that CMS apply the proton beam therapy CCR of 0.4175, based on proton beam specific cost data provided by one of these commenters, for determining the median costs of proton beam therapy. The commenters believed that the revised costs support the maintenance of CPT codes 77523 and 77525 in New Technology APC 1511 at a payment rate of $950 for CY 2005. The commenters also noted the recommendation of the Advisory Panel on APC Groups to maintain intermediate and complex proton beam therapies in New Technology APC 1511 at a payment rate of $950 for CY 2005 and urged CMS to adopt that recommendation.

Response: We will not apply the commenter's calculated CCR to determine the median costs of proton beam therapy because we are unable to replicate the commenter's proton beam therapy CCR calculation of 0.4175 by

isolating the costs and charges for proton beam therapy from the costs and charges for the overall radiation therapy department. However, having considered the concerns of numerous commenters that patient access to proton beam therapy may be impeded by a significant reduction in OPPS payment, we are setting the CY 2005 payment for CPT codes 77523 and 77525 by calculating a 50–50 blend of the median cost of $690.45 derived from 2003 claims and the CY 2004 new technology APC payment rate of $950. We will use the result of that calculation ($820) to assign intermediate and complex proton beam therapies (CPT codes 77523 and 77525) to New Technology APC 1510 for a blended payment rate of $850 for CY 2005.

After consideration of these public comments and based upon our review of the latest claims data available, we are moving the procedures listed in Table 14 from their current new technology APCs to the APCs listed, as we have adequate data on these procedures to enable us to make the necessary APC assignment.

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Table 14.--APC Reassignment of New Technology Procedures Into Clinical APCs

HCPCS	Descriptor	CY 2004 APC	CY 2005 APC	CY 2004 Payment Amount	CY 2005 Payment Amount
15860	Test for blood flow in graft	1501	0359	$ 25.00	$49.54
96003	Dynamic fine wire EMG	1503	0215	$150.00	$37.61
96000	Motion analyses, video/3D	1503	0216	$150.00	$150.20
96001	Motion test w/ft pressure measure	1503	0216	$150.00	$150.20
96002	Dynamic surface EMG	1503	0218	$150.00	$65.20
91110	GI tract capsule endoscopy	1508	0142	$650.00	$496.15
G0288	Reconstruction, CTA surgical plan	1506	0417	$450.00	$266.72
77301	Radiotherapy dose plan, IMRT	1510	0310	$850.00	$813.57
77523	Proton treatment, intermediate	1511	1510	$950.00	$850.00
77525	Proton treatment, complex	1511	1510	$950.00	$850.00
95250	Glucose monitoring, continuous	1540	0421	$150.00	$106.51
96567	Photodynamic treatment, skin	1540	0013	$150.00	$64.85
96570	Photodynamic treatment, 30 min.	1541	0015	$250.00	$98.28
96571	Photodynamic treatment, 15 min.	1541	0015	$250.00	$98.28
92973	Perc. Coronary thrombectomy	1541	0676	$250.00	$243.48
36595	Mech remov tunneled CV Cath	1541	0187	$250.00	$219.53
36596	Mech remov tunneled CV Cath	1541	0187	$250.00	$219.53
33224	Insert pacing lead and connect	1547	0418	$850.00	$4,246.04
33225	L ventricular pacing lead add-on	1550	1525	$1,150.00	$3,750.00
43257	Stretta System	1520	0422	$1,650.00	$1,264.79
47382	Perc. ablation liver tumor, rf	1557	0423	$1,850.00	$1,753.39
53853	Prostatic water thermometer	1550	0162	$1,150.00	$1,311.65
58356	Endometrial cryoablation	1557	0202	$1,850.00	$2,260.37
0008T	Bard Endoscopic Suturing Sys	1518	0422	$1,650.00	$1,264.79

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4. Public Comments Received Relating to Other New Technology APC Issues

a. Computerized Reconstruction CT of Aorta

In the August 16, 2004 proposed rule, we proposed to reassign code G0288 (Reconstruction, CTA of aorta for preoperative planning and evaluation post vascular surgery) from New Technology APC 1506 to clinical APC 0417 (Computerized Reconstruction) for CY 2005.

Comment: Several commenters expressed concern about our proposal to move G0288 from New Technology APC 1506 to clinical APC 0417. The commenter asserted that the reassignment results in a decreased payment amount from $450 to approximately $247, a rate that commenters believe is too low to cover the costs of providing the service.

The commenters suggested that CMS use external data to calculate rates rather than relying on hospital claims data, that CMS maintain G0288 in its current new technology APC assignment until hospital claims are more accurate, or that CMS go ahead with the reassignment to a clinical APC but continue to base payment on a rate that is consistent with the CY 2004 rate. One commenter provided invoices from hospitals across the country to support its assertion that our proposed payment will be to low.

One commenter also requested that CMS change the descriptor for code G0288 to read ''Three-dimensional pre-operative and post-operative computer-aided measurement planning and simulation in accordance with measurements and modeling specifications of the Society for Vascular Surgery'' in order to ensure that the code is only used for true three-dimensional preoperative and postoperative computer-aided measurement planning and simulation technologies.

Response: A predecessor C-code to G0288 had a new technology APC assignment in CY 2002, with a payment level of $625. The C-code was deleted for CY 2003, and G0288, a more general treatment planning code, was then assigned to the same new technology APC for CY 2003, with a payment of $625. For CY 2004, we proposed to move G0288 from a new technology APC to a clinical APC based on over 1,000 claims, with a median cost of $272. Based on hospital data provided by a commenter on the CY 2004 proposed rule and our conclusion that there may have been Medicare claims that understated the costs of the treatment planning software, we placed G0288 in a new technology APC with a payment of $450 for CY 2004, consistent with a 50/50 blend of our data with the analysis of a commenter. For CY 2005, we believe we have adequate claims data on which to base payment for G0288 and to reassign the service to its own clinical APC. We had almost 5,000 total claims for code C9703 (first 3 months of CY 2003 when the C-code was still in the grace period) and G0288, and over half of these were single claims available for APC median calculation. We are confident that the median cost for APC 0417 reflects hospital resource costs, and we are reassured by the consistency of our median cost data over the past several years for this service.

Accordingly, we are adopting as final our proposal to assign code G0288 to APC 0417 for CY 2005.

We are not changing the name of G0288 at this time. However, we will take the commenter's suggestion into consideration in the future if the need arises. We revised the descriptor for the code for CY 2004 to clarify that the service can be used for treatment planning prior to surgery and for postsurgical monitoring. We believe that the current G code descriptor appropriately describes the service.

b. Kyphoplasty

Comment: One commenter, a manufacturer of medical devices used to restore spinal function and treat vertebral compression fractures, suggested that CMS should place kyphoplasty, a new procedure to treat vertebral compression fractures, into New Technology APC 1535. The commenter stated that kyphoplasty is currently billed using code 22899 (Unlisted procedure of the spine). The commenter claimed that, according to our policy, because CMS received its application before June 2004, the procedure is eligible for new technology APC payments in October 2004. The commenter was surprised that it did not see a proposal to place kyphoplasty into a new technology APC in our proposed rule or in the October 2004 OPPS update. The commenter stated that using an unlisted code creates problems concerning billing and payment for hospitals.

Response: We have completed our evaluation of the new technology application for kyphoplasty and have assigned new C-codes that describe the procedure. We have assigned these codes to existing clinical APC 0051 rather than to a new technology APC. We believe that APC 0051 is appropriate for kyphoplasty in terms of clinical characteristics and resource costs. Reasonable placement into an existing APC that is appropriate in terms of clinical characteristics and resource costs is one of our criteria in deciding whether a service should be placed into a new technology APC (66 FR 59900, November 30, 2001).

Concerning the commenter's assertion that because CMS received its application before June 2004, the procedure is eligible for payment status as a new technology APC in October 2004, we remind the public that the timing of eligibility for payment, if any, is not bound to when an application is filed with CMS. As we state on the CMS Web site notice at *http://www.cms.gov,* if an application is filed by a certain date (for example, by June 1), the earliest date that such an item or service can be considered for new payment status is the following quarter (for example, October 1). This means that any additional coding and payment, if warranted, could begin later than the following quarter. Because it is important that our payment and coding systems do not impede access by Medicare beneficiaries to the best available medical care, we review all applications as quickly as possible, given the complexity of the issues and the thoroughness we believe such reviews require. The timing of completion of our evaluation of any specific application depends on such factors as the complexity of the application, the completeness of all materials submitted, whether the review team requires additional information and the amount of time before we receive additional materials and information. Of course, the service needs to be otherwise eligible for assignment to a new technology APC (or as a pass-through assignment in the case of a new device, drug, or biological).

We note that while we consider these new codes as final, the codes and the placement of the services are subject to comment within 60 days of the publication of this final rule with comment period, as stated elsewhere in this rule. Moreover, the public may comment on our placement of services to the APC Panel, which often hears comments and testimony concerning the placement of new services brought to us by interested parties.

Accordingly, the codes for kyphoplasty are:

C9718 Kyphoplasty, one vertebral body, unilateral or bilateral injection

C9719 Kyphoplasty, one vertebral body, unilateral or bilateral injection; each additional vertebral body (list separately in addition to code for primary procedure)

c. Laser Treatment of Benign Prostatic Hyperplasia (BPH)

In the August 16, 2004 proposed rule, HCPCS code C9713 (Non-contact laser vaporization of prostate, including coagulation control of intraoperative and postoperative bleeding) was assigned to New Technology APC 1525 for CY 2005. The assignment of this code to New Technology APC 1525 was a continuation of the new technology APC placement established on April 1, 2004.

Comment: One commenter, the manufacturer of medical equipment used in the treatment of benign prostatic hyperplasia (BPH) stated that its product, the GreenLight Laser, was the only technology available that uses a 532nm or ''green'' wavelength as an energy source and that CMS had assigned code C9713 in response to an application for a new technology APC assignment from Laserscope. The commenter indicated that other technologies that do not employ the same energy wavelength and the same noncontact vaporization technique should not be billed with code C9713. The commenter expressed concern that the costs of the other techniques are less than those for GreenLight Laser and thus the other techniques should not be paid under New Technology APC 1525. The commenter requested CMS to revise the descriptor of code C9713 to describe only 532nm laser technologies such as the GreenLight Laser.

Response: We acknowledge that HCPCS code C9713 was established following our review of the new technology application from Laserscope. We also agree that code C9713 may be used by hospitals to report such procedures using the Laserscope product, the GreenLight PVP, described in the application for new technology assignment. We established code C9713 based on our understanding of the information provided to us that the service may be different from other services used to treat BPH. We look forward to receiving and assessing the medical review, analysis, and evaluation of the service and technology through the usual AMA coding and payment processes. In general, we do not tailor temporary procedure codes in the ''C'' series to particular products and have not been persuaded that a redefinition of code C9713 is necessary at this time. With respect to other techniques for treatment of BPH, we would rely on the hospitals to determine which HCPCS code, whether C9713 or one of the CPT codes, most accurately describes the procedure for treatment of BPH for which they are billing. With regards to the commenter's claim that the costs of other techniques described by code C9713 are less than warranted by the New Technology APC 1525, our policy is to review the costs of services assigned to New Technology APCs each year to determine if an alternate placement in another APC is warranted. We continue to believe that placement of code C9713 in a new technology APC is appropriate for CY 2005.

d. Computerized Tomographic Angiography (CTA)

In the August 16, 2004 proposed rule, we included the APC assignment and the payment rate for computed tomographic angiography (CTA). These procedures, coded using one of several CPT codes, depending on the body region under study, involve acquisition of a CT scan with and without contrast material, as well as image post-processing. The assigned CTA CPT codes under APC 0662 had a proposed payment rate of $320.60. That proposed payment rate was slightly lower than that for a CT scan ($323.21) and significantly lower than the sum of the proposed payment for CT scan and image reconstruction, CPT code 76375 ($98), billed separately.

Comment: A number of commenters were concerned about the lower payment rates for the CTA procedures and asked CMS to review and revise the proposed payment rate.

The commenters pointed out that, prior to 2001, two codes were used to code for the procedure: one for the CT scan and another for the 3-D reconstruction. The commenters indicated that, in 2001, CPT codes were created to enable specific coding for CTA procedures, including image post-processing in the CTA codes, but those codes were still assigned to the same APC (0333) as CT procedures that did not include image reconstruction. They added that, in CY 2003, the CTA procedures were assigned to their own APC (0662). The commenters asserted that in spite of the creation of an APC specific to CTA procedures, the OPPS payment amounts have not reflected the additional costs for CTA compared to CT. They believed that the low payment rates are due to continuing confusion and conflicting information among providers concerning appropriate billing and charging practices associated with CTA procedures.

One commenter performed a number of analyses in an attempt to understand and address the apparent billing problems. In its investigation, the commenter discovered that, in 2002, only 40 percent of all hospitals that performed both CT and CTA charged more for CTA than for CT. The commenter also found in its study of hospital charge structures that there is wide variation in methods employed by hospitals and that only 29 percent of hospitals use costs to set charges.

While all commenters recommended that CMS adjust the payment rate for CTA procedures to equal that for APC 0333 plus APC 0282, one commenter recommended that we do this using the adjustment made under the Medicare Physician Fee Schedule for CY 2003 as a model. That commenter suggested that we should ignore CTA claims and instead rely on CT claims (APC 0333) plus reimbursement for image reconstruction (APC 0282) as a basis for setting the rate for CTA services.

Other alternative suggestions provided by the commenter include: use only CTA claims that are ''logical;'' change coding instructions and edits to allow CTA to be billed in addition to image reconstruction; or make an administrative adjustment to increase CTA payment.

Finally, the commenters encouraged CMS to investigate alternative methods for calculating CCRs in order to achieve more accurate costs on which to base our rates.

Response: Although we understand the commenters' points of view and appreciate the comprehensive analyses they shared with us, we cannot identify any action that would be appropriate for us to take. As the commenters are aware, we rely on hospital claims data to set payment rates and have made clear our intent to rely solely on those claims by CY 2007. If the claims data are inaccurate, especially across a broad spectrum of providers as the commenters believe is evidenced in this case, we have no way to determine which claims are more or less accurate than any others.

To implement the commenters' suggestion that we make the payment rate for CTA (APC 0662) equal to the sum of the rates for CT alone (APC 0333) plus image reconstruction (APC 0282) would require that we have accurate cost information about the cost of image reconstruction for CTA specifically and for CT alone, as utilized with CTA. This is not the case. The image reconstruction code CPT 76375 (coronal, sagittal, multiplanar, oblique, 3-dimensional and/or holographic reconstruction of computed tomography, magnetic resonance imaging, or other tomographic modality) is not limited to image reconstruction performed for CTA and may be used in any number of other procedures. Based on the available CPT codes for CTA, we

would not expect any current utilization of CPT code 76375 to be for CTA post-image processing, unless there was no appropriate CTA code to describe the body region imaged. We believe this would be rare. In addition, our current cost data for CT alone do not necessarily reflect the resources utilized for the CT portion of CTA.

We also do not believe that for the last 3 years there has been conflicting information given to providers concerning appropriate billing and charging practices associated with CTA procedures. The CPT code descriptors clearly include image post-processing for CTA procedures. In response to previous comments, we did provide a separate APC for CTA procedures beginning in CY 2003 in recognition that hospital resources might be different for CTA procedures as compared with CT procedures. From the over 100,000 claims for CTA procedures from CY 2003, we were able to use about 50 percent of the claims to determine hospitals' costs for the services. Our number of claims for CTA procedures increased significantly between CY 2002 and CY 2003. From the 2003 full year of data, we have calculated that median hospital costs for the APCs for CT and CTA services were approximately equal, at $329. Because hospitals set their own charges for services, which we then convert to costs, we see no reason why adding the costs for CT alone plus the costs for image reconstruction would necessarily provide a better estimate of costs for CTA than our analysis of our specific CTA claims.

Similarly, in order to make an adjustment akin to that made for the Medicare Physician Fee Schedule for CY 2003, we would need to have accurately coded cost data for the individual components of CTA, performed in the context of CTA, on which to base that change. We do not have that data, and the OPPS system, unlike the Medicare Physician Fee Schedule, relies upon historical hospital claims data to develop relative costs of services.

Lastly, we do not agree that we should provide coding guidance that differs from that embodied in the CPT code descriptors in this case. Our current edits that do not allow CTA to be billed in addition to image reconstruction are consistent with the CPT code descriptors for CTA procedures.

We created a separately paid, specific APC for those procedures in an attempt to provide an accurate payment for CTA. Moreover, by creating a unique APC for the procedures, we provided the means for hospitals to bill for all of the costs associated with CTA, entirely separate from their billing for CT. We cannot now assume that the claims billed for that APC are incorrect and that those billed for CT alone are correct.

We acknowledge the commenters' belief that the claims are flawed and that hospitals' divergent charge structures do not result in consistent charging for CT scans, CTAs or image reconstruction, but note that those claims comprise the data on which the OPPS relies for payment of a wide variety of hospital outpatient services. We must rely on hospitals to manage their charge structures in a manner that accurately and best reflects the services provided.

For the reasons stated above, we will not alter the payment rates for CTA, APC 0662, for CY 2005. Once again, we encourage hospitals to take all actions necessary to assure that they are billing accurately and including all resources utilized to deliver services. As discussed in detail in section III. of this preamble, we are continuing our work to refine the CCRs used for ratesetting.

e. Acoustic Heart Sound Services

Comment: Several commenters addressed the need to assign a recently created code for acoustic heart sound services for recording and computer analysis to an APC. One of the commenters indicated that the acoustic heart sound recording can be performed in the first 5 minutes of an emergency department service, together with an ECG, to enable the earliest possible detection of acute cardiac conditions. The commenter related that AMA's CPT Editorial Panel created three new Category III codes for acoustic heart sound recording that correspond to performing the procedure, physician interpretation of results, and recording and interpretation in combination. The commenter contended that one of these codes, CPT Category III code 0069T (Acoustic heart sound recording and computer analysis only) could be payable under the OPPS. The commenters noted that we did not propose an APC assignment for code 0069T in our proposed rule, and they requested an APC assignment effective January 1, 2005. One of the commenters believed that the most appropriate clinical APC to assign this code is APC 0099 (Electrocardiograms).

Response: One of the commenters, a manufacturer of the acoustic heart sound system, had previously applied for assignment of these codes to new technology APCs and we have previously evaluated the three acoustic heart sound services. We agree that only code 0069T could be payable under the OPPS. The comment that acoustic heart sound recording can be performed in the first 5 minutes of a visit by an ECG technician, together with an ECG, to enable the earliest possible detection of acute cardiac conditions, demonstrates that there are limited additional facility resources associated with the acoustic heart sound recording in conjunction with an ECG. It is also our understanding that the AMA's coding advice indicates that the acoustic heart sound services are to be used in conjunction with electrocardiography services. We believe it is worthwhile to recognize code 0069T under the OPPS to track its utilization and develop cost data. However, because the service may be performed quickly and is always accompanied by an ECG, we are assigning a packaged status to code 0069T for CY 2005. Although not separately payable under the OPPS, charges for the acoustic heart sound service will be packaged with charges for the separately payable services with which it is performed. With regards to the comment that we did not assign an APC in our proposed rule, we note that we do not recognize under the OPPS new CPT codes on a mid-year basis, even though the AMA may assign new tracking codes mid-year, as it did in this case. We assign new CPT codes on an annual basis, effective with our January 1 updates to the OPPS. Because this is a new code assignment that was not proposed in the CY 2005 proposed rule, interested parties will be able to comment on this new payment assignment in response to this final rule with comment period. This code is included in Addendum B.

f. Laparoscopic Ablation Renal Mass

Comment: Commenters asked that we move CPT code 50542 (Laparoscopic ablation renal mass) out of APC 0131 (Level II Laparoscopy) and place it in new technology APC 1574 (New Technology, Level XXXVII ($9,500–$10,000) until meaningful data can be obtained for the procedure. The commenter indicated that the procedure, including required devices, might cost approximately $10,000 because of the cost of the cryosurgery device. The commenter indicated that because they did not find any claims for this code that contained the device code for cryoablation probes (C2618), CMS should discard the data as being valid to set the weight for this code.

Response: Code 50542 represents a service that may or may not be performed with cryoablation equipment. Therefore, the absence of the device code for cryoablation probes on the

claims may be an accurate reflection of the service as it was performed. The median cost for the service appears to be appropriately placed in APC 0131 and the service is clinically coherent with other services in APC 0131. Therefore, we are retaining its placement in APC 0131 for CY 2005.

g. Intrabeam Intra-Operative Therapy

Comment. One commenter, the manufacturer of the Intrabeam Intra-Operative Therapy System, commented that this procedure, a treatment for women diagnosed with early-stage breast cancer, which is currently assigned to APC 0312 (Radioelement Applications) and is billed using CPT code 77776, is currently underpaid in APC 0312. The commenter claimed that there is no current APC mechanism to capture the cost information specific to this technology, and there are insufficient Medicare claims data at this time to make an appropriate clinical APC assignment. The commenter requested that CMS assign the Intrabeam procedure to a new technology APC. In addition, the commenter requested that CMS create two new level II HCPCS codes with the following descriptors: (1) Surgical placement and removal of intra-operative direct application x-ray source using surgical closure techniques; and (2) Administration of radiation therapy by intra-operative direct application of x-ray source.

Response. We recently received from the manufacturer of the Intrabeam Intra-Operative Radiation Therapy procedure an application for assignment of this procedure to a new technology APC. We are currently engaged in review of that application.

h. New Technology Process Issues

Comment: In response to the OPPS final rule with comment period published November 7, 2003, one commenter asserted that CMS had failed to establish an acceptable method for evaluating the costs and clinical efficacy of therapeutic medical technologies before assigning a code and New Technology APC payment under the OPPS. The commenter urged CMS to propose evaluation criteria for determining costs and clinical efficacy. In developing such criteria, the commenter encouraged CMS to require that all filings with the FDA be submitted to CMS for review and for CMS to rely heavily on the predicated device in the FDA application, require all privately held companies to provide CMS with a list of investors/owners, utilize generally accepted accounting principles, seek advice from the Medicare Coverage Advisory Committee (MCAC) or the Medical Technology Council (MTC), consider evaluation methods used by other health insurers, and consider recommendations from experts in the field. The commenter believed that if CMS had consulted the MCAC or the MTC, which advise CMS on whether specific medical treatments and technology should receive coverage, neither the MCAC nor the MTC would have recommended coverage for the CyberKnife technology, as an example.

In response to our August 16, 2004 proposed rule, one commenter, a device manufacturer, urged CMS to make changes to the pass-through and new technology application and evaluation processes to provide disclosure of applications filed with CMS and to create an opportunity for the public to comment on the disposition of proposed or final actions on applications. The commenter believed that public processes can be adopted, while retaining CMS' quarterly update capability for coding and payment.

Response: As required by section 942(a) of Pub. L. 108–173, we recently established the Council on Technology and Innovation (CTI) which brings together CMS senior leadership to better coordinate coverage, coding and payment policy to support the goal of high quality, high value care. The CTI aims to provide CMS with improved methods for developing practical information about the clinical benefits of new medical technologies to aid in achieving more efficient coverage and payment of these medical technologies. The CTI will also help identify and develop study methods for gathering reliable evidence about the risks and benefits of new and existing medical technologies that can be carried out more easily on a regular basis, such as simple protocols, registries, and other study methods.

The CTI will support CMS' efforts to develop better evidence on the safety, effectiveness, and cost of new and approved technologies to help promote their more effective use. As directed in section 942(a) of Pub. L. 108–173, the CMS Council coordinates the activities of Medicare coverage, coding, and payment for new technologies and the exchange of information on new technologies between CMS and other entities charged with making similar considerations and decisions.

G. Changes to the Inpatient List

At the APC Panel's February 2004 meeting, we advised the APC Panel of a request that we had received to move four codes for percutaneous abscess drainage 44901 (Drain append. abscess, percutaneous), 49021 (Drain abdominal abscess), 49041 (Drain percutaneous abdominal abscess), 49061 (Drain, percutaneous, retroper. abscess)) from the inpatient list and to assign them to appropriate APCs. The APC Panel also recommended that we evaluate other codes on the inpatient list for possible APC assignment and that we consider eliminating the inpatient list.

In the August 16, 2004 proposed rule, we proposed to remove the four above-cited codes and assign them to clinically appropriate APCs, as recommended by the APC Panel. We also proposed to assign code 44901 to APC 0037, code 49021 to APC 0037; code 49041 to APC 0037; and code 49061 to APC 0037. We discuss in section VII.E. of this final rule with comment period our response to the APC Panel's recommendation that we either abolish the inpatient list or evaluate it for any appropriate changes, the public comments we received on our proposal, and our responses to those public comments.

H. Assignment of ''Unlisted'' HCPCS Codes

1. Background

Some HCPCS codes are used to report services that do not have descriptors that define the exact service furnished. They are commonly called ''unlisted'' codes. The code descriptors often contain phrases such as: ''unlisted procedure,'' ''not otherwise classified,'' or ''not otherwise specified.'' The unlisted codes typically fall within a clinical or procedural category, but they lack the specificity needed to describe the resources used in the service. For example, CPT code 17999 is defined as ''Unlisted procedure, skin, mucous membrane and subcutaneous tissue.'' The unlisted codes provide a way for providers to report services for which there is no HCPCS code that specifically describes the service furnished. However, the lack of specificity in describing the service prevents us from assigning the code under the Medicare OPPS to an APC group based on clinical homogeneity and median cost.

In the August 16, 2004 proposed rule, we listed in Table 15 our proposed APC reassignments of unlisted HCPCS codes. In most cases, the unlisted codes are assigned to the lowest level, clinically appropriate APC group under the Medicare OPPS. This creates an incentive for providers to select the appropriate, specific HCPCS code to describe the service if one is available. In addition, if there is no HCPCS code that accurately describes the service, placing the unlisted code in the lowest level APC group provides an incentive

for interested parties to secure a code through the AMA's CPT process that will describe the service. Once a code that accurately describes the service is created, we can collect data on the service and place it in the correct APC based on the clinical nature of the service and its median cost.

We do not use the median cost for the unlisted codes in the establishment of the weight for the APC to which the code is assigned because, by definition of the code, we do not know what service or combination of services is reflected in the claims billed using the unlisted code.

Our review of HCPCS code assignments to APCs has revealed that there are a number of unlisted codes that are not assigned to the lowest level APC.

2. Proposed and Final Policy for CY 2005

In the August 16, 2004 proposed rule, we proposed to reassign specified unlisted HCPCS codes for CY 2005 OPPS to the lowest level APC in the clinical grouping in which the unlisted code is located. We displayed a listing of our proposed reassignment of the unlisted HCPCS codes in Table 15 of the proposed rule.

We received a number of public comments on our proposals.

Comment: Some commenters supported placing all unlisted codes in the lowest paid APC and noted that they believed that there are others, such as CPT code 43999 (Unlisted procedure stomach), which is now in APC 0141, that should be added to the list of those to be placed in the lowest APC. They recommended that CMS review the entire list of CPT codes to find others that should be moved to the lowest level APC.

Some commenters opposed placing ''unlisted'' or ''not otherwise classified'' codes in the lowest APC applicable to the category of service. They believed that it is inappropriate for CMS to develop payment policies aimed at forcing stakeholders to seek new HCPCS codes for the services being performed. They indicated that moving these codes to the lowest paying APC would decrease payment for 18 of the 20 procedures by more than 70 percent and would create a barrier to new technology. They indicated that CMS should analyze the costs associated with particular unlisted codes and assign them to APCs that appropriately reflect the cost to perform the services but in the meantime, should retain them in the existing APCs in which they are placed. One commenter urged us to follow the process that is followed for physician payment when unlisted codes are used, with fiscal intermediaries negotiating payment for the unlisted code depending on the actual service provided each time. One commenter indicated that putting the unlisted codes in the lowest level APC provides a disincentive for facilities to adopt new technology because it will not be paid adequately.

Response: We appreciate the support of the commenters who agreed with placing unlisted codes in the lowest APC for the clinical category. With respect to the comment that CPT code 43999 should be moved out of APC 0141 and should be placed in the lowest APC for gastrointestinal procedures, we have not moved it from APC 0141 because we believe that APC 0141 is the lowest APC appropriate to the clinical category of services for CPT code 43999.

We have reviewed again the proposed list of unlisted or ''not otherwise classified'' codes being moved to the lowest APC and based on that re-review have determined that we do not need to make any additional changes to that proposed list in this final rule with comment period.

By definition, ''unlisted'' or ''not otherwise classified'' codes do not describe the services being performed, and the services coded using ''unlisted'' codes vary over time as new CPT and HCPCS codes are developed. Therefore, it is impossible for any level of analysis of past hospital data to result in appropriate placement of the service for the upcoming year in an APC in which there is clinical integrity of the groups and weights. Therefore, we believe that the appropriate default, in the absence of a code that describes the service being furnished, is placement in the lowest level APC within the clinical category in which the unlisted code falls. We see no need to expand the process that is followed for physician payment of unlisted codes to the outpatient hospital setting. The assignment of the unlisted codes to the lowest level APC in the clinical category specified in the code provides a reasonable means for interim payment until such time as there is a code that specifically describes what is being paid. It encourages the creation of codes where appropriate and mitigates against overpayment of services that are not clearly identified on the bill. For new technologies that are complete services but may not have yet been granted a specific CPT code, the new technology payment mechanism is available under OPPS. Outlier payments may also be available under the OPPS in a case of an expensive new technology for which a specific code is not available and for which the costs of the new procedure exceed the outlier threshold.

Comment: One commenter indicated that the principal problem behind the use of unlisted or not otherwise classified codes is the AMA's bias against giving CPT codes for new services and technologies unless a physician group requests the code to provide a mechanism for increased physician payment for the service. The commenter asked that CMS, as the largest and most powerful licensee of CPT, influence the AMA to reduce the amount of time it takes to release new CPT codes for use in the OPPS so that the need for use of unlisted codes will diminish and the new services can be paid appropriately more quickly after they come onto the market. The commenter also asked that CMS reduce its ''barriers'' to placement of new services that require new technologies into new technology APCs or to granting of pass through payment status. The commenter indicated that lowering these ''barriers'' also would eliminate much of the use of the unlisted codes.

Response: An individual, a physician group, or a manufacturer may submit a request for a new CPT code. CMS works collaboratively with the AMA to establish new CPT codes, recognizing that the process is governed and controlled by the AMA. The AMA CPT process involves methodical consideration of new coding proposals, which may be time consuming. In addition, the payment system changes required by new codes take some time to implement. Under the OPPS, we make available the pass-through and new technology payment mechanisms, using C-codes and G-codes to allow new services, devices, and technologies to be available to clinicians and providers to facilitate appropriate payment for such services. The commenter did not indicate what ''barriers'' to placement of new services exist. However, to assist the public, we provide further guidance in section IV.C. of the preamble concerning additional comments on the topic of the surgical insertion or implantation criterion for the pass-through device payment mechanism.

In this final rule with comment period, we are adopting as final, without modification, the proposed reassignment of unlisted HCPCS codes to move all unlisted or ''not otherwise classified'' codes to the lowest level APC that is appropriate to the clinical nature of the service, as displayed in Table 15.

Table 15.--Reassignments of Unlisted HCPCS Codes

HCPCS Short Description	CY 2004 APC Assignment	CY 2005 APC Assignment
15999	0022	0019
21089	0253	0251
21299	0253	0251
21499	0253	0251
21899	0252	0251
22999	0022	0019
31299	0252	0251
31599	0254	0251
40799	0253	0251
40899	0252	0251
41899	0253	0251
42699	0253	0251
42999	0252	0251
47399	0037	0002
48999	0005	0004
49659	0131	0130
67599	0239	0238
67999	0240	0238
68399	0239	0238
68899	0699	0230
69799	0253	0251
69949	0253	0251

I. Addition of New Procedure Codes

During the first two quarters of CY 2004, we created 85 HCPCS codes that were not addressed in the November 7, 2003 final rule with comment period that updated the CY 2004 OPPS. We have designated the payment status of those codes and added them to the April and July updates of the 2004 OPPS (Transmittals 3144, 3154, 3322, and 3324). We showed these codes in Table 16 of the proposed rule. Thirty of the new codes were created to enable providers to bill for brand name drugs and to receive payments at a rate that differs from that for generic equivalents, as mandated in section 1833(t)(14)(A)(i) of the Act as added by Pub. L. 108–173. In the August 16, 2004 proposed rule, we solicited comment on the APC assignment of these services. Further, consistent with our annual APC updating policy, we proposed to assign the new HCPCS codes for CY 2005 to the appropriate APCs.

We did not receive any public comments on our proposal. Accordingly, in this final rule with comment period, we are adopting as final our proposal to assign the new HCPCS codes for CY 2005 to the appropriate APCs, as shown in Addendum B of this final rule with comment period, without modification.

J. OPPS Changes Relating to Coverage of Initial Preventive Physical Examinations and Mammography Services Under Pub. L. 108–173

1. Payment for Initial Preventive Physical Examinations (Section 611 of Pub. L. 108–173)

a. Background

Section 611 of Pub. L. 108–173 provides for coverage under Medicare Part B of an initial preventive physical examination for new beneficiaries, effective for services furnished on or after January 1, 2005. This provision applies to beneficiaries whose coverage period under Medicare Part B begins on or after January 1, 2005, and only for an initial preventive physical examination performed within 6 months of the beneficiary's initial coverage date.

Current Medicare coverage policy does not allow for payment for routine physical examinations (or checkups) that are furnished to beneficiaries. Before the enactment of Pub. L. 108–173, all preventive physical examinations had been excluded from coverage based on section 1862(a)(7) of the Act, which states that routine physical checkups are excluded services. This exclusion is specified in regulations under § 411.15(a). In addition, preventive physical examinations had been excluded from coverage based on section 1862(a)(1)(A) of the Act. This section of the Act provides that items and services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member (as implemented in regulations under § 411.15(k)).

Coverage of initial preventive physical examinations is provided only under Medicare Part B. As provided in the statute, this new coverage allows payment for one initial preventive physical examination within the first 6 months after the beneficiary's first Part B coverage begins, although that coverage period may not begin before

January 1, 2005. We also note that Pub. L. 108–173 did not make any provision for the waiver of the Medicare coinsurance and Part B deductible for the initial preventive physical examination. Payment for this service would be applied to the required Medicare Part B deductible, which is $110 for CY 2005, if the deductible has not been met, and the usual coinsurance provisions would apply.

b. Amendments to Regulations

In the August 16, 2004 proposed rule, we proposed to amend our regulations to add a new § 410.16 that would provide for coverage of initial preventive physical examinations in various settings, including the hospital outpatient department, as specified in the statute, and specify the condition for coverage and limitation on coverage. In addition, we proposed to conform our regulations on exclusions from coverage under § 411.15(a)(1) and § 411.15(k) to the provisions of section 611 of Pub. L. 108–173. Specifically, we proposed to specify an exception to the list of examples of routine physical checkups that are excluded from coverage under § 411.15(a) and to add a new exclusion under § 411.15(k)(11).

We proposed to amend § 419.21 of the OPPS regulations to add a new paragraph (e) to specify payment for an initial preventive physical examination as a Medicare Part B covered service under the OPPS if the examination is furnished within the first 6 months of the beneficiary's first Medicare Part B coverage.

We noted that the initial preventive physical examination was also addressed in detail in our proposed rule to update the Medicare Physician's Fee Schedule for CY 2005 (69 FR 47487, August 5, 2004). However, because we believe the same elements of the initial physical examination furnished in a physician's office would also apply when the examination is performed in a hospital outpatient clinic, we proposed to revise the applicable regulations to reflect this requirement.

Section 611(b) of Pub. L. 108–173 defines an ''initial preventive physical examination'' to mean physicians'' services consisting of—

(1) A physical examination (including measurement of height, weight, blood pressure, and an electrocardiogram (EKG), but excluding clinical laboratory tests) with the goal of health promotion and disease detection; and

(2) Education, counseling, and referral with respect to screening and other preventive coverage benefits separately authorized under Medicare Part B, excluding clinical laboratory tests.

Specifically, section 611(b) of Pub. L. 108–173 provides that the education, counseling, and referral services with respect to the screening and other preventive services authorized under Medicare Part B include the following:

(1) Pneumococcal, influenza, and hepatitis B vaccine and their administration;

(2) Screening mammography;

(3) Screening pap smear and screening pap smear and screening pelvic examination;

(4) Prostate cancer screening tests;

(5) Colorectal cancer screening tests;

(6) Diabetes outpatient self-management training services;

(7) Bone mass measurements;

(8) Screening for glaucoma;

(9) Medical nutrition therapy services for individuals with diabetes and renal disease;

(10) Cardiovascular screening blood tests; and

(11) Diabetes screening tests.

Section 611(d)(2) of Pub. L. 108–173 amended sections 1861(s)(2)(K)(i) and (s)(2)(K)(ii) of the Act to specify that the services identified as physicians' services and referred to in the definition of initial preventive physical examination include services furnished by a physician assistant, a nurse practitioner, or a clinical nurse specialist. We refer to these professionals as ''qualified nonphysician practitioners.''

Based on the language of the statute, our review of the medical literature, current clinical practice guidelines, and United States Preventive Services Task Force recommendations, we proposed (under proposed new § 410.16(a), Definitions) to interpret the term ''initial preventive physical examination'' for purposes of this new benefit to include all of the following services furnished by a doctor of medicine or osteopathy or a qualified nonphysician practitioner:

(1) Review of the beneficiary's comprehensive medical and social history. We proposed to define ''medical history'' to include, as a minimum, past medical and surgical history, including experience with illnesses, hospital stays, operations, allergies, injuries, and treatments; current medications and supplements, including calcium and vitamins; and family history, including a review of medical events in the patient's family, including diseases that may be hereditary or place the individual at risk. We proposed to define ''social history'' to include, at a minimum, history of alcohol, tobacco, and illicit drug use; work and travel history; diet; social activities; and physical activities.

(2) Review of the beneficiary's potential (risk factors) for depression (including past experiences with depression or other mood disorders) based on the use of an appropriate screening instrument that the physician or qualified nonphysician practitioner may select from various available standardized screening tests for this purpose, unless the appropriate screening instrument is defined through the national coverage determination (NCD) process.

(3) Review of the beneficiary's functional ability and level of safety (that is, at a minimum, a review of the following areas: Hearing impairment, activities of daily living, falls risk, and home safety), based on the use of an appropriate screening instrument, which the physician or qualified nonphysician practitioner may select from various available standardized screening tests for this purpose, unless the appropriate screening instrument is further defined through the NCD process.

(4) An examination to include measurement of the beneficiary's height, weight, blood pressure, a visual acuity screen, and other factors as deemed appropriate, based on the beneficiary's comprehensive medical and social history and current clinical standards.

(5) Performance of an electrocardiogram and interpretation.

(6) Education, counseling, and referral, as deemed appropriate, based on the results of elements (1) through (5) of the definition of the initial preventive physical examination.

(7) Education, counseling, and referral, including a written plan for obtaining the appropriate screening and other preventive services, which are also covered as separate Medicare Part B benefits; that is, pnuemococcal, influenza, and hepatitis B vaccines and their administration, screening mammography, screening pap smear and screening pelvic exams, prostate cancer screening tests, diabetes outpatient self-management training services, bone mass measurements, screening for glaucoma, medical nutrition therapy services, cardiovascular screening blood tests, and diabetes screening tests.

As we indicated in the OPPS proposed rule, we are addressing the public comments that we received on our proposal to revise our regulations to include specific coverage of initial preventive physical examinations under Medicare Part B and finalizing our coverage policy for initial preventive physical examinations in the final rule for the CY 2005 Medicare Physician Fee

Schedule published elsewhere in this issue.

c. Assignment of New HCPCS Codes for Payment of Initial Preventive Physical Examinations

There was no CPT code that contained the specific elements included in the initial preventive physical examination. Therefore, in the August 16, 2004 proposed rule, we proposed to establish a new HCPCS code to be used to bill for the new service under both the Medicare Physician Fee Schedule and the OPPS. We proposed a code, GXXXX, for the full service, including an EKG, but not including the other previously mentioned preventive services that are currently separately covered and paid under the Medicare Part B screening benefits. When these other preventive services are performed, they should be billed using the existing appropriate HCPCS and CPT codes.

For payment under the Medicare Physician Fee Schedule, relative value units were proposed for the new HCPCS code for the initial preventive physical based on equivalent resources and work intensity to those contained in CPT evaluation and management code 99203 (New patient, office or other outpatient visit) and CPT 93000 (Electrocardiogram, complete) (69 FR 47487, August 5, 2004). The ''technical component'' of the Medicare Physician Fee Schedule (the costs other than those allocated for the physician's professional services and professional liability insurance which are billed and paid for separately, when appropriate) is the portion of the fee schedule payment that is most comparable to what Medicare pays under the OPPS. The estimated ''technical component'' of the Medicare Physician Fee Schedule payment for GXXXX was between $50 and $100.

d. APC Assignment of Initial Preventive Physical Examination

Given our lack of cost data to guide assignment of the new code to a clinically appropriate APC, in our proposed rule, we proposed assignment of the new code GXXXX (Initial preventive physical examination) to New Technology APC 1539 (New Technology, Level II) with a payment level between $50 and $100. We believed that the proposed temporary assignment to a new technology APC would allow us to pay for the new benefit provided in the OPD while we accrued claims data and experience on which to base a clinically relevant APC assignment in the future.

We received a number of public comments regarding the proposed payment for the initial preventive physical examination and its proposed APC placement.

Comment: A number of commenters highlighted billing and operational concerns with the definition of a single HCPCS code, GXXXX, for the initial preventive physical examination. The commenters explained that, in hospitals where the EKG was performed in a separate department from the location of the physical examination, the technician charging for the service would have no way of distinguishing an EKG related to the initial preventive physical examination from other EKG tracings performed for diagnostic purposes, for which the hospital would bill for that specific service. The commenters noted that physicians often send their patients to hospitals for the EKG tracing, and if hospitals performed the EKG associated with the initial preventive physical examination in this context, they would have no way to bill for the EKG. The commenters presented various alternative coding possibilities for our consideration to address these situations.

Response: Section 611 of Pub. L. 108–173 does require a screening EKG to be performed as part of the initial preventive physical examination visit. In view of the different circumstances that may occur when performing the full initial preventive physical examination, we are establishing four new G codes for the initial preventative physical examination for CY 2005.

- G0344: Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 6 months of Medicare Part B enrollment. This code is assigned a status indicator ''V'' for the OPPS.
- G0366: Electrocardiogram, routine EKG with at least 12 leads; performed as a component of the initial preventive physical examination with interpretation and report. This code is assigned a status indicator ''B'' for the OPPS.
- G0367: Electrocardiogram, tracing only, without interpretation and report, performed as a component of the initial preventive physical examination. This code is assigned status indicator ''S'' for the OPPS.
- G0368: Electrocardiogram, interpretation and report only, performed as a component of the initial preventive physical examination. This code is assigned status indicator ''A'' for the OPPS.

In the hospital, performance of the complete initial preventive physical examination service would be coded using both the G0344 and G0367 codes. As required by the statute, the new codes describe the visit and the EKG, but not the other previously mentioned preventive services that are currently separately covered and paid under the Medicare Part B screening benefits. When these other preventive services are performed, they should be billed using the existing appropriate HCPCS and CPT codes.

To comply with Pub. L. 108–173, the initial preventive physical examination must include the EKG, regardless of whether a diagnostic EKG had previously been performed. Both components of the initial preventive physical examination, the examination and the EKG, must be performed to fulfill the statutory benefit for either of the components to be paid. Billing instructions for providers will be issued.

In addition to our decision to create two codes for hospitals to report for performance of the initial preventive physical examination service, we are assigning the codes to appropriate APCs as follows: G0344 is assigned to APC 0601 (Mid Level Clinic Visits), and G0367 is assigned to APC 0099 (Electrocardiograms). These APC assignments result in a total payment of approximately $78, slightly more than the $75 payment rate proposed for the comprehensive initial preventive physical examination service in the proposed rule.

Comment: A few commenters requested that CMS increase the payment for the initial preventive physical examination benefit and stated that the payment rate set is too low to cover the required clinical resources.

Response: As stated in our proposed rule, the payment rate for the comprehensive initial preventive physical examination service under the OPPS was based on the rate proposed under the Medicare Physician Fee Schedule, which utilized estimates of necessary resources for the initial preventive physical examination benchmarked against the resources required to deliver existing evaluation and management and electrocardiogram services in the physician office. Based on comments concerning the adequacy of our proposed payment for the comprehensive initial preventive physical examination service and our decision to separate the examination service from the EKG for coding and payment purposes, we explicitly compared the resources we anticipated for the examination service delivered in the hospital to the OPPS median cost for the existing new office or other outpatient visit service which was used as a crosswalk. CPT code 99203 (Office

or other outpatient visit for a new patient) is in APC 0601, which has a median cost of $57.66. The AMA/Specialty Society RVS Update Committee survey data for code 99203 showed 51 minutes of staff time, and we believe the initial preventive physical examination will reflect comparable time and consumption of hospital resources. As we expect the hospital resources utilized for code G0344 to be similar to those needed for clinic visits for which we have historical hospital cost data, we will place G0344 in APC 0601 rather than in a new technology APC as we proposed for the initial preventive physical examination comprehensive service. We expect the hospital resources utilized for the screening EKG tracing, code G0367, to be very similar to those necessary for a diagnostic EKG tracing, code 93005 and assigned to APC 0099. Together these APCs (0601 and 0099) will pay approximately $78, several more dollars than we proposed for the comprehensive service. We will monitor our claims data for the initial preventive physical examination services as hospitals gain experience delivering the services. We are finalizing our placement of code G0344 in APC 0601 for CY 2005 and code G0367 in APC 0099 for 2005.

Comment: Several commenters asked that CMS provide explicit instructions and guidelines, respectively, to providers and beneficiaries regarding the details of what will be included in the new initial preventive physical examination benefit, the eligibility requirements, and how providers should bill Medicare for the new service. One commenter asked if the preventive physical examination will be subject to the evaluation and management guidelines.

Response: We will release appropriate manual and transmittal instructions and information from the CMS educational components for the medical community, including a MedLearn Matters article and fact sheets such as the ''2005 Payment Changes for Physicians and Other Providers: News From Medicare for 2005''. The medical community can join this effort in educating physicians and beneficiaries by their own communications, bulletins, or other publications. In addition, we have specifically included information on the new initial preventive physical examination benefit in the 2005 version of the *Medicare and You Handbook* and revised booklet, *Medicare's Preventive Services*. A new 2-page fact sheet on all of the new preventive services, including the initial preventive physical examination benefit, will be available this Fall, and a bilingual brochure for Hispanic beneficiaries will also be available in the near future. Information will be disseminated by CMS regional offices, State Health Insurance Assistance Programs (SHIPs), and various partners at the national, State, and local levels. Information on the new benefit will also be made available to the public through Web site, *http://www.medicare.gov*, the partner Web site to *http://www.cms.hhs.gov*, the toll free number 1–800–MEDICARE, numerous forums hosted by CMS, and conference exhibits and presentations.

The initial preventive physical examination will not be subject to each hospital's internal set of evaluation and management guidelines that hospitals were instructed to develop at the implementation of the OPPS in the August 7, 2000 final rule (65 FR 18451) because we have defined one explicit service, without levels.

Comment: Several commenters asked how providers of initial preventive physical examination services will know if a particular beneficiary is eligible to receive the new benefit due to the statutory time and coverage frequency (one-time benefit) limitations.

Response: The statute provides for coverage of a one-time initial preventive physical examination that must be performed for new beneficiaries by qualified physicians or certain specified nonphysician practitioners within the first 6 month period following the effective date of the beneficiary's first Medicare Part B coverage. Because physicians or qualified nonphysician practitioners may not have the complete medical history for a particular new beneficiary, including information on possible use of the one-time benefit, these clinicians are largely relying on their own medical records and the information the beneficiary provides to them in establishing whether or not the initial preventive physical examination benefit is still available to a particular individual and has not been performed by another qualified practitioner. Because a second initial preventive physical examination will always fall outside the definition of the new Medicare benefit, an advance beneficiary notice (ABN) need not be issued in those instances where there is doubt regarding whether the beneficiary has previously received an initial preventive physical examination. The beneficiary will always be liable for a second initial preventive physical examination, no matter when it is conducted. However, for those instances where there is sufficient doubt as to whether the statutory 6-month period has lapsed, the physician or qualified nonphysician practitioner should issue an ABN to the beneficiary that indicates that Medicare may not cover and pay for the service. If the physician or qualified nonphysician practitioner does not issue an ABN to the beneficiary and Medicare denies payment for the service because the statutory time limitation for conducting the initial preventive physical examination has expired, the physician or qualified nonphysician practitioner may be held financially liable.

Comment: One commenter recommended that CMS compare the requirements of the initial preventive physical examination to the contemplated requirements for similar but not-yet-disclosed facility-specific evaluation and management level definitions. The commenter wanted to ensure that the technical requirements are comparable between the new benefit and similar evaluation and management service definitions being contemplated by CMS.

Response: We will take the commenter's recommendation into consideration in our ongoing work to develop new evaluation and management codes for the OPPS.

2. Payment for Certain Mammography Services (Section 614 of Pub. L. 108–173)

Section 614 of Pub. L. 108–173 amended section 1833(t)(1)(B)(iv) of the Act to provide that screening mammography and diagnostic mammography services are excluded from payment under the OPPS. This amendment applies to screening mammography services furnished on or after December 8, 2003 (the date of the enactment of Pub. L. 108–173), and in the case of diagnostic mammography, to services furnished on or after January 1, 2005. As a result of this amendment, both screening mammography and diagnostic mammography will be paid under the Medicare Physician Fee Schedule.

In the August 16, 2004 proposed rule, we proposed to amend § 419.22 of the regulations by adding a new paragraph(s) to specify that both screening mammography and diagnostic mammography will be excluded from payment under the OPPS, in accordance with section 614 of Pub. L. 108–173. We received a few public comments on our proposal.

Comment: A few commenters expressed support for the movement of payment for diagnostic mammograms from the OPPS to the Medicare Physician Fee Schedule.

Response: We appreciate the commenters' support. Additional

discussion of section 614 of Pub. L. 108–173 can be found in the final rule for the CY 2005 Medicare Physician Fee Schedule published elsewhere in this issue.

Comment: A few commenters recommended that the payment rates for mammography be increased. The commenters stated that beneficiary access to mammography is being limited due to a growing number of radiologists who refuse to read mammograms due to low payment and high malpractice rates and recent closure of a large number of centers across the country.

Response: We set the payment rates for diagnostic mammography based on hospital claims data, consistent with the payment methodology for OPPS services. In fact, in accordance with section 614 of Pub. L. 108–173, which requires that diagnostic mammography be paid now under the Medicare Physician Fee Schedule, payment is set using an entirely different process. This statutory change in the payment process results in a somewhat increased payment for mammography procedures from that under the OPPS.

Comment: One commenter asked CMS to clarify that the increase in payment for diagnostic mammography furnished in the hospital outpatient department does not ''come out of the [Medicare Physician Fee Schedule] budget.''

Response: The increase in payment for diagnostic mammography furnished in the hospital outpatient department has no effect on payment for Medicare Physician Fee Schedule services. We are using the Medicare Physician Fee Schedule rate to set Medicare payment for diagnostic mammography furnished in the hospital outpatient department, as required by statute. Further, we are not including diagnostic mammography in our model for setting the relative weights under the OPPS. Thus, the increase in payment for diagnostic mammography furnished in the hospital outpatient department also has no effect on payment for any other OPPS services.

In this final rule, we are adopting, as final without modification, our proposed revision of § 419.22 to incorporate the provisions of section 614 of Pub. L. 108–173.

III. Recalibration of APC Relative Weights for CY 2005

A. Database Construction

Section 1833(t)(9)(A) of the Act requires that the Secretary review and revise the relative payment weights for APCs at least annually, beginning in CY 2001 for application in CY 2002. In the April 7, 2000 OPPS final rule (65 FR 18482), we explained in detail how we calculated the relative payment weights that were implemented on August 1, 2000, for each APC group. Except for some reweighting due to APC changes, these relative weights continued to be in effect for CY 2001. This policy is discussed in the November 13, 2000 interim final rule (65 FR 67824 through 67827).)

In the August 16, 2004 OPPS proposed rule, we proposed to use the same basic methodology that we described in the April 7, 2000 final rule to recalibrate the relative APC weights for services furnished on or after January 1, 2005, and before January 1, 2006. That is, we proposed to recalibrate the weights based on claims and cost report data for outpatient services. We proposed to use the most recent available data to construct the database for calculating APC group weights. We provide a complete description of the data processes we proposed to use for the creation of the CY 2005 OPPS payment rates in the August 16, 2004 proposed rule (69 FR 50448).

For the purpose of recalibrating APC relative weights for CY 2005 displayed in this final rule with comment period, we used the most recent available claims data, which were the approximately 132 million final action claims for hospital OPD services furnished on or after January 1, 2003, and before January 1, 2004. Of the 132 million final action claims for services provided in hospital outpatient settings, 106 million claims were of the type of bill potentially appropriate for use in setting rates for OPPS services (but did not necessarily contain services payable under the OPPS). Of the 106 million claims, we were able to use 51 million whole claims (from which we created 84 million single procedure claim records) to set the final OPPS CY 2005 APC relative weights. We used claims from this period that had been processed before June 30, 2004, to calculate the APC weights and payments contained in Addenda A and B of this final rule with comment period.

We received one general public comment on our proposed OPPS database construction for CY 2005 discussed in the August 16, 2004 proposed rule.

Comment: One commenter suggested that CMS use a nationally representative sample of hospitals from which cost data could be collected for purposes of setting relative weights. The commenter suggested that such a sample could be used to validate findings from the larger claims data set or to establish median costs that more accurately reflect the costs of providing device-related procedures and other outpatient services, or both. As an alternative, the commenter suggested conducting a demonstration project using a sample of hospitals that would receive small grants for set up and training to test the feasibility of collecting a valid reliable and manageable data set from which to develop payment rates.

Response: We believe that the Medicare hospital outpatient claims and hospital cost reports are the best, nationally representative database of such information at present. Nevertheless, we acknowledge that an approach that would involve the collection of additional hospital data from a representative sample could have some merit. However, in addition to the resources that would be required for us to pursue such an approach, we also are concerned about the costs to hospitals associated with such an additional data collection effort. Nevertheless, we remain interested and invite additional suggestions from hospitals and other stakeholders on ways to enhance the data we now use to set relative weights for services paid under the OPPS.

1. Treatment of Multiple Procedure Claims

For CY 2005, we proposed to continue to use single procedure claims to set the medians on which the weights would be based (69 FR 50474). As indicated in the August 16, 2004 proposed rule, we received many requests that we ensure that the data from claims that contain charges for multiple procedures were included in the data from which we calculate the CY 2005 relative payment weights (69 FR 50474). Requesters believe that relying solely on single procedure claims to recalibrate APC relative weights fails to take into account data for many frequently performed procedures, particularly those commonly performed in combination with other procedures. They believe that, by depending upon single procedure claims, we base relative payment weights on the least costly services, thereby introducing downward bias to the medians on which the weights are based.

We agree that, optimally, it is desirable to use the data from as many claims as possible to recalibrate the relative payment weights, including those with multiple procedures. As discussed in the explanation of single procedure claims below, we have used the date of service on the claims and a list of codes to be bypassed to create ''pseudo'' single claims from multiple procedure claims. We refer to these newly created single procedure claims

as ''pseudo'' singles because they were submitted by providers as multiple procedure claims.

2. Use of Single Procedure Claims

We use single procedure claims to set the median costs for APCs because we are, so far, unable to ensure that packaged costs can be correctly allocated across multiple procedures performed on the same date of service. However, bypassing specified codes that we believe do not have significant packaged costs enables use of more data from multiple procedure claims. For CY 2003, we created ''pseudo'' single claims by bypassing HCPCS codes 93005 (Electrocardiogram, tracing), 71010 (Chest x-ray), and 71020 (Chest x-ray) on a submitted claim. However, we did not use claims data for the bypassed codes in the creation of the median costs for the APCs to which these three codes were assigned because the level of packaging that would have remained on the claim after we selected the bypass code was not apparent and, therefore, it was difficult to determine if the medians for these codes would be correct.

For CY 2004, we created ''pseudo'' single claims by bypassing these three codes and also by bypassing an additional 269 HCPCS codes in APCs. We selected these codes based on a clinical review of the services and because it was presumed that these codes had only very limited packaging and could appropriately be bypassed for the purpose of creating ''pseudo'' single claims. The APCs to which these codes were assigned were varied and included mammography, cardiac rehabilitation, and level I plain film x-rays. To derive more ''pseudo'' single claims, we also broke claims apart where there were dates of service for revenue code charges on that claim that could be matched to a single procedure code on the claim on the same date.

As in CY 2003, we did not include the claims data for the bypassed codes in the creation of the APCs to which the 269 codes were assigned because, again, we had not established that such an approach was appropriate and would aid in accurately estimating the median cost for that APC. For CY 2004, from about 16.3 million otherwise unusable claims, we used about 9.5 million multiple procedure claims to create about 27 million ''pseudo'' single claims. For the CY 2005 OPPS rates in this final rule with comment period, from about 24 million otherwise unusable claims, we used about 18 million multiple procedure claims to create about 52 million ''pseudo'' single claims.

For CY 2005, we proposed to continue using date of service matching as a tool for creation of ''pseudo'' single claims and take a more empirical approach to creating the list of codes that we would bypass to create ''pseudo'' single claims. The process we proposed for CY 2005 OPPS resulted in our being able to use some part of 89 percent of the total claims eligible for use in OPPS ratesetting and modeling in developing this final rule with comment period. In CY 2004, we used some part of the data from 82 percent of eligible claims. This process enabled us to use, for CY 2005, 84 million single bills for ratesetting: 52 million ''pseudo'' singles and 33 million ''natural'' single bills.

We proposed to bypass the 383 codes, which we published in Table 17 of the proposed rule (69 FR 50476 through 50486), to create new single claims and to use the line-item costs associated with the bypass codes on these claims in the creation of the median costs for the APCs into which they are assigned (69 FR 50474 through 50486). Of the codes on this list, only 123 (32 percent) were used for bypass in CY 2004.

We developed the proposed bypass list using four criteria:

a. We developed the following empirical standards by reviewing the frequency and magnitude of packaging in the single claims for payable codes other than drugs and biologicals. We proposed to use these standards to determine codes that could be bypassed to create ''pseudo'' single claims for median setting. (More explanation regarding the use of these standards is provided in our August 16, 2004 OPPS proposed rule (69 FR 50475).)

- There were 100 or more single claims for the code.
- Five percent or fewer of the single claims for the code had packaged costs on that single claim for the code.
- The median cost of packaging observed in the single claim was equal to or less than $50.
- The code is not a code for an unlisted service.

b. We examined APCs relying on a low volume of single claims, and it became apparent that several radiological supervision and interpretation codes were commonly billed with the procedural codes in the APCs. We then reviewed all radiological supervision and interpretation codes to assess their viability as bypass codes. For the codes included on the proposed list published in Table 17, we determined that, generally, the packaging on claims, including these radiological supervision and interpretation codes, should be associated with the procedure performed.

c. We examined radiation planning and related codes provided by a professional organization. In the organization's opinion, the codes could safely be bypassed and used without packaging to set medians for the APCs into which these codes are assigned. Many of the codes the organization recommended met our criteria under item a., and the remaining codes were close. Therefore, after reviewing such codes, we proposed to adopt as bypass codes all radiation planning and related codes as provided by the organization.

d. We included HCPCS codes 93005 and 71010. These codes have been bypassed for the past 3 years and generate a significant amount of new single claims because they are very commonly done on the same date of surgery. They have low median packaged costs and a low percentage of single claims with any packaged costs, 6 percent and 18 percent, respectively.

In the August 16, 2004 proposed rule, we invited public comment on the ''pseudo'' single process, including the bypass list and the criteria. We received a number of public comments on our proposals.

Comment: Some commenters stated that CMS should provide an impact analysis by medical specialty and APC for the bypass list. Commenters indicated that 26 radiation oncology codes, which represent over 40 percent of the radiation oncology codes, are on the proposed list and that it is not clear what impact the inclusion of these codes will have on payment for radiation oncology procedures.

Response: The OPPS pays hospitals for the hospital services they furnish and, therefore, we focus our impact analysis on the providers who provide services and to whom the payment is made. It is impractical to do an impact analysis by hospital category, much less medical specialty and APC, for each and every step of the process we use to establish medians on which we base our payment rates.

However, to facilitate the public's ability to do specialized detailed analyses beyond what is practical for us to do, we make available the claims we use to set median costs. Specifically, the claims we used to set the payment rates for CY 2004 OPPS and CY 2005 OPPS are available to the public for public use in extended and focused analysis at any level of interest. Moreover, exhaustive discussion of our process is contained in both the CY 2004 and CY 2005 OPPS final rule with comment period claims accounting documents that are available on *www.cms.hhs.gov/providers/*

hopps.asp, to facilitate the use of such claims for further analysis. Therefore, we provide to the public the data needed for a focused exhaustive analysis of impact by medical specialty or on any basis on which any party with a special interest has a particular concern.

The 383 bypass codes presented in Table 17 of the proposed rule represent the result of an empirical and clinical analysis that identified HCPCS codes for which we could not observe significant packaged costs in the CY 2003 claims data and for which there was no clinical reason that a procedure or service should have significant packaged costs. These criteria are detailed in the proposed rule and were carefully chosen to avoid the inaccurate redistribution of packaged costs (69 FR 50474 through 50475). Inclusion of a HCPCS code on the bypass list is not predicated on the median impact, but rather empirical evidence or clinical arguments that these procedures do not contain significant packaged costs that would call into question their appropriateness for inclusion on the bypass list.

Comment: Most commenters supported the use of a bypass list and date of service matching as a way to use more data from multiple claims. One commenter was concerned that the bypass list may inappropriately break multiple claims into single procedure claims by assuming that the amount and frequency of packaging on procedures found on single bills was the same as would exist on multiple procedure claims. The commenter stated that claims involving multiple APCs are by their nature the most complex combinations of services requiring many more resources than if they were performed singly and that, therefore, CMS may be incorrect to generalize that the packaging found on single bills would also be present for the same procedure done as a multiple procedure. Another commenter opposed the use of the bypass list, citing it as a ''bandaid'' and as not a satisfactory way to deal with the presence of multiple procedure claims over the long run. The commenter indicated that, given the OPPS experience gained over the past years, CMS should be able to perform a study of multiple procedure claims that provides a mechanism for using them.

Response: We have retained and used the proposed bypass methodology in creating the median costs used to set the CY 2005 OPPS relative payment weights in this final rule with comment period. We believe that the use of the bypass list gives us considerably more single claims for ratesetting than had we not used it and that it is a valid representation of codes for which there is seldom any packaging and for which the packaging that exist, is minimal. Given the inability of any concrete processes that provide a way to attribute packaging on multiple bill claims, we believe that the best and only alternative available is for us to use the packaging on single bill claims to determine whether a code can be safely bypassed in the creation of ''pseudo single'' claims for median setting. We continue to examine the means by which we could use all multiple procedure claims and to invite additional recommendations from the public on how we might do so.

Comment: One commenter strongly objected to any method of using multiple procedure claims that would rely in any way on payment weights because the commenter believed that any such method would compound problems in the data by carrying them forward into future years.

Response: We expect to examine a number of different ways of using the data from multiple procedure claims and will evaluate each carefully before we discard any particular process. As we have in the past for updating the OPPS, if we decide to pursue any particular process change, we will discuss our findings and any proposed changes to the OPPS median development process in the proposed rule and consider public comments on the proposal before we change the process.

Comment: Some commenters indicated that the use of single procedure claims means that the most typical correctly coded claims are not used for many services. They added that many of the procedures that implant a device are actually replacing an existing device, which means that the removal of the device is billed with one code while the implant is billed with another code on the same claim on the same date of service, thereby creating a multiple procedure claim that will become two ''pseudo'' single claims under the CMS process. The commenters also stated that services that are provided only in addition to other services, such as noncoronary intravascular ultrasound, can never be correctly coded as a single procedure claim. They contended that such correctly coded claims will be multiple major procedure claims and thus will not be used for median cost setting. The commenters stated that the nature of some services being routinely performed in combination with other services means that, under the current CMS methodology, only small percentages of the claims will be used to set the medians and that those claims are likely to be the incorrectly coded claims.

Response: We recognize that there are categories of service that are typically done in combination with other services at such frequency that acquiring valid single procedure claims is very difficult, if not impossible. We are planning to explore these services for which the medians are set based on a small percentage of the claims that are submitted with the APC Panel in the future to determine what methods may be available to deal effectively with these situations.

In the August 16, 2004 proposed rule, we also discussed suggestions that we had received for creating ''pseudo'' single claims, which included recommendations that the costs in packaged revenue codes and packaged HCPCS codes be allocated separately to paid HCPCS codes based on the prior year's payment weights or payment rates for the single procedures. Still other suggestions recommended that we allocate the packaged costs in proportion to the charges or to the costs for the major procedures based on the current year's claims. We are concerned that using a prior year's median costs, relative weights or payment rates as the basis to allocate current year's packaged costs to current year costs for payable HCPCS codes may not be appropriate. For example, if two procedures are performed and one uses an expensive device, this methodology would split the costs of the device between the service that uses the device and a service that does not use the device, thus resulting in an incorrect allocation of the packaged costs. For this reason, we did not propose to incorporate these suggestions in our ratesetting methodology. However, we stated in our proposed rule that we intended to examine them more thoroughly.

We did not propose a methodology beyond use of dates of service and the expanded bypass list. However, we solicited specific proposals that would be provided as comments on how multiple procedure claims can be better used in calculating the relative payment weights.

Comment: One commenter asked that CMS clarify whether the ''pseudo'' single claims data for CPT codes 93307 (Echo exam of heart), 93303 (Echo transthoracic), and 93320 (Doppler echo exam, heart) were used in setting APC relative weights and, if so, the impact of this proposal. Another commenter asked that CMS clarify whether HCPCS codes for drugs, radiopharmaceuticals, and blood products were bypassed to create ''pseudo'' singles. The commenter

believed that packaged costs are never associated with these items; therefore, they should always be bypassed.

Response: The claims data for the three referenced CPT codes were used in setting the APC relative weights for these services. They were included in the list of bypass codes because they met the criteria for inclusion, which focused on selecting only claims that often did not include packaged services and for which packaging on the single bills was very modest.

We agree with the commenter that drugs, radiopharmaceuticals, and blood products would rarely be expected to have associated packaged costs. Presence of codes for these items on a claim does not result in a multiple claim, as we do not consider the items to be major procedures.

Comment: One commenter asked that CMS add CPT codes 76362 (Computed tomography guidance for, and monitoring of, visceral tissue ablation), 76394 (Magnetic resonance guidance for, and monitoring of, visceral tissue ablation), and 76940 (Us guide, tissue ablation) to the bypass list because they are often billed with CPT code 47382 (Radiofrequency ablation procedures of the liver) and CPT code 20982 (Radiofrequency ablation procedures of the bone). The commenter believed that this approach would create more single claims for those codes.

Response: The three CPT codes that the commenter requested we add to the bypass list did not have sufficient claims volume at the time the bypass list was created to meet the criteria for inclusion. When we next review the bypass list, we will examine these codes for inclusion on any future bypass list.

Comment: One commenter objected to use of data-based criteria as the only determinant of whether services are included on the bypass list. Specifically, the commenter objected to the inclusion of CPT evaluation and management codes 99213 and 99214 on the bypass list even though CPT codes 99211, 99212, and 99215 are not included on the list. The commenter believed that CMS should not assume that these codes do not typically have packaged costs associated with them because less than 5 percent of the claims with the code appeared on a claim with packaged charges. The commenter believed that all codes that ''meet the 5 percent data test'' should be qualitatively reviewed to determine whether clinical practice and charging methods support the assertion that packaged dollars are not related to the service proposed for the bypass list. The commenter also recommended that CMS include on the bypass list ''add-on'' CPT codes that have a status indicator of ''N'' so that the remaining packaged services on the claim would be packaged to the main procedure if that were the only other APC reported on the claim. The commenter recommended that ''add-on'' CPT codes with APC payment should be accepted as bypass codes if the only other CPT code on the claim is the main procedure.

Response: The commenter is incorrect in believing that the only criterion used to determine if a code were suitable for inclusion on the bypass list was whether 5 percent of the claims for the code appeared with packaged charges. As we discussed above, there were a number of criteria that had to be met which were focused on ensuring that packaging did not occur often or in significant amounts when it did occur. We reviewed the clinical appropriateness of the codes that were derived from applying the criteria, and did not remove any as a result of the review. Given the large volume of evaluation and management services, we believe that the evaluation and management codes we included on the bypass list were appropriate for inclusion. As we discussed with regard to the radiological supervision and evaluation codes and the simple EKG and chest x-ray codes, clinical practice and charging methods were also factors in determining inclusion on the bypass list.

With respect to the add-on codes, those that have a status indicator of ''N'' would not cause a claim to be a multiple procedure claim (because they are not separately paid). Thus it would not be useful to add them to the bypass list (which is intended to break multiple procedure claims into two single claims). Those add-on codes that are paid separately may or may not have packaging associated with them. Thus, it would be incorrect to assume that all packaging on the claim would be associated with the core procedure to which the add-on code is an appendage. For example, insertion of a left ventricular pacing lead as an add-on procedure to the insertion of a cardioverter-defibrillator carries considerable packaged costs with the add-on service, such as the device, significant additional operating room time, and extra drugs and medical supplies, and, therefore, it would not be suitable for inclusion on the bypass list.

After carefully reviewing all public comments received, we are adopting as final the bypass codes listed in Table 16 below.

BILLING CODE 4120–01–P

Table 16.—HCPCS Bypass Codes for Creating "Pseudo" Single Claims for Calculating Median Costs

HCPCS Code	Short Description
11719	Trim nail(s)
11720	Debride nail, 1-5
11721	Debride nail, 6 or more
31579	Diagnostic laryngoscopy
54240	Penis study
70100	X-ray exam of jaw
70110	X-ray exam of jaw
70130	X-ray exam of mastoids
70140	X-ray exam of facial bones
70150	X-ray exam of facial bones
70160	X-ray exam of nasal bones
70200	X-ray exam of eye sockets
70210	X-ray exam of sinuses
70220	X-ray exam of sinuses
70250	X-ray exam of skull
70260	X-ray exam of skull
70328	X-ray exam of jaw joint
70330	X-ray exam of jaw joints
70355	Panoramic x-ray of jaws
70360	X-ray exam of neck
70371	Speech evaluation, complex
70450	Ct head/brain w/o dye
70480	Ct orbit/ear/fossa w/o dye
70486	Ct maxillofacial w/o dye
70544	Mr angiography head w/o dye
71010	Chest x-ray
71015	Chest x-ray
71020	Chest x-ray
71021	Chest x-ray
71022	Chest x-ray
71030	Chest x-ray
71034	Chest x-ray and fluoroscopy
71090	X-ray & pacemaker insertion
71100	X-ray exam of ribs
71101	X-ray exam of ribs/chest
71110	X-ray exam of ribs
71111	X-ray exam of ribs/ chest
71120	X-ray exam of breastbone
71130	X-ray exam of breastbone
71250	Ct thorax w/o dye
72040	X-ray exam of neck spine
72050	X-ray exam of neck spine
72052	X-ray exam of neck spine
72070	X-ray exam of thoracic spine
72072	X-ray exam of thoracic spine
72074	X-ray exam of thoracic spine

HCPCS Code	Short Description
72080	X-ray exam of trunk spine
72090	X-ray exam of trunk spine
72100	X-ray exam of lower spine
72110	X-ray exam of lower spine
72114	X-ray exam of lower spine
72120	X-ray exam of lower spine
72125	Ct neck spine w/o dye
72141	Mri neck spine w/o dye
72146	Mri chest spine w/o dye
72148	Mri lumbar spine w/o dye
72170	X-ray exam of pelvis
72190	X-ray exam of pelvis
72192	Ct pelvis w/o dye
72220	X-ray exam of tailbone
73000	X-ray exam of collar bone
73010	X-ray exam of shoulder blade
73020	X-ray exam of shoulder
73030	X-ray exam of shoulder
73050	X-ray exam of shoulders
73060	X-ray exam of humerus
73070	X-ray exam of elbow
73080	X-ray exam of elbow
73090	X-ray exam of forearm
73100	X-ray exam of wrist
73110	X-ray exam of wrist
73120	X-ray exam of hand
73130	X-ray exam of hand
73140	X-ray exam of finger(s)
73218	Mri upper extremity w/o dye
73221	Mri joint upr extrem w/o dye
73510	X-ray exam of hip
73520	X-ray exam of hips
73540	X-ray exam of pelvis & hips
73550	X-ray exam of thigh
73560	X-ray exam of knee, 1 or 2
73562	X-ray exam of knee, 3
73564	X-ray exam, knee, 4 or more
73565	X-ray exam of knees

HCPCS Code	Short Description
73590	X-ray exam of lower leg
73600	X-ray exam of ankle
73610	X-ray exam of ankle
73620	X-ray exam of foot
73630	X-ray exam of foot
73650	X-ray exam of heel
73660	X-ray exam of toe(s)
73700	Ct lower extremity w/o dye
73721	Mri jnt of lwr extre w/o dye
74000	X-ray exam of abdomen
74210	Contrst x-ray exam of throat
74220	Contrast x-ray, esophagus
74230	Cine/vid x-ray, throat/esoph
74235	Remove esophagus obstruction
74240	X-ray exam, upper gi tract
74245	X-ray exam, upper gi tract
74246	Contrst x-ray uppr gi tract
74247	Contrst x-ray uppr gi tract
74249	Contrst x-ray uppr gi tract
74250	X-ray exam of small bowel
74235	Remove esophagus obstruction
74300	X-ray bile ducts/pancreas
74301	X-rays at surgery add-on
74305	X-ray bile ducts/pancreas
74327	X-ray bile stone removal
74328	X-ray bile duct endoscopy
74329	X-ray for pancreas endoscopy
74330	X-ray bile/panc endoscopy
74340	X-ray guide for GI tube
74350	X-ray guide, stomach tube
74355	X-ray guide, intestinal tube
74360	X-ray guide, GI dilation
74363	X-ray, bile duct dilation
74475	X-ray control, cath insert
74480	X-ray control, cath insert
74485	X-ray guide, GU dilation
74742	X-ray, fallopian tube
75894	X-rays, transcath therapy

HCPCS Code	Short Description
75898	Followup angiography
75900	Arterial catheter exchange
75901	Remove cva device obstruct
75902	Remove cva lumen obstruct
75945	Intravascular us
75946	Intravascular us add-on
75952	Endovasc repair abdom aorta
75953	Abdom aneurysm endovas rpr
75954	Iliac aneurysm endovas rpr
75960	Transcatheter intro, stent
75961	Retrieval, broken catheter
75962	Repair arterial blockage
75964	Repair artery blockage, each
75966	Repair arterial blockage
75968	Repair artery blockage, each
75970	Vascular biopsy
75978	Repair venous blockage
75980	Contrast x-ray exam bile duct
75982	Contrast x-ray exam bile duct
75984	X-ray control catheter change
75992	Atherectomy, x-ray exam
75993	Atherectomy, x-ray exam
75994	Atherectomy, x-ray exam
75995	Atherectomy, x-ray exam
75996	Atherectomy, x-ray exam
75998	Fluoroguide for vein device
76012	Percut vertebroplasty, fluor
76013	Percut vertebroplasty, ct
76040	X-rays, bone evaluation
76061	X-rays, bone survey
76062	X-rays, bone survey
76066	Joint survey, single view
76075	Dexa, axial skeleton study
76076	Dexa, peripheral study
76078	Radiographic absorptiometry
76090	Mammogram, one breast
76091	Mammogram, both breasts
76095	Stereotactic breast biopsy

HCPCS Code	Short Description
76096	X-ray of needle wire, breast
76100	X-ray exam of body section
76101	Complex body section x-ray
76360	Ct scan for needle biopsy
76380	CAT scan follow-up study
76393	Mr guidance for needle place
76511	Echo exam of eye
76512	Echo exam of eye
76516	Echo exam of eye
76519	Echo exam of eye
76536	Us exam of head and neck
76645	Us exam, breast(s)
76700	Us exam, abdom, complete
76705	Echo exam of abdomen
76770	Us exam abdo back wall, comp
76775	Us exam abdo back wall, lim
76830	Transvaginal us, non-ob
76856	Us exam, pelvic, complete
76857	Us exam, pelvic, limited
76870	Us exam, scrotum
76880	Us exam, extremity
76941	Echo guide for transfusion
76945	Echo guide, villus sampling
76946	Echo guide for amniocentesis
76948	Echo guide, ova aspiration
76977	Us bone density measure
77280	Set radiation therapy field
77285	Set radiation therapy field
77300	Radiation therapy dose plan
77301	Radiotherapy dose plan, imrt
77315	Teletx isodose plan complex
77326	Brachytx isodose calc simp
77327	Brachytx isodose calc interm
77328	Brachytx isodose plan compl
77331	Special radiation dosimetry
77332	Radiation treatment aid(s)
77333	Radiation treatment aid(s)
77334	Radiation treatment aid(s)

HCPCS Code	Short Description
77336	Radiation physics consult
77370	Radiation physics consult
77399	External radiation dosimetry
77403	Radiation treatment delivery
77409	Radiation treatment delivery
77411	Radiation treatment delivery
77412	Radiation treatment delivery
77413	Radiation treatment delivery
77414	Radiation treatment delivery
77416	Radiation treatment delivery
77417	Radiology port film(s)
77418	Radiation tx delivery, imrt
77470	Special radiation treatment
78350	Bone mineral, single photon
78351	Bone mineral, dual photon
80502	Lab pathology consultation
85060	Blood smear interpretation
86585	TB tine test
86850	RBC antibody screen
86870	RBC antibody identification
86880	Coombs test, direct
86885	Coombs test, indirect, qual
86886	Coombs test, indirect, titer
86890	Autologous blood process
86900	Blood typing, ABO
86901	Blood typing, Rh (D)
86905	Blood typing, RBC antigens
86906	Blood typing, Rh phenotype
86930	Frozen blood prep
86970	RBC pretreatment
88104	Cytopathology, fluids
88106	Cytopathology, fluids
88107	Cytopathology, fluids
88108	Cytopath, concentrate tech
88160	Cytopath smear, other source
88161	Cytopath smear, other source
88172	Cytopathology eval of fna
88180	Cell marker study

HCPCS Code	Short Description
88182	Cell marker study
88300	Surgical path, gross
88304	Tissue exam by pathologist
88305	Tissue exam by pathologist
88311	Decalcify tissue
88312	Special stains
88313	Special stains
88321	Microslide consultation
88323	Microslide consultation
88325	Comprehensive review of data
88331	Path consult intraop, 1 bloc
88342	Immunohistochemistry
88346	Immunofluorescent study
88347	Immunofluorescent study
90801	Psy dx interview
90805	Psytx, off, 20-30 min w/e&m
90806	Psytx, off, 45-50 min
90807	Psytx, off, 45-50 min w/e&m
90808	Psytx, office, 75-80 min
90809	Psytx, off, 75-80, w/e&m
90810	Intac psytx, off, 20-30 min
90818	Psytx, hosp, 45-50 min
90826	Intac psytx, hosp, 45-50 min
90845	Psychoanalysis
90846	Family psytx w/o patient
90847	Family psytx w/patient
90853	Group psychotherapy
90857	Intac group psytx
90862	Medication management
92002	Eye exam, new patient
92004	Eye exam, new patient
92012	Eye exam established pat
92014	Eye exam & treatment
92082	Visual field examination(s)
92083	Visual field examination(s)
92135	Opthalmic dx imaging
92136	Ophthalmic biometry
92225	Special eye exam, initial

HCPCS Code	Short Description
92226	Special eye exam, subsequent
92230	Eye exam with photos
92250	Eye exam with photos
92275	Electroretinography
92285	Eye photography
92286	Internal eye photography
92520	Laryngeal function studies
92546	Sinusoidal rotational test
92548	Posturography
92552	Pure tone audiometry, air
92553	Audiometry, air & bone
92555	Speech threshold audiometry
92556	Speech audiometry, complete
92567	Tympanometry
92582	Conditioning play audiometry
92585	Auditor evoke potent, compre
93005	Electrocardiogram, tracing
93225	ECG monitor/record, 24 hrs
93226	ECG monitor/report, 24 hrs
93231	ECG monitor/record, 24 hrs
93232	ECG monitor/report, 24 hrs
93236	ECG monitor/report, 24 hrs
93270	ECG recording
93278	ECG/signal-averaged
93303	Echo transthoracic
93307	Echo exam of heart
93320	Doppler echo exam, heart
93731	Analyze pacemaker system
93733	Telephone analy, pacemaker
93734	Analyze pacemaker system
93736	Telephonic analy, pacemaker
93743	Analyze ht pace device dual
93797	Cardiac rehab
93798	Cardiac rehab/monitor
93875	Extracranial study
93880	Extracranial study
93882	Extracranial study
93886	Intracranial study

HCPCS Code	Short Description
93888	Intracranial study
93922	Extremity study
93923	Extremity study
93924	Extremity study
93925	Lower extremity study
93926	Lower extremity study
93931	Upper extremity study
93965	Extremity study
93970	Extremity study
93971	Extremity study
93975	Vascular study
93976	Vascular study
93978	Vascular study
93979	Vascular study
93990	Doppler flow testing
94015	Patient recorded spirometry
95115	Immunotherapy, one injection
95165	Antigen therapy services
95805	Multiple sleep latency test
95807	Sleep study, attended
95812	EEG, 41-60 minutes
95813	EEG, over 1 hour
95816	EEG, awake and drowsy
95819	EEG, awake and asleep
95822	EEG, coma or sleep only
95864	Muscle test, 4 limbs
95872	Muscle test, one fiber
95900	Motor nerve conduction test
95921	Autonomic nerv function test
95926	Somatosensory testing
95930	Visual evoked potential test
95937	Neuromuscular junction test
95950	Ambulatory EEG monitoring
95953	EEG monitoring/computer
96000	Motion analysis, video/3d
96100	Psychological testing
96105	Assessment of aphasia
96115	Neurobehavior status exam

HCPCS Code	Short Description
96900	Ultraviolet light therapy
96910	Photochemotherapy with UV-B
96912	Photochemotherapy with UV-A
96913	Photochemotherapy, UV-A or B
98940	Chiropractic manipulation
99213	Office/outpatient visit, est
99214	Office/outpatient visit, est
99241	Office consultation
99243	Office consultation
99244	Office consultation
99245	Office consultation
99273	Confirmatory consultation
99274	Confirmatory consultation
99275	Confirmatory consultation
C9708	Preview Tx Planning Software
D0473	Micro exam, prep & report
G0005	ECG 24 hour recording
G0006	ECG transmission & analysis
G0015	Post symptom ECG tracing
G0101	CA screen;pelvic/breast exam
G0127	Trim nail(s)
G0131	CT scan, bone density study
G0132	CT scan, bone density study
G0166	Extrnl counterpulse, per tx
G0175	OPPS Service,sched team conf
G0195	Clinicalevalswallowingfunct
G0196	Evalofswallowingwithradioopa
G0198	Patientadapation&trainforspe
G0202	Screeningmammographydigital
G0204	Diagnosticmammographydigital
G0206	Diagnosticmammographydigital
G0236	Digital film convert diag ma
Q0091	Obtaining screen pap smear

BILLING CODE 4120–01–C

B. Calculation of Median Costs for CY 2005

In this section of the preamble, we discuss the use of claims to calculate the OPPS payment rates for CY 2005. (The hospital outpatient prospective payment page on the CMS Web site on which this final rule with comment period is posted provides an accounting of claims used in the development of the final rates: *http://www.cms.hhs.gov/hopps.)* The accounting of claims used in the development of the final rule with comment period is included under supplemental materials for this final rule with comment period. That accounting provides additional detail regarding the number of claims derived at each stage of the process. In addition, we note that below we discuss the files of claims that comprise the data sets that are available for purchase under a CMS data user contract. Our CMS Web site, *http://www.cms.hhs.gov/providers/hopps* includes information about purchasing the following two OPPS data files: ''OPPS limited data set'' and ''OPPS identifiable data set.''

In this final rule with comment period, we are using the same methodology as proposed in the August 16, 2004 proposed rule to establish the relative weights that we used in calculating the OPPS payment rates for CY 2005 shown in Addenda A and B to this final rule with comment period. This methodology is as follows:

We used outpatient claims for full CY 2003 to set the relative weights for CY 2005. To begin the calculation of the relative weights for CY 2005, we pulled all claims for outpatient services furnished in CY 2003 from the national claims history file. This is not the population of claims paid under the OPPS, but all outpatient claims (for example, critical access hospital (CAH) claims, and hospital claims for clinical laboratory services for persons who are neither inpatients nor outpatients of the hospital).

We then excluded claims with condition codes 04, 20, 21, and 77. These are claims that providers submitted to Medicare knowing that no payment will be made. For example, providers submit claims with a condition code 21 to elicit an official denial notice from Medicare and document that a service is not covered. We then excluded claims for services furnished in Maryland, Guam, and the U.S. Virgin Islands because hospitals in those geographic areas are not paid under the OPPS.

We divided the remaining claims into the three groups shown below. Groups

2 and 3 comprise the 106 million claims that contain hospital bill types paid under the OPPS.

1. Claims that were not bill types 12X, 13X, 14X (hospital bill types), or 76X (CMHC bill types). Other bill types, such as ASCs, bill type 83, are not paid under the OPPS and, therefore, these claims were not used to set OPPS payment.

2. Bill types 12X, 13X, or 14X (hospital bill types). These claims are hospital outpatient claims.

3. Bill type 76X (CMHC). (These claims are later combined with any claims in item 2 above with a condition code 41 to set the per diem partial hospitalization rate determined through a separate process.)

In previous years, we have begun the CCR calculation process using the most recent available cost reports for all hospitals, irrespective of whether any or all of the hospitals included actually filed hospital outpatient claims for the data period. However, in developing the proposed rule and this final rule with comment period, we first limited the population of cost reports to only those for hospitals that filed outpatient claims in CY 2003 before determining whether the CCRs for such hospitals were valid. This initial limitation changed the distribution of CCRs used during the trimming process discussed below.

We then calculated the CCRs at a departmental level and overall for each hospital for which we had claims data. We did this using hospital specific data from the Hospital Cost Report Information System (HCRIS). As indicated in the proposed rule, we used the same CCRs as those used in calculating the relative weights that we used in developing the proposed rule. We did not recalculate CCRs to reflect updated cost report data.

We then flagged CAHs, which are not paid under the OPPS, and hospitals with invalid CCRs. These included claims from hospitals without a CCR; those from hospitals paid an all-inclusive rate; those from hospitals with obviously erroneous CCRs (greater than 90 or less than .0001); and those from hospitals with CCRs that were identified as outliers (3 standard deviations from the geometric mean after removing error CCRs). In addition, we trimmed the CCRs at the departmental level by removing the CCRs for each cost center as outliers if they exceeded +/− 3 standard deviations of the geometric mean. In prior years, we did not trim CCRs at the departmental level. However, for CY 2005, as proposed, we trimmed at the departmental CCR level to eliminate aberrant CCRs that, if found in high volume hospitals, could skew the medians. We used a four-tiered hierarchy of cost center CCRs to match a cost center to a revenue code with the top tier being the most common cost center and the last tier being the default CCR. If a hospital's departmental CCR was deleted by trimming, we set the departmental CCR for that cost center to ''missing,'' so that another departmental CCR in the revenue center hierarchy could apply. If no other departmental CCR could apply to the revenue code on the claim, we used the hospital's overall CCR for the revenue code in question.

We then converted the charges on the claim by applying the CCR that we believed was best suited to the revenue code indicated on the line with the charge. (We discussed in greater detail the allowed revenue codes in the proposed rule (69 FR 50487).) If a hospital did not have a CCR that was appropriate to the revenue code reported for a line-item charge (for example, a visit reported under the clinic revenue code but the hospital did not have a clinic cost center), we applied the hospital-specific overall CCR, except as discussed in section V.H. of this final rule with comment period, for calculation of costs for blood.

Thus, we applied CCRs as described above to claims with bill types 12X, 13X, or 14X, excluding all claims from CAHs and hospitals in Maryland, Guam, or the U.S. Virgin Islands, and flagged hospitals with invalid CCRs. We excluded claims from all hospitals for which CCRs were flagged as invalid.

We identified claims with condition code 41 as partial hospitalization services of CMHCs and removed them to another file. These claims were combined with the 76X claims identified previously to calculate the partial hospitalization per diem rate.

We then excluded claims without a HCPCS code. We also removed claims for observation services to another file. We removed to another file claims that contained nothing but flu and pneumococcal pneumonia (''PPV'') vaccine. Influenza and PPV vaccines are paid at reasonable cost and, therefore, these claims are not used to set OPPS rates. We note that the two above mentioned separate files containing partial hospitalization claims and the observation services claims are included in the files that are available for purchase as discussed above.

We next copied line-item costs for drugs, blood, and devices (the lines stay on the claim but are copied off onto another file) to a separate file. No claims were deleted when we copied these lines onto another file. These line-items are used to calculate the per unit median for drugs, radiopharmaceuticals, and blood and blood products. The line-item costs were also used to calculate the per administration cost of drugs, radiopharmaceuticals, and biologicals (other than blood and blood products) for purposes of determining whether the cost of the item would be packaged or paid separately. Section 1833(t)(16)(B) of the Act, as added by section 621(a)(2) of Pub. L. 108–173, requires the Secretary to lower to $50 the threshold for separate payment of drugs and biologicals and the per administration cost derived using these line-item cost data would be used to make that decision for CY 2005. As discussed in the November 7, 2003 OPPS final rule with comment period (68 FR 63398), we had also applied a $50 threshold to these items for the CY 2004 update to the OPPS.

We then divided the remaining claims into five groups.

1. *Single Major Claims:* Claims with a single separately payable procedure, all of which would be used in median setting.

2. *Multiple Major Claims:* Claims with more than one separately payable procedure or multiple units for one payable procedure. As discussed below, some of these can be used in median setting.

3. *Single Minor Claims:* Claims with a single HCPCS code that is not separately payable. These claims may have a single packaged procedure or a drug code.

4. *Multiple Minor Claims:* Claims with multiple HCPCS codes that are not separately payable without examining dates of service. (For example, pathology codes are packaged unless they appear on a single bill by themselves.) The multiple minor file has claims with multiple occurrences of pathology codes, with packaged costs that cannot be appropriately allocated across the multiple pathology codes. However, by matching dates of service for the code and the reported costs through the ''pseudo'' single creation process discussed earlier, a claim with multiple pathology codes may become several ''pseudo'' single claims with a unique pathology code and its associated costs on each day. These ''pseudo'' singles for the pathology codes would then be considered a separately payable code and would be used like claims in the single major claim file.

5. *Non-OPPS Claims:* Claims that contain no services payable under the OPPS are excluded from the files used for the OPPS. Non-OPPS claims have codes paid under other fee schedules, for example, durable medical equipment or clinical laboratory.

We note that the claims listed in numbers 1, 2, and 4 above are included in the data files that can be purchased as described above.

We set aside the single minor claims and the non-OPPS claims (numbers 3 and 5 above) because we did not use either in calculating median cost.

We then examined the multiple major and multiple minor claims (numbers 2 and 4 above) to determine if we could convert any of them to single major claims using the process described previously. We first grouped items on the claims by date of service. If each major procedure on the claim had a different date of service and if the line-items for packaged HCPCS and packaged revenue codes had dates of service, we broke the claim into multiple ''pseudo'' single claims based on the date of service.

After those single claims were created, we used the list of ''bypass codes'' in Table 16 of this final rule with comment period to remove separately payable procedures that we determined contain limited costs or no packaged costs from a multiple procedure bill. A discussion of the creation of the list of bypass codes used for the creation of ''pseudo'' single claims is contained in section III.A.2. of this preamble.

When one of the two separately payable procedures on a multiple procedure claim were on the bypass code list, the claim was split into two single procedure claims records. The single procedure claim record that contained the bypass code did not retain packaged services. The single procedure claim record that contained the other separately payable procedure retained the packaged revenue code charges and the packaged HCPCS charges.

We excluded those claims that we were not able to convert to singles even after applying both of the techniques for creation of ''pseudo'' singles. We then packaged the costs of packaged HCPCS (codes with status indicator ''N'' listed in Addendum B to this final rule with comment period) and packaged revenue codes into the cost of the single major procedure remaining on the claim. The list of packaged revenue codes is shown in Table 17 below.

After removing claims for hospitals with error CCRs, claims without HCPCS codes, claims for immunizations not covered under the OPPS, and claims for services not paid under the OPPS, 56 million claims were left. This subset of claims is roughly one-half of the 106 million claims for bill types paid under the OPPS. Of these 56 million claims, we were able to use some portion of 52 million (91 percent) whole claims to create the 84 million single and ''pseudo'' single claims for use in the CY 2005 median payment ratesetting.

We also excluded claims that either had zero costs after summing all costs on the claim or for which CMS lacked an appropriate provider wage index. For the remaining claims, we then wage adjusted 60 percent of the cost of the claim (which we determined to be the labor-related portion), as has been our policy since initial implementation of the OPPS, to adjust for geographic variation in labor-related costs. We made this adjustment by determining the wage index that applied to the hospital that furnished the service and dividing the cost for the separately paid HCPCS code furnished by the hospital by that wage index. As proposed, we used the final pre-reclassified wage indices for IPPS and any subsequent corrections. We used the pre-reclassified wage indices for standardization because we believe that they better reflect the true costs of items and services in the area in which the hospital is located than the post-reclassification wage indices, and would result in the most accurate adjusted median costs.

We then excluded claims that were outside 3 standard deviations from the geometric mean cost for each HCPCS code. We used the remaining claims to calculate median costs for each separately payable HCPCS code; first, to determine the applicability of the ''2 times'' rule, and second, to determine APC medians as based on the claims containing the HCPCS codes assigned to each APC. As stated previously, section 1833(t)(2) of the Act provides that, subject to certain exceptions, the items and services within an APC group cannot be considered comparable with respect to the use of resources if the highest median (or mean cost, if elected by the Secretary) for an item or service in the group is more than 2 times greater than the lowest median cost for an item or service within the same group (''the 2 times rule''). Finally, we reviewed the medians and reassigned HCPCS codes to different APCs as deemed appropriate. Section III.B. of this preamble includes a discussion of the HCPCS code assignment changes that resulted from examination of the medians and for other reasons. The APC medians were recalculated after we reassigned the affected HCPCS codes.

A detailed discussion of the medians for blood and blood products is provided at section V.I. of this preamble. We provide a discussion of the medians for APC 0315 (Level II Implantation of Neurostimulator), and APC 0651 (Complex Interstitial Radiation Application), at sections III.C.2.a. and III.C.2.b., respectively, of this preamble.

A discussion of the medians for APCs that require one or more devices when the service is performed is provided at section III.C. of this preamble. A discussion of the median for observation services is provided at section VII.D. of this preamble and a discussion of the median for partial hospitalization is provided at section X.C. of this preamble.

We received a number of public comments concerning our proposed data processes for calculating the CY 2005 OPPS relative weights and median costs.

Comment: Some commenters requested that CMS provide specialty-specific and APC-specific impact tables that provide additional information and analysis of its proposal to trim CCRs on a departmental basis. The commenters stated that CMS should justify why it trimmed departmental CCRs at ±3 standard deviations from the geometric mean and explain the impact of the change.

Response: We chose to trim at ±3 standard deviations from the geometric mean because cost and charge data are traditionally log normal distributed and because the 3 standard deviations threshold is standard policy for identifying outliers in CMS' payment systems. We do not believe that an impact analysis for the departmental-level CCR trim is necessary because the overall number of cost-centers trimmed were minimal relative to the number of hospitals and because this trim only removed extreme department CCRs, both low and high. We fully expect that, had we chosen not to trim at the department-level, extreme cost estimates would have been removed during our trim at the HCPCS-level performed later in the data development process.

For example, we trimmed the most department CCRs, 68, from cost center 5500, Medical Supplies Charged to Patients. The low CCRs that were trimmed ranged from 0.00008 to 0.0281. The high CCRs that were trimmed ranged from 0.39530 to 6069.17. Even after the department-level trim, only 7 percent of the hospitals in our data set defaulted to the overall CCR for services mapped to this cost center.

Comment: One commenter stated that the CCRs fell between 1996 and 2002 because charges were increasing faster than costs and that this change resulted in a significant payment decrease for hospitals for which we used the default CCR. The commenter urged CMS to instruct fiscal intermediaries to work with these hospitals in determining

CCRs that will provide accurate cost estimates.

Response: The commenter misunderstood the source of the CCRs used to adjust hospital costs to charges for OPPS median setting. We do not use the CCRs that fiscal intermediaries calculate for purposes of outlier payments, and cost reimbursement. Instead, we use hospital specific data from the health care cost reporting information system and independently calculate CCRs for each standard and nonstandard cost center in which the costs of outpatient services are to be found as well as an overall CCRs for the costs of outpatient care. Hence, intermediaries have no role in the calculation of the CCRs used to reduce charges to approximate costs for OPPS median cost setting.

Comment: One commenter asked that CMS justify why did it not use cost-to-charge data from all hospitals for CY 2005 OPPS calculations when, in the past, CMS used cost report data from all hospitals without regard to whether the hospital had filed data during a specified period.

Response: In the past, we first calculated CCRs for all providers, trimmed the overall hospital CCRs, and then compared the providers for which we had valid CCRs to the providers for which we had claims data. For CY 2005 OPPS, we first determined the providers for which we had claims data and we then calculated the CCRs for those hospitals so that the trimming would occur only across the hospitals for which we had claims data because a CCR is of value only if there are claims to which to apply it.

Comment: One commenter urged CMS to greatly expand the outpatient code editor (OCE) edits to return to providers claims that fail edits that are appropriate to the type of service being billed. The commenter cited as examples, the creation of edits that return claims for chemotherapy administration procedures if anti-neoplastics (cancer chemotherapy) are not also billed on the same day and edits that return claims for services that require the use of contrast agents if no contrast agent were billed. The commenter believed that this would greatly improve the data on which median costs are set.

Response: We do not intend, at this time, to greatly expand the OCE edits to force correct coding as the commenter recommends beyond the edits for correct coding of device procedures that are discussed in section III.C.4 of this final rule with comment period. While we recognize that these kinds of edits would likely result in better coding, they would also impose a significant burden on hospitals. We do, however, encourage hospitals to review their claims completion processes carefully and to edit their claims before they are submitted to maximize the likelihood that the claims are correct and complete. Such a practice would both assist us in developing better OPPS rates, but more importantly, ensure that hospitals are being correctly paid for all of the services they furnish to our beneficiaries.

Comment: One commenter noted the prevalence of drug billing and charging errors and recommended that CMS revise its median trimming methodology for drugs from ±3 standard deviations from the geometric mean to a trim by provider by drug based on the correlation of units and charges. This approach assumes that hospitals engaged in accurate and consistent unit coding and billing will demonstrate a strong correlation between units and per unit charges. The commenter noted that CMS' current trim is very conservative, especially for low costs per unit because it will only eliminate negative cost values, which do not exist in the data. The commenter further suggested that CMS' trim of department-level CCR's and the use of C-code only claims to set device medians are comparable to this proposal.

Response: We agree that billing accurate units has proven challenging for some hospitals in light of various differences in packaged versus delivered units, changing drug pricing, and unit changes in HCPCS codes. Clearly, our goal in conducting the current trim at ±3 standard deviations from the geometric mean is to remove aberrant per unit costs, or costs that are so far removed from the geometric mean that the probability of their occurrence is less than 1 percent. However, even after this trim is conducted, we remain concerned about the per unit cost estimates for some drug codes.

We believe, however, that the current trim of drug costs, while conservative, is not as limiting as suggested in the comment. The natural logarithm of costs per unit less than $1 will be negative. The trim compares the natural logarithm of the cost to the geometric mean, ±3 standard deviations and removes low and high cost observations. The low trim threshold may also be negative if costs are less than $1. In addition to using a trim, we also rely on a median cost rather than an average cost. Averages are subject to the influence of extreme outliers. Using a median instead of a mean eliminates this concern. Assuming most line-items for any given drug are coded correctly, using a trim and the median should provide a robust per unit cost estimate. Nonetheless, we do recognize that for selected low-volume or complex products, this approach is still not sufficient to remove all errors.

We are concerned, however, about implementing systematic trimming at the provider-level as suggested by the commenter for several reasons. First, this approach would remove the data for multiple providers from any given median calculation, making the assumption that their data were inaccurate, when, in fact, a few instances of poor coding may adversely impact the provider's correlation coefficient. Thus, a provider may actually be coding and charging accurately in many cases. In rare instances, we have removed a specific provider when it is more than obvious that the data are erroneous, but we only do this after a careful review of the provider's claims data. It is our preference to remove aberrant line-items rather than a provider's entire data for any given drug. Second, correlation coefficients for a provider may fluctuate if they are based on very low-volume, even if the majority of line-items appear accurate. Third, the commenter's proposed correlation coefficient approach lacks a generally accepted threshold when a providers' data should be removed, unlike the widely accepted trim of 3 standard deviations from the mean. Finally, this approach assumes that a negative correlation coefficient implies that a provider erred in setting its charging practices.

While we agree that the proposed trim seeks to improve the accuracy of the claims data, which is the goal of all trimming, we disagree that the commenter's proposed trim is necessarily comparable to the use of a department-level CCR trim and the limitation of claims to those with C-codes for estimating medians for device-dependent APCs. The department-level trim does not eliminate a provider entirely, it eliminates the department-level CCR for a specific hospital and replaces this CCR with the overall CCR for that hospital. Relying on C-coded claims to calculate device-dependent medians assures us that the device was used with the device-dependent procedure. The specific cost associated with the device code is not considered in subsetting claims and the subsetting is done by claim, not by provider. While the commenter's proposed methodology is not appropriate for use at this time, we nonetheless believe that the commenter's suggested approach can serve as a useful tool in helping us begin the process of identifying providers

Comment: One commenter indicated that using the overall CCR where the

departmental CCR cannot be used may skew the costs derived from application of CCRs to charges. The commenter suggested that CMS develop a method for replacing departmental CCRs similar to that used for blood and blood products whereby the CCR that would apply would not be the overall CCR but a national CCR calculated based on the departmental CCRs of hospitals that do report the more pertinent specific cost centers on their cost reports.

Response: We will consider whether doing so is practical and whether it would yield more accurate cost estimates. However, there were very specific characteristics of the reporting of blood such as a very specific cost center and very specific revenue codes that may not exist for other services.

Comment: One commenter asked that CMS undertake a study to improve the reporting of costs in conjunction with the CCR development. The commenter stated that a more timely process should be implemented so that currently accurate CCRs are used to translate hospital charges to costs and that consideration should be given to attaining greater detail from the hospitals to calculate the CCRs to better reflect the full line of services being offered by hospitals.

Response: We study means by which we could improve the development of cost-to-charge ratios annually. We also use the most current cost report data from the HCRIS system to calculate the cost to-charge-ratios and we use charges from the most current claims data. However, hospitals have great latitude in the way they organize their costs and complete their cost reports. We have no plans to alter the existing instructions to require cost report detail that is not currently provided. We will, instead, continue to examine how the data currently submitted by hospitals can be used to secure the most accurate estimates of cost for the full range of services furnished by hospitals.

After carefully reviewing all comments, we are adopting as final, for OPPS services furnished on or after January 1, 2005, the process for calculating median costs that we described in this section and the list of packaged services shown in Table 17 below. This table contains the list of packaged services by revenue code that we used in developing the APC weights and medians listed in Addenda A and B of this final rule with comment period.

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Table 17.--Packaged Services by Revenue Code

Revenue Code	Description
250	PHARMACY
251	GENERIC
252	NONGENERIC
254	PHARMACY INCIDENT TO OTHER DIAGNOSTIC
255	PHARMACY INCIDENT TO RADIOLOGY
257	NONPRESCRIPTION DRUGS
258	IV SOLUTIONS
259	OTHER PHARMACY
260	IV THERAPY, GENERAL CLASS
262	IV THERAPY/PHARMACY SERVICES
263	SUPPLY/DELIVERY
264	IV THERAPY/SUPPLIES
269	OTHER IV THERAPY
270	M&S SUPPLIES
271	NONSTERILE SUPPLIES
272	STERILE SUPPLIES
274	PROSTHETIC/ORTHOTIC DEVICES
275	PACEMAKER DRUG
276	INTRAOCULAR LENS SOURCE DRUG
278	OTHER IMPLANTS
279	OTHER M&S SUPPLIES
280	ONCOLOGY
289	OTHER ONCOLOGY
290	DURABLE MEDICAL EQUIPMENT
343	DIAGNOSTIC RADIOPHARMS
344	THERAPEUTIC RADIOPHARMS
370	ANESTHESIA
371	ANESTHESIA INCIDENT TO RADIOLOGY
372	ANESTHESIA INCIDENT TO OTHER DIAGNOSTIC
379	OTHER ANESTHESIA
390	BLOOD STORAGE AND PROCESSING
399	OTHER BLOOD STORAGE AND PROCESSING
560	MEDICAL SOCIAL SERVICES
569	OTHER MEDICAL SOCIAL SERVICES
621	SUPPLIES INCIDENT TO RADIOLOGY
622	SUPPLIES INCIDENT TO OTHER DIAGNOSTIC
624	INVESTIGATIONAL DEVICE (IDE)
630	DRUGS REQUIRING SPECIFIC IDENTIFICATION, GENERAL CLASS
631	SINGLE SOURCE
632	MULTIPLE
633	RESTRICTIVE PRESCRIPTION
637	SELF-ADMINISTERED DRUG (INSULIN ADMIN. IN EMERGENCY DIABETIC COMA)
681	TRAUMA RESPONSE, LEVEL I
682	TRAUMA RESPONSE, LEVEL II
683	TRAUMA RESPONSE, LEVEL III

Revenue Code	Description
684	TRAUMA RESPONSE, LEVEL IV
689	TRAUMA RESPONSE , OTHER
700	CAST ROOM
709	OTHER CAST ROOM
710	RECOVERY ROOM
719	OTHER RECOVERY ROOM
720	LABOR ROOM
721	LABOR
762	OBSERVATION ROOM
810	ORGAN ACQUISITION
819	OTHER ORGAN ACQUISITION
942	EDUCATION/TRAINING

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C. Adjustment of Median Costs for CY 2005

1. Device-Dependent APCs

Table 19, which we published in the proposed rule (69 FR 50492), contains a list of APCs consisting of HCPCS codes that cannot be provided without one or more devices. For CY 2002 OPPS, we used external data in part to establish the medians used for weight setting. At that time, many devices were eligible for pass-through payment. For that year, we estimated that the total amount of pass-through payments would far exceed the limit imposed by statute. To reduce the amount of a pro rata adjustment to all pass-through items, we packaged 75 percent of the cost of the devices (using external data furnished by commenters on the August 24, 2001 proposed rule) into the median cost for the APCs associated with these pass-through devices. The remaining 25 percent of the cost was considered to be pass-through payment. (Section VI. of this preamble includes a discussion of the pro rata adjustment.)

For CY 2003 OPPS, which was based on CY 2001 claims data, we found that the median costs for certain device-dependent APCs when all claims were used were substantially less than the median costs used for CY 2002. We were concerned that using the medians calculated from all claims would result in payments for some APCs that would not compensate the hospital even for the cost of the device. Therefore, we calculated a median cost using only claims from hospitals that had separately billed the pass-through device in CY 2001 (that is, hospitals whose claims contained the C-code for the pass-through device). Furthermore, for any APC (whether device-dependent or not) where the median cost would have decreased by 15 percent or more from CY 2002 to CY 2003, we limited decreases in median costs to 15 percent plus half of the amount of any reduction beyond 15 percent (68 FR 47984). For a few particular device-dependent APCs for which we believed that access to the service was in jeopardy, we blended external data furnished by commenters on the August 9, 2002 proposed rule (67 FR 57092) with claims data to establish the median cost used to set the payment rate. For CY 2003, we also eliminated the HCPCS C-codes for the devices and returned to providers those claims on which the deleted device codes were used. (The November 1, 2002 OPPS final rule (67 FR 66750) and section III.C.4 of this preamble contain a discussion regarding the required use of C-codes for specific categories of devices.)

For CY 2004 OPPS, which was based on CY 2002 claims data, we used only claims on which hospitals had reported devices to establish the median cost for the device-dependent APCs in Table 18. We did this because we found that the median costs calculated when we used all claims for these services were inadequate to cover the cost of the device if the device was not separately coded on the claim. Using only claims containing the code for the device (a C-code) provided costs that were closer to those used for CY 2002 and CY 2003 for these services. For a few particular APCs in which we believed that access to the service was in jeopardy, we used external data provided by commenters on the August 12, 2003 proposed rule in a 50 percent blend with claims data to establish the device portion of the median cost used to set the payment rate (68 FR 63423). We also reinstated for CY 2004, but on a voluntary basis, the reporting of C-codes for devices.

Thus, in developing the median costs for device-dependent APCs for CYs 2002, 2003, and 2004, we applied certain adjustments to our claims data as provided under the authority of section 1833(t)(9)(A) of the Act to ensure equitable payments to the hospitals for the provision of such services. As stated in the August 16, 2004 proposed rule, we have continued to receive comments from interested parties as part of the APC Panel process urging us to determine whether the claims data that would be used in calculating the median costs for device-dependent APCs for payment in CY 2005 would represent valid relative costs for these services (69 FR 50490). Careful analysis of the CY 2003 data that we used in calculating the median costs for the CY 2005 OPPS payment rates revealed problems similar to those discussed above in calculating device-dependent APC median costs based solely on claims data. Calculation of the CY 2005 median costs for the device-dependent APCs indicated that some of the medians appeared to appropriately reflect the costs of the services, including the cost of the device, and others did not. Of the 41 device-dependent APCs analyzed, 27 have median costs that are lower than the medians on which the OPPS payments were based in CY 2004. In contrast, 14 device-dependent APCs have median costs that are higher than the medians on which OPPS payments were based in CY 2004.

The differences between the CY 2004 payment medians and the proposed CY 2005 median costs using CY 2003 claims data are attributable to several factors. As discussed above, the CY 2004 payment medians were based on a subset of claims that contained the codes for the devices without which the procedures could not be performed, and several APCs were adjusted using external data. The CY 2005 OPPS median costs on which the proposed payment rates in the August 16, 2004 proposed rule were based, were calculated based on all single bills, including ''pseudo'' single bills, for the services in the APCs and (not a subset

of claims containing device codes) and were not adjusted using external data. In fact, as stated previously, we eliminated device coding requirements for hospitals in CY 2003. Consequently, there were no device codes reported for almost all devices in the CY 2003 claims data. Thus, it was not possible to use only the CY 2003 claims data containing device codes to calculate APC device-dependent medians as was done in CY 2004. Similarly, it was not possible to calculate a percentage of the APC cost attributed to device codes based on CY 2003 claims data.

In light of these data issues for CY 2005, we examined several alternatives to using CY 2003 claims data to calculate the proposed median costs for device-dependent APCs. As discussed in the August 16, 2004 proposed rule, we considered using CY 2004 OPPS medians with an inflation factor, as recommended by the APC Panel and by several outside organizations. We rejected this option because it would not recognize any changes in relative costs for these APCs and would not direct us towards our goal of using all single claims data as the basis for payment weights for all OPPS services.

We also considered using the medians we calculated from all single bills with no adjustments. However, the results of using this approach without increasing the payments for some important high cost services for CY 2005 could result in the closing of hospital programs that provide these services thus, jeopardizing access to needed care. Therefore, we did not adopt this approach.

In addition, we considered subsetting claims based on the presence of charges in certain revenue codes. These revenue codes include: 272, sterile supplies; 275, pacemakers; 278, other implants; 279, other supplies/devices; 280, oncology; 289, other oncology; and 624, investigational devices. We determined that the medians increased for some device-dependent APCs when we used only claims with a charge in at least one of these revenue codes, but our analysis provided no reliable evidence that the charges that would be found in these revenue codes were necessarily for the cost of the device.

Further, we considered using CY 2002 claims to calculate a ratio between the median calculated using all single bills and the median calculated using only claims with HCPCS codes for devices on them, and applying that ratio to the median calculated using all single bills from CY 2003 claims data. We rejected this option because it assumes that the relationship between the costs of the claims with and without codes for devices is a valid relationship not only for CY 2002 but CY 2003 as well. It also assumes no changes in billing behavior. We have no reason to believe either of these assumptions is true and, therefore, we did not choose this option.

In summary, we considered and rejected all of the above options. We have given special treatment to the device-dependent APCs for the past 3 years, recognizing that, in a new payment system, hospitals need time to establish correct coding processes and, considering the need to ensure continued access to these important services. After 3 years of such consideration, we believe that it is time to begin a transition to the use of pure claims data for these services (reflected in these APCs) to ensure the appropriate relativity of the median costs for all payable OPPS services. Our goal is to establish payment rates that provide appropriate relative payment for all services paid under the OPPS without creating payment disincentives that may reduce access to care.

Therefore, we proposed to base median costs for device-dependent APCs in CY 2005 on the greater of (1) median costs calculated using CY 2003 claims data, or (2) 90 percent of the APC payment median for CY 2004 for such services. We proposed this adjustment because we believe that some variation in median costs is to be expected from year to year, and we believe that recognizing up to a 10 percent variation in our payment approach is a reasonable limit. In the August 16, 2004 proposed rule, we solicited comments on all aspects of theses issues and particularly on steps that can be taken in the future to transition from the historic payment medians to claims based median costs for OPPS ratesetting for these important services. In addition, we discussed this issue with the APC Panel at its September 1 through 2, 2004 meeting. The Panel recommended that we base median costs for these APCs on no less than 95 percent of the CY 2004 median not to exceed 105 percent of the CY 2004 payment median.

We received numerous public comments on our proposals.

Comment: A number of commenters objected to the proposal to set the payment medians for device APCs at 90 percent of the CY 2004 payment median for the APC. They indicated that many of these APCs had already been reduced substantially over the past few years and that permitting them to be reduced another 10 percent would mean that some hospitals may close their programs and send patients to other hospitals for these services. Some commenters recommended that the median costs for these APCs be set at 100 percent of the CY 2004 payment median. Some commenters recommended that CMS use the CY 2004 payment median plus an update amount as the median cost for the CY 2005 OPPS. Commenters also recommended that instead of using median costs from claims data with any adjustment, that we collect actual hospital acquisition data or use cost data provided by manufacturers and other stakeholders and substitute that data for the device portion of the median costs. They indicated that we used external data in the past and that we should do so this year also. They cited APCs 0081, 0107, 0108, 0225, 0229, 0259, 0385, and 0386 as cases in which the proposed APC payment rates were less than the cost of the devices and as those for which CMS should use external data in setting the payment rates for CY 2005. A commenter supported the proposal to pay the greater of the CY 2005 claims based median or 90 percent of the CY 2004 payment median.

Response: For the reasons discussed below, we set the adjusted CY 2005 OPPS device-dependent median at the greater of the CY 2005 OPPS unadjusted median or 95 percent of the CY 2004 OPPS adjusted final payment median rather than the greater of the CY 2005 unadjusted median or 90 percent of the CY 2004 OPPS adjusted final median as we proposed in the August 16, 2004 proposed rule. We view this as a transition to the full use of claims data to set the medians for these services. The integrity of a prospective payment system lies heavily in its reliance on a standardized process applied to a standardized data source. The use of external data can, as some commenters point out, unfairly unbalance the payments and result in inequities in payment. (Section III.C.5. of this preamble includes a discussion on the use of external data.)

We considered setting the medians at the CY 2004 adjusted final payment medians with and without further inflation, but we think a certain amount of fluctuation in costs from year to year is to be expected as the costs of services decline after they have been on the market for some time. Moreover, we considered our proposal to pay the greater of the CY 2005 unadjusted median or 90 percent of the CY 2004 OPPS adjusted final payment median, but acknowledged the concerns of the commenters who believe that setting the comparison at 95 percent of the CY 2004 OPPS final adjusted payment median was more appropriate and less likely to impede access to these important services. We recognize that adjustments

to median costs derived from claims data may be necessary yet again in the CY 2006 OPPS due to the voluntary nature of the reporting of device codes in CY 2004. However, as discussed further below at section III.C.4. of this preamble in our discussion of mandatory coding for devices, we expect that reporting of device codes in the CY 2005 claims will enable us to rely upon the claims data for setting the median costs without adjustment in CY 2007.

Comment: Some commenters opposed the APC Panel's recommendation to limit increases in median costs for device APCs to 5 percent over the CY 2004 payment median because the commenters believe such a limit would be arbitrary and would be a hindrance to the improvement of cost data.

Response: We agree and we have not limited the extent to which the median costs for device-dependent APCs may increase for the CY 2005 OPPS. We believe that in a number of cases, providers are reporting the charges for the devices and have otherwise greatly improved coding of their services, resulting in increases in median costs that appear to appropriately reflect the costs of the services furnished. We have no indication that the increases do not otherwise properly reflect the costs of services and, therefore, see no reason to constrain the increases that have resulted.

Comment: Some commenters stated that CMS should look long term to determining a factor through regression analysis that enables CMS to adjust the charges for high cost devices so that the methodology will result in more accurate costs for high cost devices.

Response: We will review and consider the results of credible studies of the possible compression of all charges, both for high cost services and low cost services. Studies that focus only on part of the spectrum of hospital charges, for example, those which look at low markup of high cost items but not at high markup of low cost items, would not be useful in a relative weight system.

Comment: Some commenters indicated that hospitals typically markup high cost items and services less than they markup low cost items and services and that CMS' cost finding methodology does not recognize this because it applies a uniform cost-to-charge ratio (for the department or hospital overall) to the charges, which then yields distorted costs. They recommended that CMS resolve this problem using external data from manufacturers and other stakeholders until such time that CMS can comply with the GAO study that recommended that CMS ''analyze variation in hospital charge setting to determine if the OPPS payment rates uniformly reflect hospitals' costs of provided outpatient services and if they do not, to make appropriate changes to the methodology.'' The commenters asked that CMS provide explicit instructions to hospitals regarding how to adequately capture and charge for high cost devices.

Response: As we discussed previously, we have decided not to use external data to adjust the APC payment rates for CY 2005 OPPS. We do, however, reassess our existing methodology each year to determine how we can best create rates that uniformly reflect hospitals' cost of providing outpatient services. We will not provide instructions to hospitals regarding how to capture and charge for high cost devices. As a matter of policy, we do not tell hospitals how to set their charges for their services. However, we will continue to inform hospitals of the importance of their charge data in future ratesetting and encourage them to include all appropriate charges on their Medicare claims.

Comment: One commenter objected to us applying the wage index adjustment to the cost of a device in a device-dependent APC because, as the commenter stated, the wage index is intended to address the identified differential in wages across localities. The commenter contends that there is no demonstration of a similar differential in the costs of devices across localities.

Response: Previous studies have shown that across the entirety of all services paid under OPPS, approximately 60 percent of total cost is labor related. Therefore we believe it is appropriate to apply the wage index to 60 percent of the payment for each service. The application of the wage index to the payment for the device-dependent APC can either inflate the total payment for the device-dependent APC or reduce it depending on whether the hospital is in a high cost or low cost area. In many cases, if we ceased to apply the wage index adjustment to 60 percent of the APC payment, the payment to the hospital for the APC would be significantly reduced. We will, however, consider whether it is appropriate to continue to apply the wage index adjustment as we currently do.

Comment: One commenter asked that we add CPT codes 47382, (Radiofrequency ablation procedures of the liver) and CPT code 20982, (Radiofrequency ablation procedures of the bone) to the list of device-dependent APCs because they require the use of devices.

Response: We will consider whether these services should be added to the list of device-dependent APCs in the future. However, it is unclear to us what proportion of total cost of each of these procedures is the cost of the device because codes are not reported for the devices. We do not agree that the cost of the devices could be derived from charges reported in particular revenue codes because there is no identification of the items charged under any revenue code.

Comment: Some commenters indicated that the reductions in APC payments following termination of pass-through status for devices have resulted in the elimination of programs at hospitals that have chosen to no longer implant prosthetic devices.

Response: We share the concern that beneficiaries should have access to services covered under Medicare and believe that our payment policies under OPPS have consistently taken this concern into account.

Comment: Some commenters indicated that the proposed payment rates for APCs 0081, 0107, 0108, 0222, 0229, 0385, and 0386 are inadequate and do not cover the cost of the device; therefore, they do not provide payment for the facility services. The commenters stated that hospitals have taken a loss on these services for several years and cannot continue to provide the services at a loss. The commenters developed alternative cost estimates using external data and urged CMS to use these data rather than its claims data as the basis for developing median costs.

Response: As stated, for device-dependent APC in general, we have not used external data to adjust any median costs for CY 2005 OPPS. Instead, we set the medians for these APCs at the greater of the median cost for CY 2005 derived using claims data or 95 percent of the CY 2004 OPPS adjusted payment median. Beginning in CY 2005, we will also require that the claims containing codes assigned to these APCs also contain a code for an appropriate device for the claim to be paid, so that in CY 2007 we will have correctly coded claims to help us in setting the payment weights.

Comment: Some commenters stated that the proposed payment for cryoablation of the prostate (CPT code 55873) is insufficient to cover the cost for the procedure. They further stated that CMS should factor in external data that shows hospital costs to exceed $9,000, eliminate or adjust claims for APC 0674 in which the charges for

cryoablation probes are less than $7500, or discard all claims containing CPT code 55873 in the Medicare database for which the total hospital costs are less than $6500. The commenters indicated that access to this care would be impeded if the APC payment is not sufficient to pay the full cost of the service. The commenters believed that APC payment at less than full costs for the service will give rise to the use of alternative means of treating prostate cancer. These commenters indicated that the charges hospitals report on their claims are seldom sufficient to result in the full cost of all of the supplies and equipment needed to furnish the service. The commenters also indicated that when the only claims used to set the median are those for which the code for cryoablation probes is found, the median increases significantly.

Response: The codes for the cryoablation probes used in providing cryoablation of the prostate were billed in CY 2003 because they were paid as pass-through payments in CY 2003. Therefore, they exist in the claims data and we used them to screen for correctly coded claims in setting the median cost for APC 0674. The median derived using the subset of claims is $6,562.69, a decrease of 5.10 percent from the CY 2004 final payment median for APC 0674. Therefore, based on the device-dependent APC policy that we are finalizing for CY 2005, we set the median for APC 0674 at 95 percent of the CY 2004 final payment median, or $6,569.33.

Comment: Some commenters supported the increased payment for cochlear implant services (CPT code 69930 in APC 0259) even though they indicated that they believe that the Medicare payment continues to be insufficient to fully pay for the costs of both the device and the procedure. One commenter provided an independent statistical analysis of the Medicare claims data and invoice data that the commenter indicated revealed hospital costs of $27,954 based on a screen of claims that contained HCPCS code L8614 and asked that CMS set the payment at that amount. Some commenters stated that they believe that some hospitals are using the cochlear implant codes to code implantation of less expensive implantable hearing aid devices. The commenter also asked that CMS provide education and develop a guidance document for hospitals specific to coding and billing for cochlear implant surgery.

Response: The device code for cochlear implants remained active in CY 2003 because Medicare uses it for purposes other than the OPPS. In developing the CY 2005 OPPS medians, we created a subset of claims for implantation of cochlear implants that contained the device code and calculated the median for the CY 2005 OPPS using only those correctly coded claims. This yielded a median cost of $26,006.74, which we used as the basis for the APC 0259 payment weight for the CY 2005 OPPS. While it is certainly possible that some hospitals are misusing the code for cochlear implantation to bill for less costly implanted hearing aid devices, we have no way to make that determination using the claims data. However, we note that hospitals billing in such a manner do so at their own risk of being found to have filed a false claim. We will consider what general education activities we need to undertake with regard to all devices but we are disinclined to focus on specific devices to the exclusion of others.

Comment: One commenter indicated that the proposed decrease in payment rates for APC 0039 (Level I Implantation of Neurostimulator) is not acceptable as it would not enable hospitals to cover the cost of the service. Moreover, the commenter stated that hospitals have failed to code and bill correctly for this service and that there are no disincentives for incorrect coding and billing. The commenter further stated that the only diagnosis on the claims for APC 0039 should be that for epilepsy because that is the fundamental reason for implanting the device. However, according to the commenter, examination of the claims for APC 0039 revealed that only 12 percent of those claims contained an epilespsy diagnosis; therefore, the remaining claims caused the median to incorrectly represent the implantation of the device for treatment of epilepsy. The commenter recommended that CMS use external data to ensure that the costs of the device and procedure are adequate to avoid discouraging hospitals from providing the care.

Response: As with other device-dependent APCs, the absence of device codes on the claims for CY 2003 means that we were unable to screen the claims to positively identify which claims include the neurostimulator device costs and we are not confident that screening only for the diagnosis of epilepsy will resolve the coding problem. Therefore, we have set the median for APC 0039 at 95 percent of the CY 2004 final adjusted payment median.

Comment: Some commenters objected to the assignment of status indicator ''T'' to APC 0229 (Transcatheter Placement of Intravascular Stent) because they believe it should not be subject to the multiple procedure reduction due to its dependence on a device. They believed that the payment for the services is undervalued because it is typically done with other procedures and that it is further underpaid by the application of the multiple procedure reduction.

Response: We have not changed the status indicator for APC 0229 because the cost of the device for services in this APC is less than 50 percent of the total cost of the service. Therefore, the multiple procedure reduction of 50 percent does not result in the APC payment being less than the device cost. Moreover, there are efficiencies when multiple services are performed on the same day that we believe justify applying the multiple procedure reduction to the services in this APC.

Comment: One commenter asked that CMS require hospitals to show the actual acquisition cost for devices on the bill using a UB92 value code and the amount. The commenter recommended that where 50 percent or more of the APC is attributable to packaged device cost, CMS should obtain actual device information and use it to determine if APC cost calculations are reasonable.

Response: We do not believe the imposition of an additional reporting requirement would be effective. Such a requirement would be both burdensome and unlikely to provide the actual hospital acquisition cost because hospitals have the ability to reflect general rebates and discounts on a per device basis.

Comment: One commenter asked that we make separate payments for CRT–Ds (pacemaker-defibrillators) for which there was a new technology add-on payment under the IPPS for FY 2005, so that payment for this service under the IPPS and the OPPS would be better aligned.

Response: CRT–Ds were paid on a pass-through basis under the OPPS in CYs 2001 and 2002. Their OPPS pass-through status expired in CY 2003 and their component services were packaged into clinical APC 0107 (Insertion of Cardioverter-Defibrillator) and APC 0108 (Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads) and. Accordingly, no separate additional payment is appropriate for these devices.

After carefully reviewing the comments, considering the APC Panel recommendations and examining the claims data, we are adjusting the medians for device-dependent APCs based on comparison of the CY 2005 median costs and the CY 2004 final payment median costs. Specifically, we decided to set the median costs for these

APCs at the higher of the CY 2005 median cost from our claims data or 95 percent of the CY 2004 final adjusted median cost used to set the payment in CY 2004 rather than 90 percent of the CY final adjustment median cost as we proposed.

We believe that this adjustment methodology provides an appropriate transition to eventual use of all single bill claims data without adjustment, and that the methodology moves us towards the goal of using all single bill data without adjustment by CY 2007. It is a simple and easily understood methodology for adjusting median costs. Where reductions occur compared to CY 2004 OPPS, we believe that, under this methodology, the reductions will be sufficiently modest that providers will be able to accommodate them without ceasing to furnish services that Medicare beneficiaries need.

In addition, beginning in CY 2005, as proposed, we are requiring hospitals to bill all device-dependent procedures using the appropriate C-codes for the devices. We believe that this approach mitigates against the reduction of access to care while encouraging hospitals to bill correctly for the services they furnish. We intend this requirement to be the first step towards use of all available single bill claims data to establish medians for device-dependent APCs. Our goal is to use all single bills for device-dependent APCs in developing the CY 2007 OPPS, which we expect to base on data from claims for services furnished in CY 2005. We further discuss our coding requirement in section III.C.4. of this preamble.

Table 18 below, which is sorted by APC, contains the CY 2004 OPPS payment medians, the CY 2005 OPPS final adjusted medians using single bill claims from January 1, 2003, through December 31, 2003), and the medians derived from the adjustment processes discussed further below.

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Table 18.-- Median Costs for Device-Dependent APCs

APC	Description	SI	Final CY 2004 OPPS APC Median	Unadjusted CY 2005 OPPS APC Median Cost	Percentage Change from CY 2004 to CY 2005	Adjusted Final CY 2005 OPPS Median	CY 2005 Total Frequency
0032	Insertion of Central Venous/Arterial Catheter	T	$662.31	$475.76	-28.17%	$629.19	79,381
0039	Implantation of Neurostimulator (new for 2004 OPPS; breakout of APC 222)	S	$13,555.80	$10,015.34	-26.12%	$12,878.01	1,833
0040	Level II Implantation of Neurostimulator Electrodes (new for 2004 OPPS; breakout of APC 225)	S	$3,002.98	$2,885.37	-3.92%	$2,885.37	10,657
0080	Diagnostic Cardiac Catheterization	T	$2,075.91	$2,123.65	2.30%	$2,123.65	396,154
0081	Non-Coronary Angioplasty or Atherectomy	T	$2,018.99	$1,782.44	-11.72%	$1,918.04	127,156
0082	Coronary Atherectomy	T	$6,352.89	$4,546.84	-28.43%	$6,035.25	632
0083	Coronary Angioplasty and Percutaneous Valvuloplasty	T	$3,412.47	$2,920.81	-14.41%	$3,241.85	8,364
0085	Level II Electrophysiologic Evaluation	T	$2,041.13	$2,034.82	-0.31%	$2,034.82	19,113
0086	Ablate Heart Dysrhythm Focus	T	$2,590.21	$2,637.96	1.84%	$2,637.96	8,792
0087	Cardiac Electrophysiologic Recording/Mapping	T	$2,294.94	$559.11	-75.64%	$2,180.19	11,859
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	T	$6,754.63	$6,279.62	-7.03%	$6,416.90	5,016
0090	Insertion/Replacement of Pacemaker Pulse Generator	T	$5,581.04	$4,996.52	-10.47%	$5,301.99	8,148
0104	Transcatheter Placement of Intracoronary Stents	T	$4,765.05	$4,750.06	-0.31%	$4,750.06	21,614
0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes	T	$3,399.05	$1,649.73	-51.46%	$3,229.10	4,355
0107	Insertion of Cardioverter-Defibrillator	T	$19,431.68	$12,119.59	-37.63%	$18,460.10	7,224
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	T	$26,092.91	$18,077.80	-30.72%	$24,788.26	5,281
0115	Cannula/Access Device Procedures	T	$1,478.06	$1,502.71	1.67%	$1,502.71	106,398
0119	Implantation of Infusion Pump (we proposed to remove 49419 from APC 119 and place it in 115); the 2005 median was calculated from 25 claims after examination of all single bills and removal of erroneously coded claims	T	$7,765.02	$5,320.82	-31.48%	$7,376.77	385
0122	Level II Tube changes and Repositioning	T	$510.80	$473.64	-7.27%	$485.26	18,775

APC	Description	SI	Final CY 2004 OPPS APC Median	Unadjusted CY 2005 OPPS APC Median Cost	Percentage Change from CY 2004 to CY 2005	Adjusted Final CY 2005 OPPS Median	CY 2005 Total Frequency
0167	Level III Urethral Procedures	T	$1,730.23	$1,664.80	-3.78%	$1,664.80	10,194
0202	Level X Female Reproductive Proc	T	$2,246.87	$2,322.83	3.38%	$2,322.83	13,526
0222	Implantation of Neurological Device (APC 39 was part of 222 in 2003)	T	$13,383.79	$9,056.69	-32.33%	$12,714.60	5,224
0225	Level I Implementation of Neurostimulator Electrodes	S	$11,873.72	$12,327.52	3.82%	$12,327.52	1,482
0227	Implantation of Drug Infusion Device	T	$9,270.36	$8,542.64	-7.85%	$8,806.84	3,408
0229	Transcatherter Placement of Intravascular Shunts	T	$3,572.98	$3,638.52	1.83%	$3,638.52	41,858
0259	Level VI ENT Procedures (Cochlear implants; median uses device code only single bills)	T	$22,643.98	$26,006.74	14.85%	$26,006.74	945
0313	Brachytherapy	S	$795.83	$812.60	2.11%	$812.60	15,859
0384	GI Procedures with Stents	T	$1,669.39	$1,232.28	-26.18%	$1,585.92	20,108
0385	Level I Prosthetic Urological Procedures	S	$3,870.60	$4,080.56	5.42%	$4,080.56	843
0386	Level II Prosthetic Urological Procedures	S	$6,699.79	$6,674.53	-0.38%	$6,674.53	4,817
0418	Left ventricular lead In new tech 1547 at $850 for 2004; device coming off pass through for 2005	T		$4,363.37		$4,363.37	530
0425	Level II Arthroplasty with prosthesis (new for 2005; broken out of APC 48; data 2004 is from APC 48)	T	$2,966.13	$5,715.97	92.71%	$5,715.97	795
0648	Breast Reconstruction with Prosthesis	T	$3,113.43	$2,875.96	-7.63%	$2,957.76	1,329
0652	Insertion of Intraperitoneal Catheters	T	$1,558.34	$1,626.29	4.36%	$1,626.29	5,473
0653	Vascular Reconstruction/Fistula Repair with Device	T	$1,731.08	$1,638.33	-5.36%	$1,644.53	29,776
0654	Insertion/Replacement of a permanent dual chamber pacemaker	T	$6,495.61	$6,060.94	-6.69%	$6,170.83	21,197
0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker	T	$8,225.23	$7,913.85	-3.79%	$7,913.85	15,152
0656	Transcatheter Placement of Intracoronary Drug Eluting Stents	T	$5,965.05	$6,156.14	3.20%	$6,156.14	5,759
0670	Intravenous and Intracardiac Ultrasound	S	$1,582.08	$1,779.08	12.45%	$1,779.08	4,335
0674	Prostate Cryoablation (device was on pass through in 2003; 2003 claims median for 2005 is based on C-code claims)	T	$6,915.08	$6,562.69	-5.10%	$6,569.33	1,516
0680	Insertion of Patient Activated Event Recorders	S	$3,621.15	$3,744.69	3.41%	$3,744.69	2,067
0681	Knee Arthroplasty	T	$5,657.87	$5,353.66	-5.38%	$5,374.98	788

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We also note that as a result of our initial data analysis for device-dependent APCs, we proposed to make the following additional adjustments to specific device-dependent APCs for the reasons specified:

a. APC 0226: Implantation of Drug Infusion Reservoir

We proposed to remove APC 0226 (Implantation of Drug Infusion Reservoir) from the list of device-dependent APCs and to use its unadjusted single bill median of $2,793.30 as the basis for the payment weight. CPT code 62360 (Implantation or replacement of device for intrathecal or epidural drug infusion, subcutaneous reservoir) is assigned to APC 0226. In CY 2002, when we packaged 75 percent of the cost of the device into the payment for the procedure with which the device was billed to reduce the pro rata adjustment, we inadvertently packaged the cost of an implantable infusion pump (C1336 and C1337) rather than that of a drug reservoir. Our data indicated that the reservoir used in performing CPT code 62360 costs considerably less than an implantable infusion pump, and we believe that the median cost for APC 0226 appropriately reflects the relative cost of the service and the required device.

We did not receive any public comments on this proposal. Accordingly, we have removed APC 0226 from the device-dependent APC list and used its unadjusted single bill median of $2,541.43 as the basis for its CY 2005 relative payment weight.

b. APC 0048: Arthroscopy With Prosthesis

In addition, we proposed to delete APC 0048 (Arthroplasty with Prosthesis) from the list of device-dependent APCs for CY 2005 and to not adjust the median costs for this APC because we believe that the CY 2005 median cost for this APC as restructured is reasonable and appropriate. Based on our careful analysis of the CY 2003 claims data for this APC, we believe the difference between the CY 2004 and CY 2005 median cost is attributable to the migration of certain high cost CPT codes (23470, 24361, 24363, 24366, 25441, 25442, 25446) from APC 0048 to new APC 0425 (Level II Arthroplasty with Prosthesis) and, as such, this change would not adversely limit beneficiary access to this important service. Therefore, we did not propose to apply a device-dependent adjustment to the median cost for APC 0048.

We did not receive any public comments on this proposal. Accordingly, for CY 2005 we are removing APC 0048 from the device-dependent list and are not adjusting the median cost for this APC.

c. APC 0385: Level I Prosthetic Urological Procedures

We proposed to move CPT code 52282 (Cystourethroscopy, insert urethral stent), from APC 0385 (Level I Prosthetic Urological Procedure) and assign it to APC 0163 (Level IV Cystourethoscopy and other Genitourinary Procedures), for clinical homogeneity. As titled, APC 0385 was intended for the assignment of certain urological procedures that require the use of prosthetics. However, CPT code 52282 requires the use of a stent rather than a urological prosthetic. Therefore, we proposed to reassign CPT code 52282 to APC 0163. Recalculation of the median cost for APC 0385 after reassigning CPT code 52282 yielded a median cost for that APC that is consistent with its CY 2004 median payment. Thus, we did not propose a device-dependent adjustment for the median cost for APC 0385.

Comment: Some commenters asked that we keep CPT code 52282 in APC 0385 and not move it to APC 0163. These commenters believed that placement of CPT code 52282 in APC 0385 would maintain clinical coherence and resource similarity. They also supported the APC Panel's recommendation that all three codes, which we proposed to move from APC 0385 to 0386 (CPT codes 53440, 53444, and 54416) should be retained in APC 0385 for CY 2005 OPPS because they are dissimilar in terms of the nature of the surgical procedure and the sophistication of the prosthetic urology device that is implanted.

Response: We have moved CPT code 52282 from APC 0385 to APC 0163 because we believe that this service is more compatible from a clinical and resource perspective with the other cystourethroscopy services assigned to APC 0163 than with services assigned to APC 0385. We have retained CPT codes 53440 and 53444 to APC 0385 because the median costs for these procedures in the CY 2003 data that were used to develop this final rule with comment period indicate that the resources required for them are similar to those for CPT code 54400, which is also assigned to APC 0385. However, we have placed CPT code 54416 in APC 0386 because the median cost shows that the resources are much more like those for services assigned to APC 0386 than the median costs for services in APC 0385. CPT code 54416 requires removal and replacement of a non-inflatable or inflatable prosthesis and our resource data demonstrate relatively high costs for the service, most typically associated with replacement of an inflatable prosthesis. Thus, the nature of the services are sufficiently similar such that CPT code 54416 is clinically coherent with the services in APC 0386.

d. APC 0119: Implantation of Infusion Device and APC 0115: Cannula/Access Device Procedures

We proposed to remove CPT code 49419 (Insert abdom cath for chemo tx), from APC 0119 (Implantation of Infusion Pump) and assign it to APC 0115 (Cannula/Access Device Procedures) to achieve clinical homogeneity within APC 0115. Unlike all the other codes assigned to APC 0115, HCPCS code 49419 does not require the use of an infusion pump. Rather, this code is used when inserting an intraperitoneal cannula or catheter with a subcutaneous reservoir. Thus, we believed it would be more appropriate clinically to reassign HCPCS code 49419 to APC 0115 that includes procedures that require the use of devices similar to that required for CPT code 49419.

Comment: One commenter recommended that we move the CPT code 36260 (Insertion of infusion pump) and CPT code 36563 (Insert tunneled cv catheter) from APC 0119 to APC 0227 (Implantation of Drug Infusion Device), which is also for implantation of infusion pumps. The commenter indicated that all of these services are for implantation of infusion pumps and that the external cost data on the pumps are not dissimilar.

Response: We have not combined the codes in these APCs because they are not clinically homogeneous. Specifically, the services in APC 0227 are for the insertion of spinal infusion pumps and those in APC 0119 are for insertion of vascular infusion pumps. We see no clinical reason to move these codes as suggested by the commenter.

2. Treatment of Specified APCs

a. APC 0315: Level II Implantation of Neurostimulator

As stated in the August 16, 2004 proposed rule, CPT code 61866 (Implant neurostim arrays) was brought to our attention by means of an application for a new device category for transitional pass-through payment for the Kinetra® neurostimulator, a dual channel neurostimulator currently approved and used for Parkinson's disease. We denied approval for a new device category for the Kinetra® neurostimulator because the device is described by a previously

existing category, C1767 (Generator, neurostimulator (implantable)).

The manufacturer of Kinetra® stated that the AMA created CPT 61886 to accommodate implantation of the Kinetra® neurostimulator and that no services other than implantation of the Kinetra® are currently described by that CPT code. Even though the Kinetra® did not receive full FDA pre-market approval until December 2003, hospital outpatient claims were reported in CYs 2002 and 2003 (289 total claims in CY 2003) for this device. The manufacturer asserted that these claims must have been miscoded because the Kinetra® could not have been used in performing CPT code 61886 before obtaining FDA approval in December 2003. Therefore, the manufacturer did not believe that the device cost could be included in the median for CPT code 61886, which has been assigned to APC 0222.

In examining the CY 2003 claims for CPT code 61866, we noted that many of the claims also contained codes for procedures related to treatment with cranial nerve stimulators, including the placement of electrodes for cranial nerve stimulation. The placement of the cranial neurostimulator electrodes used with the Kinetra® is currently an inpatient rather than outpatient procedure. Therefore, we would not expect patients being prepared for cranial nerve stimulation to also have a Kinetra® neurostimulator for deep brain stimulation for Parkinson's disease placed at the same time. Thus, it seems possible that the CY 2003 claims for CPT code 61886, generally, are incorrectly coded and do not include the dual chamber neurostimulator in the reported charges.

Prior to the availability of the dual channel neurostimulator Kinetra® for bilateral deep brain stimulation, it is our understanding that patients diagnosed with Parkinson's disease had two single channel neurostimulator generators implanted in the same operative session. According to the Kinetra® manufacturer, this device will now replace the insertion of two single channel neurostimulators and the cost of the Kinetra® is equivalent to the cost of two single channel neurostimulators. Given this information, we examined our CY 2003 claims data and found that 69 single claims were reported for patients with a diagnosis of Parkinson's disease and that 2 single channel neurostimulator pulse generators (CPT code 61885) were implanted on the same day. The median cost for these claims was $20,631. Other than the device costs, we believe the procedural costs for the insertion of two single channel devices or one dual channel device should be roughly comparable. Therefore, we proposed to establish a new APC 0315, Level II Implantation of Neurostimulator, for CPT code 61886, and assign it a median cost of $20,631. Because of our concern that hospitals correctly code OPPS claims for CPT code 61886, we also proposed to require device coding (C-code) for APC 0315 to improve the coding on all claims for placement of a dual channel cranial neurostimulator pulse generator or receiver, as we proposed for APC 0039, Implantation of Neurostimulator, for placement of a single channel cranial neurostimulator, discussed in section III. C. of this preamble.

Comment: We received one comment in support of our proposed median cost for APC 0315.

Response: We appreciate the commenter's support. Accordingly, we are finalizing our CY 2005 proposal to assign CPT code 61886 to APC 0315 with an assigned median cost of $20,633.70.

b. APC 0651: Complex Interstitial Radiation Application

For CY 2003, APC 0651 included CPT code 77778 (Complex interstitial radiation source application). This code was not to be used for prostate brachytherapy because we created HCPCS codes G0256 (Prostate brachytherapy with palladium sources) and G0261 (Prostate brachytherapy with iodine sources) in which we packaged the cost for placement of needles or catheters and sources into a single APC payment for each G code (67 FR 66779). When we calculated the median from all single bills for CPT code 77778 from CY 2003 data for CY 2005 OPPS, we found that 73 percent of the single bills for this APC were for prostate brachytherapy and, therefore, were miscoded. The median for APC 0651, using all single bills, including those miscoded for prostate brachytherapy, was $2,641.67. When we removed the incorrectly coded claims for prostate brachytherapy, which we believed to contain brachytherapy sources and which are paid separately for CY 2004 and will be paid separately for CY 2005, the median was $1,491.39. This is the amount that we proposed for payment for CY 2005 OPPS for APC 0651. The proposed median was considerably higher than the median cost of $589.72 for CY 2004 OPPS (from CY 2002 claims data).

We believed that this adjusted median was appropriate for APC 0651 when used for prostate brachytherapy because the service described by CPT code 77778 is only one of several components of the payment for the service in its entirety. When it is used for prostate brachytherapy, hospitals should also bill for the placement of the needles and catheters using CPT code 55859 and should also bill the brachytherapy sources separately. Hospitals will be paid for both APCs and for the cost of sources.

Section 621(b)(1) of Pub. L. 108–173 specifically provides separate payment in CY 2005 ''* * * for a device of brachytherapy, consisting of a seed or seeds (or radioactive source) * * *'' at the hospital's charge adjusted to cost. We proposed to package the cost of other services such as the needles or catheters into the payment for the brachytherapy APCs and not to pay on the same basis as the brachytherapy sources because the law does not include needles and catheters in its definition of brachytherapy sources to be paid on charges adjusted to cost.

We also recognized that APC 0651 is used for brachytherapy services other than prostate brachytherapy and that, in some of those cases, there are no other separate procedure codes for placement of the needles or catheters. In those cases, which are represented in the claims we used to calculate the proposed median (once the miscoded claims for prostate brachytherapy were excluded), we believed that the charges for CPT code 77778 may have included the placement of the needles or catheters and, therefore, the median may be somewhat overstated when used as the basis for payment for prostate brachytherapy and the other forms of brachytherapy that have procedure codes for placement of needles and catheters. Similarly, we believed that the median may be understated when used to pay for brachytherapy services for which there are no separate HCPCS codes for needle or catheter placement. We considered whether to create new G codes for the placement of catheters and needles for the brachytherapy services for which such codes do not exist, but we were concerned that doing so might create unneeded complexity and that the existing data may not support establishing medians for the new codes. We requested comments on how to address those services for which there are currently no HCPCS codes for placement of needles and catheters for brachytherapy applications.

Comment: Commenters indicated that the absence of codes for brachytherapy needle/catheter placement is problematic because hospitals are forced to use existing ''not otherwise classified'' codes that makes claims analysis difficult for ratesetting. They asked that we create three ''not otherwise classified'' HCPCS codes for the placement of needles and catheters

for application of brachytherapy sources other than prostate brachytherapy so that they can be billed and paid appropriately. Specifically, they asked (1) that CMS create a code for 1–4 needles/catheters and place it in APC 1507; (2) that CMS create a code for placment of 5–10 catheters and place it in New Technology APC 1513; and (3) that CMS create a new code for more than 10 needles/catheters and place it in New Technology APC 1522.

Response: We have not created HCPCS codes for needle/catheter placement for CY 2005 as suggested by the commenters. We do not believe that the requested new, ''not otherwise classified'' codes would be any more meaningful for OPPS ratesetting than the existing ''not otherwise classified'' codes.

As explained in the November 30, 2001 final rule (66 FR 59897), new Technology APCs are for complete procedures, not devices or drugs or biologicals, but such items may be part of the cost of the complete service. To qualify for OPPS payment under the new technology APCs, a service must meet the following criteria:

- Service must be a complete service.
- Service must not be described by an existing HCPCS code or combination of codes.
- Service could not have been adequately represented in the claims data used for the most current annual OPPS payment update.
- Service does not qualify for additional payment under pass-through payment provisions.
- Service cannot reasonably be placed in an existing APC group that is appropriate in terms of clinical characteristics and resource costs.
- Service is medically reasonable and necessary.
- Service falls within scope of Medicare benefits.

Processes and requirements for pass-through and new technology service APC applications are provided in more detail on the OPPS Web site: *http://www.cms.hhs.gov/poviders/hopps/.*

Implicit in the criteria is that there exists a meaningful description of the services for which new technology status is being requested. We do not believe the ''not otherwise classified'' codes proposed by the commenters are sufficiently specific that they could satisfy the criteria. We believe that CPT already contains sufficient ''not otherwise classified'' codes for the coding of placement of brachytherapy needles and catheters in locations of the body for which specific codes do not now exist. We are unable to specify the ''not otherwise classified'' codes that should be used because the ''not otherwise classified'' codes are generally categorized by body part or function, and, therefore, the code that would apply depends on the location in the body in which the needles and catheters are being placed. For example, placement of needles or catheters in a shoulder muscle would be coded differently from placement of needles or catheters in the pancreas.

Comment: Some commenters supported the proposed payment for APC 0651 (Complex Interstitial Radiation Source Application). They indicated that, together with separate payment for the brachytherapy sources and the placement of needles and catheters, the proposed payment would provide adequate payment for these important services.

Response: We appreciate the commenters' support. Further discussion regarding the payment for APC 0651 is provided at III.C.2.b.

Comment: One commenter indicated that there are many supplies and devices other than needles and catheters that are used in providing brachytherapy and asked that CMS develop codes for them so that they could be billed as coded items because such coding would facilitate capture of all the costs associated with performing the services.

Response: We have not created new device codes for the supplies and equipment that the commenter requested because such items are incidental to the service. We do not believe that such incidental items justify development of new device codes.

In this final rule with comment period, the median cost for APC 0651 is $1,283.44, resulting in a national unadjusted payment rate of $1,248.93. There were fewer CY 2003 final action claims for this service in the database that was constructed from the most current claims data and used to develop the weights and median costs for this final rule with comment period. Twelve hospitals whose claims had appeared in the CY 2003 claims data used to calculate the proposed weights and median costs withdrew their claims before we pulled the data for this final rule with comment period. This may have been because they realized that they had billed incorrectly and withdrew the claims to bill correctly.

Our examination of the claims data set for this final rule with comment period reveals that the claims largely appear to not include charges for brachytherapy sources. The unadjusted median cost that resulted from use of these claims is $1,283.44, a 117 percent increase over the median cost for CY 2004 for this APC. As we noted previously, the median should reflect accurately the appropriate claims for the APC. We have no reason to believe that this median is flawed. Therefore, we have used it as the basis for the CY 2005 OPPS unadjusted payment rate of $1,248.93.

c. APC 0659: Hyperbaric Oxygen Therapy

In the August 16, 2004 proposed rule, we stated that over the past year, we have received a number of questions about billing and payment for HCPCS code C1300 (Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval). In light of these issues, we carefully examined the CY 2003 single procedure claims data that we proposed to use to calculate the CY 2005 median for APC services. Based on our examination of single procedure claims filed for HCPCS code C1300 in CY 2003, we believe that the claims for these services were either miscoded or the therapy was aborted before its completion. The claims that we examined reflected a pattern that is inconsistent with the clinical delivery of this service. Hyperbaric oxygen therapy (HBOT) is prescribed for clinical conditions such as promoting the healing of chronic wounds. It is typically prescribed on average for 90 minutes and, therefore, you would expect hospitals to bill multiple units of HBOT to achieve full body hyperbaric oxygen therapy. In addition to the therapeutic time spent at full hyperbaric oxygen pressure, treatment involves additional time for achieving full pressure (descent), providing air breaks to prevent neurological and other complications from occurring during the course of treatment, and returning the patient to atmospheric pressure (ascent). Our examination of the claims data revealed that providers who billed multiple units of C1300 reported a consistent charge for each ''30 minute'' unit. Conversely, providers who billed only a single unit of C1300, suggesting either a miscoded or aborted service, reported a charge that was 3 to 4 times greater than the per ''30 minute'' unit reported by providers billing multiple units of HCPCS code C1300. While it appears that many of the single procedure HBOT claims that we examined represented billing for a full 90 to 120 minutes of HBOT (including ascent, descent, and air break time), they were improperly billed as 1 unit rather than as 3 or 4 units of HBOT. Consequently, this type of incorrect coding would result in an inappropriately high per 30 minute median cost for HBOT or a median cost

for HBOT of $177.96 derived using single service claims and ''pseudo'' single service claims. This is a significant issue because HBOT is the only procedure assigned to APC 0659.

Our initial analysis of the HBOT claims data further revealed that about 40 percent of all HBOT claims included packaged costs. To confirm our belief that these packaged costs were not associated with HBOT, we examined the other major payable procedures billed in conjunction with HBOT. As a result, we identified billed services such as drug administration and wound debridement that we would typically expect to have associated packaged services. We also looked at the magnitude of packaged costs in our single bills and found the majority of these costs were small, less than $30, and concentrated in revenue codes 25X, Pharmacy, and 27X, Medical/Surgical Supplies.

As a result of these coding anomalies, we proposed to calculate a ''30 minute'' median cost for APC 0659, using a total of 30,736 claims containing multiple units or multiple occurrences of HBOT, about 97 percent of all HBOT claims. Based on our finding, we proposed to exclude claims with only one unit of HBOT. We estimated costs on these claims using the respiratory therapy cost center CCR when one was available. Otherwise we used the hospital's overall CCR. Using this proposed methodology, the proposed median cost per unit of C1300 was $82.91. Based on hospitals' charges on correctly coded claims, we believe this estimate is much more accurate for 30 minutes of HBOT. Thus, we proposed a median cost for APC 0659 of $82.91 for CY 2005.

We received many public comments on this proposal.

Comment: Overall, commenters expressed concern about the proposed reduction in payment for HBOT. There also was great consistency in the comments. Almost all the commenters cited a recent research report by The Lewin Group (Lewin) that examined our methodology for calculating a payment rate for APC 0659 and offered us several alternatives for identifying a median for HBOT. In their evaluation of our proposed change for calculating a median for HBOT, The Lewin Group ultimately concluded that, while our proposed use of claims with multiple units of C1300 in lieu of the clams with a single unit of C1300 was appropriate for calculating the median cost, we used an inappropriate cost-to-charge ratio to estimate costs from charges on those multiple unit claims.

Lewin surveyed the majority of hospitals billing Medicare for HBOT, requesting specific pages from each hospital's cost report to determine where HBOT services are reported and the associated CCR. Lewin received completed responses from 120 hospitals, a 30 percent response rate. The majority of responding hospitals, 63 percent, frequently broke out the costs of hyperbaric/wound care in a subscripted cost center on their cost report. In addition, 24 percent included their costs in the respiratory therapy cost center, and the remainder included their costs in disparate cost centers including emergency room and physical therapy. For those hospitals reporting separate line-items for hyperbaric/wound care, Lewin used CMS claims data to estimate a median CCR of 0.400 as compared with the median CCR for respiratory therapy of 0.248. Lewin also sought to establish the generalizability of their sample findings by demonstrating that responding hospitals were geographically diverse and that the respiratory therapy CCR for the responding hospitals was comparable to that observed in the claims data. Finally, Lewin used their survey findings to estimate a proportional difference in CCRs between respiratory therapy and the observed, hyperbaric-related CCRs of 1.411 and, applying this adjustment to the CMS claims data, they calculated a payment rate of $118.21.

Practically all commenters offered four possible alternatives to our proposed methodology. First, commenters suggested that CMS leave HBOT reimbursement at its CY 2004 level until CMS can accurately estimate costs and charges for HBOT. Second, commenters suggested that CMS apply The Lewin Group methodology in estimating median cost. Third, commenters suggested that CMS adopt The Lewin Group's estimated median of $118.21 per 30 minutes. With regard to this specific recommendation, several commenters stated that they thought that the $118 rate was appropriate, and one commenter believed a rate of $120 or greater would be acceptable. Finally, commenters suggested that CMS default to the overall CCR of 0.47 in lieu of using the respiratory therapy CCR.

Response: We agree with the commenters that The Lewin Group analysis provides sufficient evidence that the CCR for HBOT is not reflected solely in the respiratory therapy cost center. With regard to the first recommended alternative, we do not believe it is appropriate to maintain the CY 2004 HBOT payment rate for CY 2005. We have clearly demonstrated that the single procedure claims are inappropriate for calculating a median cost, and the submitted research did not dispute our median calculation methodology. We cannot undertake the recommended second alternative and replicate The Lewin Group's methodology because the hyperbaric/wound care cost report cost center line-items are neither standard nor non-standard cost centers. We presume that these line-items for hyperbaric/wound care are subscripted cost centers that are ultimately rolled-up in to a standard cost center on the electronic cost report data. Without the specific subscripted information, we cannot calculate a cost-to-charge ratio specific to HBOT.

We also do not believe it is appropriate to adopt the $118.21 estimate made by Lewin using its survey results and our data, the third recommended alternative. The Lewin survey indicates diversity among hospitals in the subscripted location of reported hyperbaric oxygen costs on the cost report. In addition, the $118.21 is based on an adjustment to the CCR that assumes all nonresponding hospitals report their costs in the hospital-specific hyperbaric oxygen-related cost centers, even though roughly one-fourth of hospitals in the Lewin sample were demonstrated to report costs in the respiratory therapy cost center and 13 percent reported costs in other cost centers. The submitted research further indicates fairly substantial variation in the CCRs for the responding hospitals in the HBOT-related cost centers. In light of this, we agree to adopt the last recommended alternative, which is to calculate the median using the overall CCR. As several commenters noted, defaulting to the hospital's overall CCR is standard OPPS policy when an appropriate cost center cannot be assigned to a revenue code. We estimate an overall, hospital-weighted, median CCR for all hospitals of 0.33 and a hospital-weighted, median CCR for respiratory therapy for all hospitals of 0.27. Using the overall CCR to estimate costs from charges associated with HCPCS code C1300, we calculated a median cost of $93.26 using 38,505 claims in the final rule data. We used this median to set the final CY 2005 payment for APC 0659.

Comment: One commenter conducted an internal study of 11 member hospitals and reported a median total cost of $126.42. The study findings acknowledged that we found billing anomalies in the claims with single units, but noted that our proposed approach will have unintended financial consequences. The commenter requested that we review our claims data to ensure HBOT rates that reflect the full cost of providing HBOT services.

Response: As discussed above, we agree that the proposed cost for HBOT was too low because it relied solely on the respiratory therapy CCR. However, based on the volume and consistency of claims for HBOT, we still believe that the claims data are correct. As already discussed, we will base payment for HBOT on a median calculated using the overall hospital CCR. Further, the purpose of OPPS is not to pay the full cost of a service for any given hospital, but rather to proportionally redistribute total OPPS dollars in a manner that reflects relative resource use. APC payment rates are based on the median cost of a group of services, or in this case, one service, to achieve the averaging effect of a prospective payment system and are not intended to reimburse the full cost to a specific hospital. The costs for these 11 member hospitals may fall above the median cost for all hospitals billing HBOT.

Comment: One commenter reviewed CMS claims with multiple units and found an overall average of 15 units of HBOT per claim. This commenter recommended that CMS review a sample of medical records.

Response: We expect that this finding is the result of outlier claims and unit coding errors. In our analyses of HBOT claims for the proposed rule, we found that the vast majority of claims, 93 percent, were for 3 to 5 units of service. Further, The Lewin Group analysis reviewed above did not dispute the appropriateness of using claims with multiple units for calculating a median cost. As discussed above, we believe that the appropriate concern in estimating a median cost for HBOT is the disparity in charging and cost reporting practices among hospitals and not with the claims themselves, a finding that mitigates the need for medical record review.

Comment: One commenter recommended that CMS continue to compile claims data on HBOT and refer this issue to the APC Panel before making changes.

Response: By using claims with multiple units, we believe that we have ample claims data. However, the APC Panel is an official public forum designed to consider and advise us on APC-related issues. If this is a particular concern to the public, the public is invited to present this concern at the next APC Panel meeting.

After carefully reviewing all comments received, we are basing payment for HBOT on a median calculated using the overall hospital CCR rather than the respiratory therapy CCR as proposed. As discussed above, using the overall CCR to estimate costs from charges associated with HCPCS code C1300, we calculated a final CY 2005 payment for APC 0659 of $90.75.

3. Other APC Median Cost Issues

a. APC 0312 Radioelement Applications

Comment: Some commenters stated that the payment rate for APC 0312 (Radioelement Applications) is inadequate to pay for the staff, supplies and appliances that are needed to furnish the service. The commenters further stated that the APC payment should be similar to that for APC 0651.

Response: The median for APC 0312 has increased significantly from the CY 2004 payment median of $199.90 to the CY 2005 OPPS final rule with comment period median of $326.65. Moreover, we were able to use 28 percent of the total claims in CY 2003 for this APC to set the median cost for the CY 2005 OPPS. Therefore, we see no reason to adjust the median for this APC to the level of APC 0651.

b. Percutaneous Radiofrequency Ablation of Liver Tumors

Comment: Some commenters objected to the proposal to move CPT code 47382 (Percutaneous radiofrequency of liver tumors), from a New Technology APC to clinical APC 0423 (Level II Percutaneous Abdominal and Biliary Procedures) because they believe that there is an inadequate number of claims on which to base median costs, and that median costs are inappropriately low because device costs associated with performing this procedure are underreported. They indicated that the proposed reimbursement does not cover the costs of the single use catheters used in performing the service. The commenters stated that revenue codes should be used to screen for appropriately coded claims. They contended that if CMS cannot complete this analysis for this final rule with comment period, CMS should retain CPT code 47382 in a new technology APC at the CY 2004 payment rate until more representative cost data are available. They argued that this latter approach is consistent with how CMS has handled APC payments for PET services since CY 2001. The commenters also recommended that CPT codes 76362 (CT guidance for and monitoring of visceral tissue ablation), 76394 (Magnetic resonance imaging for and monitoring of visceral tissue ablation), and 76940 (Ultrasound guidance for and monitoring of visceral tissue ablation) be added to the bypass list so that more single bills could be used to set the median for CPT code 47382.

Response: We believe that the claims volume is sufficiently adequate to remove CPT code 47382 from New Technology APC 1557 and place it in a clinical APC. Moreover, the median cost, $1,801.84, derived from the CY 2003 claims data for APC 0423, is very close to the payment that was made for New Technology APC 1557 of $1,850. Therefore, as proposed, this service will be placed in clinical APC 0423 and paid based on its historic claims data for services furnished for the CY 2005 OPPS.

In addition, the three CPT codes that the commenter recommended we add to the bypass list do not meet the CY 2005 criteria for inclusion on the list. However, we will consider their inclusion when we next review items for inclusion in CY 2006.

c. Heparin Coated Stents

Comment: One commenter objected to CMS' policy that heparin coated stents should be coded under C1874 (Stent, coated/cov w/del sys) because the commenter believes that to do so will adversely affect the median cost of the stents. The commenter urged us to create a unique C-code if HCPCS codes G0290 and G0291, which are used for placement of drug eluting stents, are retired.

Response: HCPCS codes G0290 and G0291 will remain active codes for CY 2005 and we see no reason to create another C-code at this time. We will determine whether there is a need for another C-code to differentiate between stents if and when HCPCS codes G0290 and G0291 are retired.

d. Aqueous Drainage Assist Device

Comment: One commenter asked that CMS ensure that the costs of code C1783 (Aqueous drainage assist device) are packaged with the costs of the procedures with which the device is most commonly billed. The commenter stated that codes C1783, L8610 and L8612 would usually be billed with procedures that are in APC 0673.

Response: We package the costs of devices that are billed on the same claim with the procedural APCs into the cost of the procedural APC. Thus, the extent to which the costs of these devices are packaged into the median cost for the procedure depends upon the extent to which the hospitals include the charges for the devices on the claim, with or without including the code for the device. To the extent that hospitals included charges for these devices on the claims for the procedures in which they were used, those charges would be converted to costs and packaged into the median cost for the procedure.

4. Required Use of C-Codes for Devices

An important ancillary issue in regard to using hospital outpatient claims data to calculate median costs for a device-dependent APC is whether to require that hospitals bill the HCPCS codes for the devices that are required for use in the provision of the services in these APCs. We deleted HCPCS codes for devices in CY 2003 because hospitals objected to the complexity of this coding, and we believed that hospitals would charge for the devices in appropriate revenue codes. Our review of the claims data does not support this belief. Hospitals do not appear to routinely include the charges for the devices they use when they bill for all of the related services in the device-dependent APCs. Therefore, as discussed in the August 16, 2004 proposed rule, we proposed requiring hospitals to code devices for APCs to improve the quality of the claims data in support of our transition to the use of all single claims to establish payment rates for those APCs. We made this proposal cautiously, as we realize that it imposes a burden on hospitals to code the devices.

For the CY 2005 OPPS, we proposed to require coding of devices required for APCs for which we proposed to adjust the median costs for the CY 2005 OPPS. The APCs and the devices that were proposed for device coding were published in Table 20 of the August 16, 2004 proposed rule (69 FR 50497 through 50499). Specifically, if one device is shown for one APC, that device would have to be billed on the claim for a service in that APC or the claim would be returned to the provider for correction. If more than one device is shown for one APC, the provider would be required to bill one of the device codes shown on the same claim with the service in that APC for the claim to be accepted.

We also proposed to require coding of C1900 (Left ventricular lead) required to perform the service described in APC 0418, Left Ventricular Lead, because the service cannot be done without the lead, and because the device has been billed separately for pass-through payment in CYs 2003 and 2004. We believe that continued coding of the device would not impose a burden on hospitals. Similarly, because of our concerns regarding the correct coding of claims for CPT code 61886 (Implant neurostim arrays), assigned to APC 0315 (discussed in greater detail in section III.C.2.a. of this preamble), we proposed to require device coding for APC 0315 (Level II Implantation of Neurostimulator) to improve the coding on claims for placement of a dual channel cranial neurostimulator pulse generator or receiver, just as we proposed to require device coding for APC 0039 (Implantation of Neurostimulator) for placement of a single channel cranial neurostimulator as noted below.

We solicited comments on the proposed C-code requirements.

In addition, we announced in the proposed rule that we are considering expanding the device coding requirements in the future. We believed that, by requiring device coding for a small subset of device-dependent APCs each year, we would minimize the marginal annual coding burden on hospitals and begin to improve data for these APCs, which have consistently proven to be problematic. We believed coding of devices was essential if we were to improve the accuracy of claims data sufficiently to better calculate the correct relative costs of device-dependent APCs in relation to the other services paid under the OPPS.

We asked that the public inform us of the device codes that are essential to the procedures contained in the device-dependent APCs listed in Table 20 of the proposed rule. The alphanumeric HCPCS codes for devices that were reactivated for CY 2004 OPPS can be found on the CMS Web site at *http://www.cms.hhs.gov/providers* under coding. They are in the section of alphanumeric codes that begin with the initial letter ''C.''

We received a number of comments regarding our request.

Comment: In general, commenters supported a requirement for mandatory device coding for all devices, not only those for which CMS proposed mandatory reporting. However, they had different views regarding what the requirement should contain and how it should be enforced. Some commenters asked that we require that all procedures for device-dependent APCs contain a C-code to identify the device used in the procedure. They indicated that they believed that this requirement is crucial to acquiring valid cost data for these services. Some commenters were concerned about the administrative burden that required C-coding imposes on hospitals and urged CMS to reassess the burden within 2 years if it imposes mandatory C-coding for devices. Other commenters urged CMS to implement a grace period of no less than 90 days after implementation of the CY 2005 OPPS to enable hospitals to be sure that they are prepared for device code edits. During this period, the commenters wanted intermediaries to accept the codes and not return incorrectly coded claims. The commenters indicated that the edits should be included in this final rule with comment period so that hospitals can begin to work on them as soon as possible. Those commenters suggested that the device codes for which edits will not be implemented in CY 2005 should not be required until CY 2006. The commenters indicated that both OCE and intermediary systems must be ready to handle this change, and that no edits should be implemented if they are not and if providers have not had at least 30 days notice. Some commenters urged CMS to base any edits or list of required device codes on CPT codes, not APCs, because in some cases, not all codes in an APC require the same device. One commenter objected to the use of edits to return to providers claims that contain a procedure code that cannot be done without a device but which contain no device code. The commenter indicated that CMS has been inconsistent in its policies governing coding of devices since the inception of the OPPS and should provide some greater period of stability in coding before it edits for the presence of the device codes.

Response: We appreciate the comments, but continue to believe coding of devices is vital to enhancing the device-dependent APC claims data. Therefore, as proposed, effective for services provided on or after January 1, 2005, we will require hospitals to include device category codes on claims when such devices are used in conjunction with procedures billed and paid for under the OPPS. While we are requiring use of these device codes for reporting all such devices effective January 1, 2005, we will not implement the edits contained in Table 19 until April 1, 2005, to provide time for further review and for hospitals to prepare for them. The edits will not apply to claims that contain a procedure code reported with a modifier 73 or 74 to signify an interrupted procedure because we recognize that in those cases, the procedure might have been interrupted before the device was implanted.

We will apply the edits at the CPT/HCPCS code level to be as precise as possible. Table 19 includes the edits that we expect to go into effect April 1, 2005. The table of edits and the definitions of the C-codes (Table 20 of this preamble) will be posted on the CMS Web site on the OPPS page. As noted on Table 19, there are some CPT codes for which edits cannot be established, for example, because of the optional nature of the use of a device when performing the service. Although there is no official comment period

associated with implementation of the edits, we welcome comments on the edits to be implemented on April 1, 2005, particularly from hospitals to whose claims the edits will apply and from medical specialties whose physicians use the devices in the procedures performed in hospital outpatient settings. Comments may be sent to *OutpatientPPS@cms.hhs.gov* if possible, by December 1, 2004.

In the future, we will consider edits for additional procedure codes in other device-dependent APCs. We will post all final edits on the CMS Web site with an announcement of the calendar quarter in which we expect to implement them. We will also provide them in a Medlearn Matters article. Any future edits will be implemented as always as part of the quarterly OCE release. We intend to expand the editing of device-dependent procedure codes for appropriate device C-codes as expeditiously but also as carefully as possible. The next group of device procedures for which we will consider edits will include those procedures in APCs for which we set the median cost at 95 percent of the CY 2004 payment median but for which we did not propose edits in the August 16, 2004 proposed rule.

Comment: One commenter asked that CMS encourage manufacturers to put the applicable HCPCS device C-code on the device package and that CMS work with FDA to expedite placement of C-codes on device packages. The commenter also urged CMS to simplify the C-codes to be consistent with the information routinely reported by physicians in operative reports. The commenter gave, as an example, the seven device codes used with APC 0087 (Noncoronary Angioplasty or Atherectomy), all of which could be reported using only one code for ''transluminal catheter''. The commenter stated that such simplification would greatly improve the likelihood that the device is coded on the claim because the description that distinguishes one of the seven codes from another is typically not documented in the hospital's record and is not information the coder would know. Other commenters asked that CMS actively undertake a program designed to educate providers on how to bill for devices and how to set charges for high cost devices so that future updates to the OPPS will more accurately reflect the costs of these services. Some commenters urged CMS to create and maintain a file on the CMS Web site that contains a complete crosswalk of devices codes to CPT codes in the device APCs. Some commenters asked that CMS provide a detailed revenue code to device code crosswalk so that hospitals will promote more uniformity in billing for devices.

Response: We will carefully examine how we can facilitate correct coding of devices, including possible communication with the FDA. We will also consider the extent to which we can simplify the HCPCS codes for devices to facilitate straightforward coding. Finally, we will determine the extent to which we can improve provider education regarding correct coding for devices. However, we will not undertake any activity designed to advise hospitals on how to set charges for their services or to designate what revenue codes hospitals should use on a device-specific basis.

The edits that we created to ensure the coding of devices for the selected APCs that are listed in Table 19 of this preamble are also available as an Excel file in the supporting documentation of this final rule with comment period that will be posted on the CMS Web site and will also be contained in the transmittals for the January 2005 OPPS update and OCE release. Moreover, as described above, we will post any added edits for device coding on the OPPS page of the CMS Web site so that providers can have ready access to them.

Comment: Some commenters asked that we add particular device and procedure combinations to the table of edits. Specifically, a commenter asked that we add APC 0259 (Cochlear Implant Surgery) as paired with device code L8614 (Cochlear implant), and APC 0040 paired with both device codes C1778 (Lead neurostimulator) and C1883 (Adapter/extension packing lead or neurostimulator lead). Another commenter asked that we add code C1787 (Patient programmer, neurostimulator) to the required devices for APC 0222. Another commenter asked that the same device codes be required for the CPT codes in APC 0087 as we proposed to require for APC 0085 because the commenter believes that the same devices are used in both APCs. Other commenters asked that we include edits for other APCs, for example, APC 0385 (Level I Prosthetic Urological Procedures) and APC 0386 (Level I Prosthetic Urological Procedures).

Response: Except as discussed below, we have not added any APCs to the list that we proposed be edited for device codes at this time. Although our policy to require hospitals to code all devices is effective January 1, 2005, we will not implement edits until April 1, 2005. We will consider the comments regarding additional edits for later implementation. We believe that it is preferable to focus first on the APCs most affected and to add subsequent edits after careful deliberation. In this manner we can minimize the potential for adverse effects on claims processing and hospitals' cash flow.

However, we have added one CPT code to the list of codes that will be edited for device codes. We inadvertently omitted a proposed edit for CPT code 33225 (Left ventricular pacing lead add-on), which we proposed to place in New technology APC 1525. This procedure uses the device code C1900 (Left ventricular lead), whose pass-through status expires in January 2005. We proposed that when the lead is implanted as a stand-alone procedure using CPT code 33224 (Insert pacing lead and connect), we would edit for the presence of the device code for the lead on the claim. However, we believe that it is also appropriate to edit for the presence of the lead on a claim for the add-on code, CPT code 33225, and that it should pose no additional burden on hospitals because hospitals have been required to bill the device code C1900 for pass-through payment since CY 2004.

Summary of provisions related to required use of C-codes for devices that we are making final beginning in CY 2005:

1. Hospitals are required to report device category codes on claims when such devices are used in conjunction with procedure(s) billed and paid for under the OPPS in order to improve the claims data used annually to update the OPPS payment rates.

2. Beginning April 1, 2005, the OCE will include edits to ensure that certain procedure codes are accompanied by an associated device category code.

3. CMS will post the OCE edits that are to be implemented beginning April 1, 2005 on the CMS Web site to give hospitals and the provider community ample opportunity to review them and provide feedback prior to implementation.

4. Edits will apply at the CPT/HCPCS code level rather than the APC level.

5. Edits will not apply when a procedure code is reported with a modifier −73 or −74 to designate an incomplete procedure.

6. CMS will add edits as needed in future quarterly updates of the OCE to ensure that hospitals are reporting device category codes appropriately with associated procedure codes. CMS will post future device category and procedure code edits on the CMS Web site to give hospitals and the provider

community ample opportunity for input prior to implementation.

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Table 19.—Device Codes Required for Select Device-Dependent APCs

HCPCS	SI	Short Description	APC	Allowed Device Codes
36557	T	Insert tunneled cv cath	0032	C1751
36558	T	Insert tunneled cv cath	0032	C1751
36570	T	Insert tunneled cv cath	0032	C1751 C1788
36571	T	Insert tunneled cv cath	0032	C1751 C1788
36581	T	Replace tunneled cv cath	0032	C1751
36585	T	Replace tunneled cv cath	0032	C1751 C1788
36640	T	Insertion catheter, artery	0032	C1751
61885	S	Implant neurostim one array	0039	C1767
35458	T	Repair arterial blockage	0081	C1885 C1725
35459	T	Repair arterial blockage	0081	C1885 C1725
35460	T	Repair venous blockage	0081	C1885 C1725
35470	T	Repair arterial blockage	0081	C1885 C1725
35471	T	Repair arterial blockage	0081	C1885 C1725
35472	T	Repair arterial blockage	0081	C1885 C1725
35473	T	Repair arterial blockage	0081	C1885 C1725
35474	T	Repair arterial blockage	0081	C1885 C1725
35475	T	Repair arterial blockage	0081	C1885 C1725
35476	T	Repair venous blockage	0081	C1885 C1725

HCPCS	SI	Short Description	APC	Allowed Device Codes
35484	T	Atherectomy, open	0081	C1714 C1724
35485	T	Atherectomy, open	0081	C1714 C1724
35490	T	Atherectomy, percutaneous	0081	C1714 C1724
35491	T	Atherectomy, percutaneous	0081	C1714 C1724
35492	T	Atherectomy, percutaneous	0081	C1714 C1724
35493	T	Atherectomy, percutaneous	0081	C1714 C1724
35494	T	Atherectomy, percutaneous	0081	C1714 C1724
35495	T	Atherectomy, percutaneous	0081	C1714 C1724
61626	T	Transcath occlusion, non-cns	0081	C2628 C1887
92997	T	Pul art balloon repr, percut	0081	C1885 C1725
92998	T	Pul art balloon repr, percut	0081	C1885 C1725
92995	T	Coronary atherectomy	0082	C1714 C1724
92996	T	Coronary atherectomy add-on	0082	C1714 C1724
92982	T	Coronary artery dilation	0083	C1725 C1885
92984	T	Coronary artery dilation	0083	C1725 C1885
92986	T	Revision of aortic valve	0083	No edit; no suitable device code
92987	T	Revision of mitral valve	0083	No edit; no suitable device code
92990	T	Revision of pulmonary valve	0083	No edit; no suitable device code
93600	T	Bundle of His recording	0087	C1730 C1731 C1733 C1766 C1892 C1893 C1732 C1894

HCPCS	SI	Short Description	APC	Allowed Device Codes
93602	T	Intra-atrial recording	0087	C1730 C1731 C1733 C1766 C1892 C1893 C1732 C1894
93603	T	Right ventricular recording	0087	C1730 C1731 C1733 C1766 C1892 C1893 C1732 C1894
93609	T	Map tachycardia, add-on	0087	C1730 C1731 C1733
93610	T	Intra-atrial pacing	0087	C1730 C1731 C1733 C1766 C1892 C1893 C1732 C1894
93612	T	Intraventricular pacing	0087	C1730 C1731 C1733 C1766 C1892 C1893 C1732 C1894
93613	T	Electrophys map 3d, add-on	0087	C1732
93615	T	Esophageal recording	0087	C1730 C1731 C1733 C1766 C1892 C1893 C1732 C1894
93616	T	Esophageal recording	0087	C1730 C1731 C1733 C1766 C1892 C1893 C1732 C1894

HCPCS	SI	Short Description	APC	Allowed Device Codes
93618	T	Heart rhythm pacing	0087	C1730 C1731 C1733 C1766 C1892 C1893 C1732 C1894
93623	T	Stimulation, pacing heart	0087	C1730 C1731 C1733 C1766 C1892 C1893 C1732 C1894
93631	T	Heart pacing, mapping	0087	C1730 C1731 C1733 C1766 C1892 C1893 C1732 C1894
33212	T	Insertion of pulse generator	0090	C1786 C2620
33210	T	Insertion of heart electrode	0106	No edit; no device code for some procedure options
33211	T	Insertion of heart electrode	0106	C1779
33216	T	Revise eltrd pacing-defib	0106	C1779 C1777 C1895 C1896 C1899
33217	T	Insert lead pace-defib, dual	0106	C1779 C1777 C1895 C1896 C1899
33218	T	Repair lead pace-defib, one	0106	No edit; code is for repair only
33220	T	Repair lead pace-defib, dual	0106	No edit; code is for repair only
G0297	T	Insert single chamber/cd	0107	C1722 C1882
G0298	T	Insert dual chamber/cd	0107	C1721 C1882
G0299	T	Inser/repos single icd+leads	0108	C1722 C1882

HCPCS	SI	Short Description	APC	Allowed Device Codes
G0300	T	Insert reposit lead dual+gen	0108	C1721 C1882
36260	T	Insertion of infusion pump	0119	C1772 C1891 C2626
36563	T	Insert tunneled cv cath	0119	C1772 C1891 C2626
36583	T	Replace tunneled cv cath	0119	C1772 C1891 C2626
63685	T	Implant neuroreceiver	0222	C1767
64590	T	Implant neuroreceiver	0222	C1767
61886	T	Implant neurostim arrays	0315	C1767
43219	T	Esophagus endoscopy	0384	No edit; no device code for some procedure options
43256	T	Uppr gi endoscopy w stent	0384	C2617 C2625 C1874 C1875 C1876 C1877
43268	T	Endo cholangiopancreatograph	0384	No edit; no device code for some procedure options
43269	T	Endo cholangiopancreatograph	0384	No edit; device optional
44370	T	Small bowel endoscopy/stent	0384	C2617 C2625 C1874 C1875 C1876 C1877
44379	T	S bowel endoscope w/stent	0384	C2617 C2625 C1874 C1875 C1876 C1877
44383	T	Ileoscopy w/stent	0384	C2617 C2625 C1874 C1875 C1876 C1877

HCPCS	SI	Short Description	APC	Allowed Device Codes
44397	T	Colonoscopy w/stent	0384	C2617 C2625 C1874 C1875 C1876 C1877
45327	T	Proctosigmoidoscopy w/stent	0384	C2617 C2625 C1874 C1875 C1876 C1877
45345	T	Sigmoidoscopy w/stent	0384	C2617 C2625 C1874 C1875 C1876 C1877
45387	T	Colonoscopy w/stent	0384	C2617 C2625 C1874 C1875 C1876 C1877
33224	T	Insert pacing lead & connect	0418	C1900
55873	T	Cryoablate prostate	0674	C2618
33225	S	L ventricular pacing lead add-on	1525	C1900

Table 20.—Device Code Descriptors for Select Device-Dependent APCs

Device code	Descriptor
C1714	Catheter, transluminal atherectomy, directional
C1721	Cardioverter-defibrillator, dual chamber (implantable)
C1722	Cardioverter-defibrillator, single chamber (implantable)
C1724	Catheter, transluminal atherectomy, rotational
C1725	Catheter, transluminal angioplasty, non-laser (may include guidance, infusion/perfusion capability)
C1730	Catheter, electrophysiology, diagnostic, other than 3d mapping (19 or fewer electrodes)
C1731	Catheter, electrophysiology, diagnostic, other than 3d mapping (20 or more electrodes)
C1732	Catheter, electrophysiology, diagnostic/ablation, 3d or vector mapping
C1733	Catheter, electrophysiology, diagnostic/ablation, other than 3d or vector mapping, other than cool-tip
C1751	Catheter, infusion, inserted peripherally, centrally or midline (other than hemodialysis)
C1766	Introducer/sheath, guiding, intracardiac electrophysiological, steerable, other than peel-away
C1767	Generator, neurostimulator (implantable)
C1772	Infusion pump, programmable (implantable)
C1777	Lead, cardioverter-defibrillator, endocardial single coil (implantable)
C1779	Lead, pacemaker, transvenous vdd single pass
C1786	Pacemaker, single chamber, rate-responsive (implantable)
C1788	Port, indwelling (implantable)
C1874	Stent, coated/covered, with delivery system
C1875	Stent, coated/covered, without delivery system
C1876	Stent, non-coated/non-covered, with delivery system
C1877	Stent, non-coated/non-covered, without delivery system
C1882	Cardioverter-defibrillator, other than single or dual chamber (implantable)
C1885	Catheter, transluminal angioplasty, laser
C1887	Catheter, guiding (may include infusion/perfusion capability)
C1891	Infusion pump, non-programmable, permanent (implantable)
C1892	Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, peel-away
C1893	Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, other than peel-away
C1895	Lead, cardioverter-defibrillator, endocardial dual coil (implantable)
C1896	Lead, cardioverter-defibrillator, other than endocardial single or dual coil (implantable)
C1899	Lead, pacemaker/cardioverter-defibrillator combination (implantable)
C1900	Lead, left ventricular coronary venous system
C2617	Stent, non-coronary, temporary, without delivery system
C2618	Probe, cryoablation
C2620	Pacemaker, single chamber, non rate-responsive (implantabe)
C2625	Stent, non-coronary, temporary, with delivery system
C2626	Infusion pump, non-programmable, temporary (implantable)
C2628	Catheter, occlusion

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5. Submission of External Data

In the August 16, 2004 proposed rule, we stated that we would consider external data submitted with respect to any APC to the extent that such data enable us to verify or adjust claims data where we are convinced that such an adjustment to the median cost is appropriate. Further, we stated that all comments and any data we use would be available for public inspection and commenters should not expect that any data furnished as part of the comment

would be withheld from public inspection. We also stated that parties who submit external data for devices should also submit a strategy that can be used to determine what part of the median cost represents the device to which the external data applies. We stated in the proposed rule that external data that are likely to be of optimal use should meet the following criteria:

- Represent a diverse group of hospitals both by location (for example, rural and urban) and by type (for example, community and teaching). We preferred that commenters identify each hospital, including location with city and State, nonprofit vs. for profit status, teaching vs. nonteaching status, and the percent of Medicare vs. non-Medicare patients receiving the service. A pseudo identifier could be used for the hospital identification. Data should be submitted both ''per hospital'' and in the aggregate.
- Identify the number of devices billed to Medicare by each hospital as well as any rebates or reductions for bulk purchase or similar discounts and identify the characteristics of providers to which any such price rebates or reductions apply.
- Identify all HCPCS codes with which each item would be used.
- Identify the source of the data.
- Include both the charges and costs for each hospital for CY 2003.

Meeting the criteria would help enable us to compare our CY 2003 claims data to the submitted external data and help us determine whether the submitted data are representative of hospitals that submit claims under the OPPS.

We noted in the proposed rule that information containing beneficiary-specific information (for example, medical records, and invoices with beneficiary identification on it) must be altered, if necessary, to remove any individually identifiable information, such as information that identifies an individual, diagnoses, addresses, telephone numbers, attending physician, medical record number, and Medicare or other insurance number. Moreover, individually identifiable beneficiary medical records, including progress notes, medical orders, test results, and consultation reports must not be submitted to us. Similarly, photocopies of checks from hospitals or other documents that contain bank routing numbers must not be submitted to us.

We received a number of public comments concerning the submission of external data.

Comment: Some commenters supported use of claims data and strongly opposed use of data from external sources to set the OPPS payment rates. They believed that claims data more accurately reflects the costs hospitals incur to provide outpatient services. They strongly opposed use of external data because they believe that item specific adjustments will make OPPS unduly complex and result in unfair imbalances in payments. They believed that CMS should remain committed to the principles of prospective payment and the use of the averaging process rather than seeking to pay actual cost for one element of costs (for example, new technology) at the expense of all other items, which would result after application of mandated budget neutrality adjustments. Conversely, other commenters indicated that CMS should rely on external data in lieu of claims data for procedures that require high cost devices because the CMS methodology of applying a cost-to-charge ratio to charges to acquire costs will always result in costs that are below the actual acquisition cost of the device and that, barring a significant change in CMS' cost finding process, external data are the only means by which valid cost data for high cost devices can be introduced into the OPPS. Some commenters provided external data on the devices of interest to them and some provided specific amounts calculated using external data, which they asked that we substitute for claims data in setting the weight for the APC of interest to them.

Response: We have not applied numbers from external data in our adjustments of median costs for the CY 2005 OPPS. While recognizing that external data aids in our general analysis of determining payment rates, we believe that generally such use of external data is not the optimal way to set payment rates for services in a relative weight system. As we discussed in section III.C.5. of this preamble, we believe that using external data has a significant potential for creating an unfair imbalance in a prospective payment system. However, we appreciate the efforts of some commenters in providing us with external data.

Comment: Some commenters urged us to use external data in the construction of APC rates and urged us to use confidential data for this purpose. Some commenters are concerned about the criteria CMS proposed for external data and urged us to expand the use of confidential external data to calculate future payment rates whenever such data are indicated and proven reliable based on the data's merits. The commenter did not suggest criteria for determining if confidential proprietary external data are reliable.

Response: As we indicated in the August 16, 2004 proposed rule, all information sent in response to comments will be made available to the public for review. We believe that all parties who are affected by the payment rates set under this system should have access to the information on which the rates are set.

Comment: One commenter indicated that CMS should use external data for all device APCs in which the device cost exceeds 5 percent of the total APC cost because to do otherwise would unfairly benefit some categories of services compared to other categories of services.

Response: We have not used external data to adjust any medians for the CY2005 OPPS. As discussed above, we applied the same adjustment rules to all device medians.

After carefully reviewing all public comments received, we have decided not to use any external data to adjust the median costs for the CY 2005 OPPS for the reasons discussed above.

D. Calculation of Scaled OPPS Payment Weights

Using the median APC costs discussed previously, we calculated the relative payment weights for each APC for CY 2005 shown in Addenda A and B to this final rule with comment period. As in prior years, we scaled all the relative payment weights to APC 0601 (Mid-Level Clinic Visit) because it is one of the most frequently performed services in the hospital outpatient setting. We assigned APC 0601 a relative payment weight of 1.00 and divided the median cost for each APC by the median cost for APC 0601 to derive the relative payment weight for each APC. Using CY 2003 data, the median cost for APC 0601 is $57.32 for CY 2005.

Section 1833(t)(9)(B) of the Act requires that APC reclassification and recalibration changes, wage index changes, and other adjustments be made in a manner that assures that aggregate payments under the OPPS for CY 2005 are neither greater than nor less than the aggregate payments that would have been made without the changes. To comply with this requirement concerning the APC changes, we compared aggregate payments using the CY 2004 relative weights to aggregate payments using the CY 2005 proposed relative weights. Based on this comparison, we proposed to make an adjustment to the weights for purposes of budget neutrality. The unscaled weights were adjusted by 0.984667135 for budget neutrality. The CY 2005

relative weights, which incorporate the recalibration adjustments explained in this section, are listed in Addendum A and Addendum B to this final rule with comment period.

Section 1833(t)(14)(H) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, states that ''Additional expenditures resulting from this paragraph shall not be taken into account in establishing the conversion factor, weighting and other adjustment factors for 2004 and 2005 under paragraph (9) but shall be taken into account for subsequent years.'' Section 1833(t)(14) provides the payment rates for certain specified covered outpatient drugs. Therefore, the incremental cost of those specified covered outpatient drugs (as discussed in section II.J. of this final rule with comment period) is excluded from the budget neutrality calculations but the base median cost of the drugs continues to be a factor in the calculation of budget neutrality. Accordingly, we calculated median costs for the specified covered outpatient drugs to which this section applies and used those medians and the frequencies in the calculation of the scaler for budget neutrality.

Under section 1833(t)(16)(C) of the Act, as added by section 621(b)(1) of Pub. L. 108–173, payment for devices of brachytherapy consisting of a seed or seeds (or radioactive source) is to be made at charges adjusted to cost for services furnished on or after January 1, 2004 and before January 1, 2006. As we stated in our January 6, 2004 interim final rule, charges for the brachytherapy sources will not be used in determining outlier payments and payments for these items will be excluded from budget neutrality calculations, consistent with our practice under the OPPS for items paid at cost. (We provide a discussion of brachytherapy payment issues at section VII.G. of this final rule with comment period.)

IV. Payment Changes for Devices

A. Pass-Through Payments for Devices

1. Expiration of Transitional Pass-Through Payments for Certain Devices

Section 1833(t)(6)(B)(iii) of the Act requires that, under the OPPS, a category of devices be eligible for transitional pass-through payments for at least 2, but not more than 3 years. This period begins with the first date on which a transitional pass-through payment is made for any medical device that is described by the category. In our November 7, 2003 final rule with comment period (68 FR 63437), we specified six device categories currently in effect that would cease to be eligible for pass-through payment effective January 1, 2005.

The device category codes became effective April 1, 2001, under the provisions of the BIPA. Prior to pass-through device categories, we paid for pass-through devices under the OPPS on a brand-specific basis. All of the initial category codes that were established as of April 1, 2001, have expired; 95 categories expired after CY 2002 and 2 categories expired after CY 2003. All of the categories listed in Table 21, along with their expected expiration dates, were created since we published the criteria and process for creating additional device categories for pass-through payment on November 2, 2001 (66 FR 55850 through 55857). We based the expiration dates for the category codes listed in that table on the date on which a category was first eligible for pass-through payment.

There are six categories for devices that would have been eligible for pass-through payments for at least 2 years as of December 31, 2004. In our November 7, 2003 final rule with comment period, we finalized the December 31, 2004 expiration dates for these six categories. (Three other categories listed in Table 21, as proposed, C1814, C1818, and C1819, will expire on December 31, 2005.) As indicated in Table 21, as proposed, the six categories that will expire as of December 31, 2004, are: C1783, C1884, C1888, C1900, C2614, and C2632. Each category includes devices for which pass-through payment was first made under the OPPS in CY 2002 or CY 2003.

In the November 1, 2002 final rule, we established a policy for payment of devices included in pass-through categories that are due to expire (67 FR 66763). For CY 2003, we packaged the costs of the devices no longer eligible for pass-through payments into the costs of the procedures with which the devices were billed in CY 2001. There were few exceptions to this established policy (brachytherapy sources for other than prostate brachytherapy, which is now also separately paid in accordance with section 621(b)(2) of Pub. L. 108–173). For CY 2004, we continued to apply this policy for categories that expired on January 1, 2004.

2. Proposed and Final Policy for CY 2005

In the August 16, 2004 proposed rule, we proposed to continue to base the expiration date for a device category on the earliest effective date of pass-through payment status of the devices that populate the category. This basis for determining the expiration date of a device category is the same as that used in CY 2003 and CY 2004.

We also proposed that payment for the devices that populate the six categories that would cease to be eligible for pass-through payment after December 31, 2004, would be made as part of the payment for the APCs with which they are billed. This methodology for packaging device cost is consistent with the packaging methodology that we describe in section III. of this final rule with comment period. To accomplish this, we proposed to package the costs of devices that would no longer be eligible for pass-through payment in CY 2005 into the HCPCS codes with which the devices are billed.

In the proposed rule, we noted that category C1819 (Tissue localization excision device) was added subsequent to our proposed rule for CY 2004. We first announced the start date and the proposed expiration date for this device category in our November 7, 2003 final rule with comment period. Therefore, we proposed to maintain the category's December 31, 2005 expiration date. We invited specific comments on the proposed expiration date for category C1819.

We received a number of public comments on our proposals relating to the expiration dates for transition pass-through devices.

Comment: One commenter noted that C1884 (Embolization protection system) is used for carotid stenting. The commenter recommended that CMS continue paying pass-through payment for C1884 until carotid stenting APC costs are established.

Response: Carotid stenting procedures are on the inpatient list for the OPPS and, therefore, are not paid by Medicare when performed in the outpatient hospital setting. To the extent that C1884 has been used with other procedures payable under the OPPS, we packaged the costs of C1884 into the APCs that include the procedures with which this device code was billed.

Comment: One commenter objected to our proposal to remove HCPCS code C1884 from pass-through status, effective January 1, 2005. The commenter believed that the service had been unfairly subjected to the device offset because it was totally new and did not replace any existing device. The commenter claimed that, for CY 2003, code C1884 inappropriately received very little pass-through payment when the device was used. The commenter indicated that CMS subsequently recognized its error by changing the offset policy for CY 2004, the second year of the device's pass-through status,

and, therefore should give the device a third year of pass-through payment.

Response: We disagree with the commenter that we inappropriately made little pass-through payments for C1884. The commenter is correct that, for CY 2004, following notice and comment rulemaking, we changed the policy for applying offsets. As of January 1, 2004, we apply offsets, on a device-category-specific basis, when we determine that an APC contains costs associated with the device. Under the policy in effect prior to CY 2004, we applied offsets when a device category was billed with any of the APCs on our device offset list. This policy change affected all the categories in effect in CYs 2003 and 2004, including C1884. Some of these categories went into effect as of January 1, 2003; thus their pass-through status will expire after exactly 2 years. Other categories began receiving pass-through payments in the middle of 2002. Therefore, their categories will have more than 2, but less than 3 years with pass-through payment. We would not be able to extend pass-through payment for the second group of categories for an additional year, because they would then have greater than the statutory maximum of 3 years of pass-through payment.

We see no reason to adopt the commenter's suggestions to only change the status for code C1884. In CY 2003, C1884, like all our other pass-through categories, was subject to the same offset policy. Therefore, we are not changing the expiration date of device category C1884.

This device will cease to be a pass-through device effective January 1, 2005, at which time it will have had 2 years of pass-through payment.

We note that the expiration dates of C1884 and most other categories (the exception being C1819, discussed below) that were in effect at the time of our final rule for CY 2004 (68 FR 63437) were made final in that same rule, having been proposed in the proposed rule for CY 2004. We are now merely reaffirming that policy.

A few commenters supported our proposal to remove the six device categories from further pass-through payments and our proposal to package the costs of these devices into the cost of the APCs with which they are billed. The commenters indicated that incorporating these technologies into the APC system will minimize special payment incentives to use certain devices over others.

Comment: One commenter was concerned that pass-through payment for a brachytherapy-related solution (C2632, Brachytherapy solution, Iodine-125, per mCi) would expire from pass-through payment after December 31, 2004, under our proposal, and requested a third year of pass-through payment, until December 31, 2005, because pass-through payment has been made only since January 1, 2003. The commenter claimed that this category still qualifies for another year of pass-through payment.

Response: Because the brachytherapy solution in question, C2632, is a brachytherapy source separately payable under the OPPS according to section 621(b) of Pub. L. 108–173, it will continue to receive cost-based payment as of January 1, 2005, based on those statutory provisions, rather than on the pass-through payment provisions. Section VII.G. of this final rule with comment period explains those provisions and includes code C2632 for cost-based payment in CY 2005. As indicated, in regard to other comments concerning expired categories, this brachytherapy device will have had 2 years of pass-through status on January 1, 2005. Our policy is that pass-through devices are removed from pass-through status as soon as permitted under the statute. Therefore, this device will cease to be a pass-through device effective January 1, 2005, at which time it will have had 2 years of pass-through payment.

Comment: A few commenters were concerned that pass-through payment for C2614 (Probe, percutaneous lumbar diskectomy) in APC 0220 (Level I Nerve Procedures) would expire from pass-through payment after December 31, 2004, under our proposal, and requested that CMS continue to pay for this device category separately on a pass-through basis. The commenters were under the impression that the methodology used to determine whether or not a device category would continue to be eligible for payment in CY 2005 was if it showed ''that there were no close or identifiable costs associated with the devices relating to the respective APCs that are normally billed with them.''

One commenter indicated that the payment for APC 0220 is not sufficient to cover the cost of the high end disposable RF lumbar probe coded under C2614. The commenter was also concerned that this device, which is used in performing CPT code 62287 (Percutaneous diskectomy), and which costs $1,150, will cease to be eligible for pass-through payments effective January 2005. The commenter stated that the device has increased effectiveness and reduced recovery time for patients but unless CMS increases the payment for APC 0220 for which we proposed to pay $996.69, hospitals will be forced to cease using it in 2005. The commenter urged that CMS continue pass-through payment for C2614 until such time as the payment rate for APC 0220 is adequate to cover the cost of the probe.

Response: The commenters are incorrect in their understanding of our criteria for proposing to expire device categories. We proposed to expire C2614 because it has received pass-through payment for at least 2 years, which is also the basis for our proposal to expire the other five device categories listed for expiration in CY 2005 in our proposed rule. A device with no close or identifiable costs associated with the devices relating to the respective APCs that are normally billed with them is actually a factor in determining whether to apply an offset, which would reduce the pass-through payment amount, as explained in the August 16, 2004 proposed rule (69 FR 50501). As indicated, similar to other responses in regard to other comments concerning other categories due to expire, this disc decompression device will have had 2 years of pass-through status on January 1, 2005. Our policy is that pass-through devices are removed from pass-through status as soon as permitted under the statute. Therefore, this device will cease to be a pass-through device effective January 1, 2005, at which time it will have had 2 years of pass-through payment.

We have considered the commenter's concern regarding placement of code C2614, the code for a device that is used in performing CPT code 62287, in APC 0220 and find that the resource costs for CPT code 62287 may be more appropriate for APC 0221 (Level II Nerve Procedures). Therefore, we have reassigned CPT code 62287 to APC 0221, for which the CY 2005 payment rate is $1,635.87.

Comment: One commenter recommended that CMS continue to pay for C2614 as a pass-through device category until CMS determines how the procedure, percutaneous lumbar diskectomy, is coded for determination of accurate APC cost weighting.

Response: As explained previously, we packaged costs of the C-code devices into the APCs that include the procedures with which the device codes were billed. We are packaging the costs related to code C2614 in this manner.

Comment: One commenter, a device manufacturer, recommended that CMS extend the expiration date for pass-through payment of C1819 (Tissue localization excision device) until December 31, 2006, instead of ending pass-through payment after CY 2005. The commenter claimed that CMS will have only a partial year of data for the

CY 2006 year, unless it extends the date that the category is effective for pass-through payment. This commenter claimed that the proposed payment for APC 0028, in which therapeutic breast cancer procedures, CPT codes 19125 and 19160, are placed, increased by only $100 and does not represent any device codes. The commenter asserted that CMS needs to collect data over 2 years and increase payment for APC 0028 to at least $1,345 starting in CY 2007. The commenter also pointed out that two categories set to expire after December 31, 2005, C1814 (Retinal tamonade device, silicone oil) and C1818 (Integrated keratoprosthesis), would be paid as pass-through devices several months longer than C1819, resulting in a greater amount of data for ratesetting than will be available for C1819.

Response: We believe it is premature to make any conclusions and recommendations concerning the payment rate for APC 0028 for CY 2006 or CY 2007. Presumably, after the pass-through period ends, the device costs of category code C1819 will be included in the median costs of APC 0028 if the device is billed with procedures that are included in that APC. We reiterate that, as with other categories due to expire, this tissue localization device will have had 2 years of pass-through status on January 1, 2006. Our policy is that pass-through devices are removed from pass-through status as soon as permitted under the statute. Therefore, this device will cease to be a pass-through device effective January 1, 2006.

In this final rule with comment period, we are finalizing the proposed expiration dates for device categories as specified in the proposed rule, as indicated in Table 21 below.

Table 21.--List Of Current Pass-Through Device Categories By Expiration Date

HCPCS Codes	Category Long Descriptor	Date(s) Populated	Expiration Date
C1783	Ocular implant, aqueous drainage assist device	7/1/02	12/31/04
C1888	Catheter, ablation, noncardiac, endovascular (implantable)	7/1/02	12/31/04
C1900	Lead, left ventricular coronary venous system	7/1/02	12/31/04
C1884	Embolization protective system	1/1/03	12/31/04
C2614	Probe, percutaneous lumbar discectomy	1/1/03	12/31/04
C2632	Brachytherapy solution, iodine-125, per mCi	1/1/03	12/31/04
C1814	Retinal tamponade device, silicone oil	4/1/03	12/31/05
C1818	Integrated keratoprosthesis	7/1/03	12/31/05
C1819	Tissue localization excision device	1/1/04	12/31/05

B. Provisions for Reducing Transitional Pass-Through Payments to Offset Costs Packaged into APC Groups

1. Background

In the November 30, 2001 final rule, we explained the methodology we used to estimate the portion of each APC rate that could reasonably be attributed to the cost of the associated devices that are eligible for pass-through payments (66 FR 59904). Beginning with the implementation of the CY 2002 OPPS update (April 1, 2002), we deducted from the pass-through payments for the identified devices an amount that reflected the portion of the APC payment amount that we determined was associated with the cost of the device, as required by section 1833(t)(6)(D)(ii) of the Act. In the November 1, 2002 final rule, we published the applicable offset amounts for CY 2003 (67 FR 66801).

For the CY 2002 and CY 2003 OPPS updates, to estimate the portion of each APC rate that could reasonably be attributed to the cost of an associated pass-through device eligible for pass-through payment, we used claims data from the period used for recalibration of the APC rates. Using those claims, we calculated a median cost for every APC without packaging the costs of associated C-codes for device categories that were billed with the APC. We then calculated a median cost for every APC with the costs of the associated device category C-codes that were billed with the APC packaged into the median. Comparing the median APC cost without device packaging to the median APC cost including device packaging enabled us to determine the percentage of the median APC cost that is attributable to the associated pass-through devices. By applying those percentages to the APC payment rates, we determined the applicable amount to be deducted from the pass-through payment, the ''offset'' amount. We created an offset list comprised of any APC for which the device cost was at least 1 percent of the APC's cost.

As first discussed in our November 1, 2002 final rule (67 FR 66801) the offset list that we publish each year is a list of offset amounts associated with those APCs with identified offset amounts developed using the methodology described above. As a rule, we do not know in advance which procedures and APCs may be billed with new categories. Therefore, an offset amount is applied only when a new device category is billed with an APC appearing on the offset list. The list of potential offsets for CY 2004 is currently published on the CMS Web site: *http://www.cms.hhs.gov,* as ''Device-Related Portions of Ambulatory Payment Classification Costs for 2004.''

For CY 2004, we modified our policy for applying offsets to device pass-through payments. Specifically, we indicated that we would apply an offset to a new device category only when we could determine that an APC contains costs associated with the device. We continued our existing methodology for determining the offset amount, described above. We were able to use this methodology to establish the device offset amounts for CY 2004 because providers reported device codes (C-codes) on the CY 2002 claims used for CY 2004 OPPS. However, for the CY 2005 update to the OPPS, we proposed to use CY 2003 claims that do not include device coding. (Section III. of this final rule with comment period contains a fuller discussion of our proposed and final requirement for use

of C-codes for CY 2005.) In the CY 2004 OPPS update, we reviewed the device categories eligible for continuing pass-through payment in CY 2004 to determine whether the costs associated with the device categories are packaged into the existing APCs. Based on our review of the data for the categories existing in CY 2004, we determined that there were no close or identifiable costs associated with the devices relating to the respective APCs that are normally billed with them. Therefore, for those device categories, we set the offset to $0 for CY 2004.

2. Proposed and Final Policy for CY 2005

As we proposed in the August 16, 2004 proposed rule, in this final rule with comment period for CY 2005, we are continuing to review each new device category on a case-by-case basis as we did in CY 2004 to determine whether device costs associated with the new category are packaged into the existing APC structure. We are setting the offsets to $0 for the currently established categories that would continue for pass-through payment into CY 2005. If, during CY 2005, we create a new device category and determine that our data contain identifiable costs associated with the devices in any APC, we will adjust the APC payment if the offset is greater than $0. If we determine that device offsets greater than $0 are appropriate for any new category that we create during CY 2005, we will announce the offset amounts in the program transmittal that announces the new category.

Further, as we proposed, in this final rule with comment period for CY 2005, we are using the device percentages (portion of the APC median cost attributable to the packaged device) that we developed for potential offsets in CY 2004 and apply these percentages to the CY 2005 payment amounts to obtain CY 2005 offset amounts, in cases where we determine that an offset is appropriate. As proposed, we are using the device percentage developed for CY 2004 because, as noted above, for the CY 2005 update to the OPPS, we are using CY 2003 claims that do not include device codes. Therefore, we are not easily able to determine the device portions of APCs for CY 2003 claims data. We have posted the list of device-dependent APCs and their respective device portions on the CMS Web site: *http://www.cms.hhs.gov* for CY 2004 We will update the device portions as a percentage of final CY 2005 APC payments and post these on the CMS Web site.

We did not receive any public comments on our proposed policy for reducing transitional pass-through payments to offset costs packaged into APC groups.

C. Criteria for Establishing New Pass-Through Device Categories

Comment: Several commenters from the medical device community asked that CMS revise the criteria under which it evaluates applications for pass-through status for new device categories. The commenters specifically requested that CMS eliminate the current requirement that items that are included in new pass-through device categories must be surgically inserted or implanted through a surgically created incision. The commenters expressed concern that the current requirement may prevent access to innovative and less invasive technologies, particularly in the areas of gynecologic, urologic, colorectal and gastrointestinal procedures. These commenters asked that CMS change the surgical insertion or implantation criterion to allow pass-through payment for potential new device categories that include items introduced into the human body through a natural orifice, as well as through a surgically created incision.

Several of the commenters recommended that CMS allow the creation of a new pass-through category for items implanted or inserted through a natural orifice, as long as the other existing criteria are met. The commenters do not believe that such an expansion of the criteria would significantly increase the amount spent on pass-through device categories and asked that CMS implement this change in January 2005. A few commenters predicted that this modification would result in expenditures of less than one quarter of the total amount available for pass-through payments. A few commenters further asked that CMS allow new categories, even if the name or terminology associated with the requested category resembles an expired category, even if that entails modifying the description of the expired category. One commenter claimed that manufacturers of technologies that are implanted through a surgically created opening have two options for incremental payment: (1) Pass-through payment; and (2) new technology APC, and that those not requiring a surgical incision have only one option for additional payment (the new technology APC).

Response: We share the views of the commenters about the importance of ensuring access for Medicare beneficiaries to new technologies that offer substantial clinical improvement in the treatment of their medical conditions. We also recognize that, since the initial implementation of the OPPS, there have been beneficial changes in the methods by which some conditions are treated. These are issues that the agency takes very seriously and considers in the context of both pass-through device categories and payment for new, complete procedures through assignment to either a new technology APC or an existing clinical APC.

We note that other payment mechanisms exist within the OPPS for complete procedures that use new technology. These other payment mechanisms (establishment of a new code, where appropriate, and assignment to either a new technology APC or to a clinical APC) are already available, and do not require the implantation of a device through a surgical incision.

We are also interested in hearing the views of other parties and receiving additional information on these issues. While we appreciate and welcome additional comments on these issues from the medical device makers, we are also interested in hearing the views of Medicare beneficiaries, of the hospitals that are paid under the OPPS and of physicians and other practitioners who attend to patients in the hospital outpatient setting. For that reason, we are soliciting additional comments on this topic within the 60-day comment period for this final rule with comment period. (See the **ADDRESSES** section of this preamble for information on submitting comments. When submitting comments on this issue, please include the caption ''Device Categories'' at the beginning of your comment.) In framing their comments, commenters are asked to consider the following questions:

1. The comments discussed above refer to devices introduced into the body through natural orifices. We are seeking comments on whether this includes orifices that are either naturally or surgically created, as in the case of ostomies? If you believe this includes only natural orifices, why do you distinguish between natural and surgically created orifices?

2. How would you define ''new,'' with respect to time and to predecessor technology? What additional criteria or characteristics do you believe distinguish ''new'' devices that are surgically introduced through an existing orifice from older technology that also is inserted through an orifice?

3. What characteristics do you consider to distinguish a device that might be eligible for a pass-through category even if inserted through an

existing orifice from materials and supplies such as sutures, clips or customized surgical kits that are used incident to a service or procedure?

4. Are there differences with respect to instruments that are seen as supplies or equipment for open procedures when those same instruments are passed through an orifice using a scope?

Concerning the request that we allow new categories for new devices by modifying the descriptors of existing categories, we note there are systems difficulties with changing a descriptor of an existing HCPCS code, such as payment considerations of claims prior to when a modification would be made. Moreover, both hospitals and manufacturers have informed us in the past that coding changes have led to confusion on the part of hospital coders. Modifying established device category C-codes would only exacerbate any such coding confusion. Therefore, we note that we are not inclined to change the descriptors of existing C-codes at this time.

Comment: One commenter recommended that CMS revise the cost significant criterion for establishing new device categories for pass-through payment. The commenter stated that medical devices are sometimes used as part of procedures that are secondary to a primary procedure, and in these cases the cost significance threshold of at least 25 percent of the APC rate associated with the services performed with the device should be adjusted downward to reflect the lower APC payment made for the secondary service. The commenter provided as an example those cases when the secondary procedure would be subject to the multiple procedure discount, thus lowering the APC payment associated with the procedure by 50 percent. The commenter indicated that this scenario happens infrequently.

Response: We disagree that our cost significance criterion for a proposed new device category for pass-through payment requires revision or adjustment. The criterion commented on requires that the estimated average reasonable cost of devices in a proposed new device category exceeds 25 percent of the applicable APC payment amount for the service associated with the device category (67 FR 66785). Very few new device category applications are denied for pass-through payment because they do not meet this cost criterion. If the proposed category of devices can be billed with more than one APC, we generally use the lowest APC payment rate applicable for use with the nominated device when we test against this cost criterion, thus increasing the probability the device will pass the cost significance criterion. We do not believe any further adjustment is needed for this cost criterion.

Therefore, we are not making any additional changes to our policy for CY 2005.

V. Payment Changes for Drugs, Biologicals, Radiopharmaceutical Agents, and Blood and Blood Products

A. Transitional Pass-Through Payment for Additional Costs of Drugs and Biologicals

1. Background

Section 1833(t)(6) of the Act provides for temporary additional payments or ''transitional pass-through payments'' for certain drugs and biological agents. As originally enacted by the BBRA, this provision required the Secretary to make additional payments to hospitals for current orphan drugs, as designated under section 526 of the Federal Food, Drug, and Cosmetic Act (Pub. L. 107–186); current drugs and biological agents and brachytherapy used for the treatment of cancer; and current radiopharmaceutical drugs and biological products. For those drugs and biological agents referred to as ''current,'' the transitional pass-through payment began on the first date the hospital OPPS was implemented (before enactment of BIPA (Pub. L. 106–554), on December 21, 2000).

Transitional pass-through payments are also required for certain ''new'' drugs, devices and biological agents that were not being paid for as a hospital OPD service as of December 31, 1996, and whose cost is ''not insignificant'' in relation to the OPPS payment for the procedures or services associated with the new drug, device, or biological. Under the statute, transitional pass-through payments can be made for at least 2 years but not more than 3 years. In Addenda A and B to this final rule with comment period, pass-through drugs and biological agents are identified by status indicator ''G.''

The process to apply for transitional pass-through payment for eligible drugs and biological agents can be found on pages of our CMS Web site: *http://www.cms.hhs.gov.* If we revise the application instructions in any way, we will post the revisions on our Web site and submit the changes to the Office of Management and Budget (OMB) for approval, as required under the Paperwork Reduction Act (PRA). Notification of new drugs and biological application processes is generally posted on the OPPS Web site at: *http://www.cms.hhs.gov/hopps.*

2. Expiration in CY 2004 of Pass-Through Status for Drugs and Biologicals

Section 1833(t)(6)(C)(i) of the Act specifies that the duration of transitional pass-through payments for drugs and biologicals must be no less than 2 years and no longer than 3 years. The drugs whose pass-through status will expire on December 31, 2004, meet that criterion. In the August 16, 2004 proposed rule, Table 22 listed the 13 drugs and biologicals for which we proposed that pass-through status would expire on December 31, 2004.

Comment: One commenter, a national hospital association, supported our proposal to remove these 13 drugs from the pass-through status on December 31, 2004.

Response: We appreciate the commenters' support for our proposal.

For this final rule with comment period, in Table 22 below, we are specifying the drugs and biologicals for which pass-through status will expire on December 31, 2004. This listing is the same as that published in the proposed rule.

Table 22.--List of Drugs and Biologicals for Which Pass-Through Status Expires December 31, 2004

HCPCS	APC	Long Descriptor	Trade Name
J0583	9111	Injection, Bivalirudin, per 1 mg	Angiomax Inj (single source)
C9112	9112	Injection, Perflutren lipid microsphere, per 2 ml	Definity (single source)
C9113	9113	Injection, Pantoprazole sodium, per vial	Protonix (single source)
J1335	9116	Injection, Ertapenem sodium, per 500 mg	Invanz (single source)
J2505	9119	Injection, Pegfilgrastim, per 6 mg single dose vial	Neulasta (single source)
J9395	9120	Injection, Fulvestrant, per 25 mg	Faslodex (single source)
C9121	9121	Injection, Argotroban, per 5 mg	Acova (single source)
C9200	9200	Orcel, per 36 square centimeters	Orcel (single source)
C9201	9201	Dermagraft, per 37.5 square centimeters	Dermagraft (single source)
J2324	9114	Injection, Nesiritide, per 0.5 mg	Natrecor (single source)
J3315	9122	Injection, Triptorelin pamoate, per 3.75 mg	Trelstar depot Trelstar LA (single source)
J3487	9115	Injection, Zoledronic acid, per 1 mg	Zometa (single source)
Q0137	0734	Injection, Darbepoetin Alfa, 1 mcg (non-ESRD use)	Aranesp® (single source)

3. Drugs and Biologicals With Pass-Through Status in CY 2005

As we proposed in the August 16, 2004 proposed rule, we are continuing pass-through status for CY 2005 for 18 drugs and biologicals listed in Table 23 of this final rule with comment period. The APCs and HCPCS codes for drugs and biologicals that will have pass-through status in CY 2005 are assigned status indicator ''G'' in Addendum A and Addendum B, respectively, to this final rule with comment period.

Section 1833(t)(6)(D)(i) of the Act sets the payment rate for pass-through eligible drugs (assuming that no pro rata reduction in pass-through payment is necessary) as the amount determined under section 1842(o) of the Act. Section 303(c) of Pub. L. 108–173 amended Title XVIII of the Act by adding new section 1847A. This new section establishes the use of the average sales price (ASP) methodology for payment for drugs and biologicals described in section 1842(o)(1)(C) of the Act furnished on or after January 1, 2005. Therefore, as we proposed in the August 16, 2004 proposed rule, in CY 2005, we will pay under the OPPS for drugs and biologicals with pass-through status consistent with the provisions of section 1842(o) of the Act as amended by Pub. L. 108–173 at a rate that is equivalent to the payment these drugs and biologicals will receive in the physician office setting, and established in accordance with the methodology described in the CY 2005 Physician Fee Schedule final rule published elsewhere in this issue.

Section 1833(t)(6)(D)(i) of the Act also sets the amount of additional payment for pass-through eligible drugs and biologicals (the pass-through payment amount). The pass-through payment amount is the difference between the amount authorized under section 1842(o) of the Act, and the portion of the otherwise applicable fee schedule amount (that is, the APC payment rate) that the Secretary determines is associated with the drug or biological.

In this final rule with comment period, we are adopting as final our proposal to amend § 419.64 of the regulations to conform this section to these changes. Specifically, we are revising paragraph (d) to provide that, subject to any reduction determined under § 419.62(b), the payment for a drug or biological with pass-through status equals the amount determined under section 1842(o) of the Act, minus the portion of the APC payment amount that we determine is associated with the drug or biological.

As we explained in the August 16, 2004 proposed rule, we will make separate payment, beginning in CY 2005, for new drugs and biologicals with an HCPCS code consistent with the provisions of section 1842(o) of the Act, as amended by Pub. L. 108–173, at a rate that is equivalent to the payment they would receive in a physician office setting, whether or not we have received a pass-through application for the item. Accordingly, beginning in CY 2005, the pass-through payment amount for new drugs and biologicals that we determine have pass-through status equals zero. That is, when we subtract the amount to be paid for pass-through drugs and biologicals under section 1842(o) of the Act, as amended by Pub. L. 108–173, from the portion of the otherwise applicable fee schedule amount, or the APC payment rate associated with the drug or biological that would be the amount paid for drugs and biologicals under section 1842(o) of the Act as

amended by Pub. L. 108–173, the resulting difference is equal to zero.

We have used the second quarter ASP numbers for budget neutrality estimates, impact analysis, and for completing Addenda A and B because those were the most recent numbers available to us in time for publication. Changes in program payments due to quarterly updates of ASP for pass-through drugs are factored into our budget neutrality estimates. To be consistent with the ASP-based payments that will be made when these drugs and biologicals are furnished in physician offices, we plan to make any appropriate adjustments to the amounts shown in Addendum A and B if later quarter ASP submissions indicate that adjustments to the payment rate are necessary. We will announce such changes in our program instructions to implement quarterly releases and post any revisions to the Addenda on the *http://cms.hhs.gov* Web site.

In the proposed rule, we listed in Table 23 the drugs and biologicals for which we proposed pass-through status continuing in CY 2005. We also included in Addendum B to the proposed rule the proposed CY 2005 rates for these pass-through drugs and biologicals based on data reported to CMS as of April 30, 2004. Since publication of the proposed rule on August 16, 2004, we have approved two additional drugs and biologicals for pass-through payment beginning on or after October 1, 2004. These products are Vidaza that has been assigned HCPCS code C9218 (Injection, azacitidine, per 1 mg) and Myfortic that has been assigned HCPCS code J7518 (Mycophenolic acid, oral, per 180 mg). (*See* Change Request 3420, Transmittal 290 issued August 27, 2004.) In addition, three more products have been approved for pass-through status beginning or after January 1, 2005. They are Orthovice (HCPCS code C9220, Sodium Hyaluronate per 30 mg dose, for intra-articular injection), GraftJacket (Repair)(HCPCS code C9221, Acellular dermal tissue, matrix per 16cm2), and GraftJacket (Soft Tissue)(HCPCS code C9222, Decellularized Soft Tissue Scaffold, per 1 cc). These new eligible pass-through items are listed in Table 23 below.

We received several public comments on the proposed listing and payment rates for drugs and biologicals for pass-through status continuing in CY 2005.

Comment: Two commenters stated that the proposed payment rate for HCPCS code C9203 (Injection, Perflexane lipid microsphere, per single use vial) is inappropriate and should be re-examined. They state that the methods used to price the drug are inconsistent with the Pub. L. 108–173, which requires that payments for pass-through drugs be based at either 106 percent of reported average sales price (ASP) or 83 percent of the average wholesale price (AWP). Pricing at 95 percent of AWP for C9203 creates a competitive disadvantage for contrast agents no longer being paid as pass-through drugs.

One commenter suggests that CMS create a class of echocardiography contrast agents similar to the class established for anti-emetic drugs. This allows for a uniform methodology to price drugs and ensures patient access to all drugs in the same therapeutic class. An alternative proposal identified by the commenter, is to base the payment for Imagent on the method applicable to the pricing for all other specified covered outpatient drugs (that is, 83 percent of the AWP). Yet another proposal included either maintaining pass-through status for all contrast agents or removing Imagent from pass-through designation. Another commenter recommended that the payment rate for all contrast agents be based on median costs reflected in hospital outpatient claims data.

Response: Whereas separate payment was already being made for the contrast agents, either as a pass-through item or as a ''specified covered outpatient drug,'' the 5HT3 anti-emetic products varied in their payment status, that is, some were packaged and some were paid separately. Although we are making final our proposal to pay separately for the 5HT3 anti-emetic products in CY 2005 in this final rule with comment period, the intent of this policy discussed in section IV.B.2. of this preamble is not to standardize payment for already separately payable drugs. For this reason, the policy does not apply to the echocardiography contrast agents. Therefore, we are not accepting the commenter's recommendation that we create a class of echocardiography contrast agents similar to the class for anti-emetic drugs.

Other proposals to: (1) Change the pass-through payment status for Imagent to a ''specified covered outpatient drug,'' (2) extend the pass-through payment status for other contrast agents, or (3) use hospital claims data to establish payment for Imagent are not provided for under the statute. Imagent obtained pass-through status effective on April 1, 2003, and will remain a pass-through drug for CY 2005.

Since the ASP for contrast agents was not reported in time for use in developing the APC payments for this final rule with comment period, the CY 2005 first quarter APC payment for Imagent is based on 95 percent of the AWP reported as of May 1, 2003. As previously stated, we plan to update payments for pass-through drugs on a quarterly basis. Beginning in April 2005, payment for Imagent will be based on 106 percent of the reported ASP.

Comment: Several commenters wrote in support of our proposal to remove 13 drugs and biologic agents from the pass-through table as the pass-through period for these items will end on January 1, 2005. Many commenters were very much in favor of our proposal for setting the pass-through payment portion of drugs. They wrote that zero pass-through payments ensures pass-though drugs and biologicals receive the full payment while at the same time eliminates the risk of a pro-rata reduction from occurring. Other commenters urged CMS to update ASP based payment rates for therapies with transitional pass-through status on a quarterly basis as is done for the drugs and biologicals administered in physician offices and paid for in accordance with the same statutory requirements as the drugs and biologicals with pass-through status under the OPPS. Otherwise, they argued, patient access to innovative drug and biological therapies in appropriate outpatient settings could be jeopardized.

Response: We appreciate the comments that support our decision to remove 13 drugs pass-through and biologicals for which pass-through status expires at the end of CY 2004 from the table. With respect to those drugs and biologicals that will continue to be on pass-through status or that may be granted pass-through status in CY 2005, we agree that our payment rules and amounts should be consistent with the ASP-based payments that will be made when these drugs and biologicals are furnished in physician offices since payment for both settings is governed by the same provisions of the Act. Therefore, we plan to make any appropriate adjustments to the amounts shown in Addendum A and B if later quarter ASP submissions indicate that adjustments to the payment rate are necessary. Changes in total payments due to quarterly updates of ASP for pass-through drugs are factored into our budget neutrality estimates.

In this final rule with comment period, we are not making any changes to the listing as a result of public comments. Table 23 below lists the drugs and biologicals that will have pass-through status in CY 2005. Addendum B of this final rule with

comment period lists the final CY 2005 rates for these pass-through drugs and biologicals, which are assigned status indicator "G" based on data reported to CMS as of July 30, 2004.

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Table 23.-- List of Drugs and Biologicals With Pass-Through Status in CY 2005

HCPCS Code	APC	Long Descriptor	Trade Name
C9123	9123	TransCyte, per 247 sq. cm	TransCyte
C9205	9205	Injection, Oxaliplatin, per 5 mg	Eloxatin
C9203	9203	Injection, Perflexane lipid microspheres, per single use vial	Imagent
J3486	9204	Injection, Ziprasidone mesylate, per 10 mg	Geodon
C9211	9211	Injection, IV, Alefacept, per 7.5 mg	Amevive
C9212	9212	Injection, IM, Alefacept, per 7.5 mg	Amevive
J9041	9207	Injection, IV, Bortezomib, per 0.1 mg	Velcade
J0180	9208	Injection, IV, Agalsidase beta, per 1 mg	Fabrazyme
J1931	9209	Injection, IV, Laronidase, per 0.1 mg	Aldurazyme
J2469	9210	Injection, IV, Palonosetron HCI per 0.025 mg (25 microgram)	Aloxi
J0878	9124	Injection, daptomycin, per 1 mg	Cubicin
J2794	9125	Injection, risperidone, per 0.5 mg	Risperdal Consta
J2783	0738	Injection, rasburicase, 0.5 mg	Elitek
J9305	9213	Injection, Pemetrexed, per 10 mg	Alimta
J9035	9214	Injection, Bevacizumab, per 10 mg	Avastin
J9055	9215	Injection, Cetuximab, per 10 mg	Erbitux
J0128	9216	Abarelix for Injectable Suspension, per 10 mg	Plenaxis
J2357	9300	Injection, Omalizumab, per 5 mg	Xolair
C9218	9218	Injection, azacitidine, per 1 mg	Vidaza[1]
J7518	9219	Mycophenolic acid, oral, per 180 mg	Myfortic[1]
C9220	9220	Sodium Hyaluronate per 30 mg dose, for intra-articular injection	Orthovisc
C9221	9221	Acellular dermal tissue, matrix, per 16cm2	GraftJacket (Repair)
C9222	9222	Decellularized Soft Tissue Scaffold, per 1 cc	GraftJacket (Soft Tissue)

[1]Approved for pass-through payment beginning on or after October 1, 2004

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B. Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Status

1. Background

Under the OPPS, we currently pay for drugs, biologicals including blood and blood products, and radiopharmaceuticals that do not have pass-through status in one of two ways: packaged payment and separate payment (individual APCs). We explained in the April 7, 2000 final rule (65 FR 18450) that we generally package the cost of drugs and radiopharmaceuticals into the APC payment rate for the procedure or treatment with which the products are usually furnished. Hospitals do not receive separate payment from Medicare for packaged items and supplies, and hospitals may not bill beneficiaries separately for any packaged items and supplies whose costs are recognized and paid for within the national OPPS payment rate for the associated

procedure or service. (Program Memorandum Transmittal A–01–133, issued on November 20, 2001, explains in greater detail the rules regarding separate payment for packaged services.)

Packaging costs into a single aggregate payment for a service, procedure, or episode of care is a fundamental principle that distinguishes a prospective payment system from a fee schedule. In general, packaging the costs of items and services into the payment for the primary procedure or service with which they are associated encourages hospital efficiencies and also enables hospitals to manage their resources with maximum flexibility. Notwithstanding our commitment to package as many costs as possible, we are aware that packaging payments for certain drugs, biologicals, and radiopharmaceuticals, especially those that are particularly expensive or rarely used, might result in insufficient payments to hospitals, which could adversely affect beneficiary access to medically necessary services. As discussed in the November 7, 2003 OPPS final rule with comment period (68 FR 63445), in CY 2004 we packaged payment for drugs, biologicals, and radiopharmaceuticals into the APCs with which they were billed if the median cost per day for the drug, biological, or radiopharmaceutical was less than $50. We established a separate APC payment for drugs, biologicals, and radiopharmaceuticals for which the median cost per day exceeded $50. Our rationale for establishing a $50 threshold was also discussed in the November 7, 2003 OPPS final rule with comment period (68 FR 63444 through 63447).

2. Criteria for Packaging Payment for Drugs, Biologicals, and Radiopharmaceuticals

Section 621(a)(2) of Pub. L. 108–173 amended section 1833(t)(16) of the Act by adding a new subparagraph (B) to require that the threshold for establishing separate APCs for drugs and biologicals be set at $50 per administration for CYs 2005 and 2006. For CY 2005, we proposed to continue our policy of paying separately for drugs, biologicals, and radiopharmaceuticals whose median cost per day exceeds $50 and packaging the cost of drugs, biologicals, and radiopharmaceuticals whose median cost per day is less than $50 into the procedures with which they are billed.

We calculated the median cost per day using claims data from January 1, 2003, to December 31, 2003, for all drugs, biologicals, and radiopharmaceuticals that had an HCPCS code during this time period and were paid (via packaged or separate payment) under the OPPS. Items such as single indication orphan drugs, certain vaccines, and blood and blood products were excluded from these calculations and our treatment of these is discussed separately in sections V.F., E., and I., respectively, of this preamble. In order to calculate the median cost per day for drugs, biologicals, and radiopharmaceuticals to determine their packaging status in CY 2005, in the August 16, 2004 proposed rule, we proposed to use the methodology that was described in detail in the CY 2004 OPPS proposed rule (68 FR 47996 through 47997) and finalized in the CY 2004 final rule with comment period (68 FR 63444 through 63447). We requested comments on the methodology we proposed to continue to use to determine the median cost per day of these items.

We proposed to apply an exception to our packaging rule to one particular class of drugs, the injectible and oral forms of anti-emetic treatments. The HCPCS codes to which our exception to the packaging rule for CY 2005 would apply were listed in Table 24 of the proposed rule (69 FR 50506). Our calculation of median cost per day for these products showed that, if we were to apply our packaging rule to these items, two of the injectible products would be packaged and one would be separately payable. In addition, two of the oral products would be separately payable and one would be packaged. Chemotherapy is very difficult for many patients to tolerate as the side effects are often debilitating. In order for beneficiaries to achieve the maximum therapeutic benefit from chemotherapy and other therapies with side effects of nausea and vomiting, anti-emetic use is often an integral part of the treatment regimen. We wanted to ensure that our payment rules did not impede a beneficiary's access to the particular anti-emetic that is most effective for him or her as determined by the beneficiary and his or her physician. Therefore, we proposed to pay separately for all six injectible and oral forms of anti-emetic products in CY 2005.

We received several public comments on our proposed criteria for packaging payment for drugs, biologicals, and radiopharmaceuticals.

Comment: Many commenters supported our proposal to continue paying separately for drugs, biologicals, and radiopharmaceuticals whose median costs per day exceed $50. The commenters encouraged CMS to continue to maintain the threshold at $50 after CY 2006 and recommended that any additional packaging threshold be examined carefully prior to future implementation so that beneficiary access to therapies will not be compromised as a result. One of the commenters, however, remained concerned about the packaging of other drugs and biologicals that fell below the $50 threshold and recommended that CMS make separate payments for drugs and biologicals that meet one or both of the following criteria: products with median cost per day of at least $50; or products that are eligible for separate payment in other outpatient sites of care and that received a separate payment previously under the OPPS. Another commenter expressed concern about the site of service incentives presented by some drugs being paid when furnished in the physicians' offices, while being packaged in the hospital setting. The commenter urged CMS to consider several options, including: Making separate payment for all drugs in CY 2005 that were separately paid under a previous OPPS payment rate and are separately paid for in physicians' offices; lowering the packaging threshold, for example, to $10 or $20; paying separately for all drugs for which the 106 percent of ASP payment amount in the physicians' office is at least $10; or establishing procedures to ensure that drugs used for similar indications (including off-label uses) are either all packaged or all paid separately. MedPAC, to the contrary, expressed concern about the use of an arbitrary cut-off of $50 per administration for separate payment of drugs. It stated that separate payment for certain more expensive drugs gave hospitals an incentive to use those drugs rather than those that are packaged, and the threshold also gave manufacturers an incentive to price their drugs to ensure that they are above $50 per administration. MedPAC recommended that CMS should carefully analyze alternative thresholds or the creation of larger bundles to allow for alternative approaches once the MMA provision requiring a $50 threshold expires in CY 2007.

Response: We appreciate the support of many commenters for our packaging policy for CY 2005. Section 621(a)(2) of Pub. L. 108–173 requires that the threshold for establishing separate APCs for drugs and biologicals be set at $50 per administration for CYs 2005 and 2006. Therefore, we cannot change the threshold amount for CY 2005 as some of the commenters have suggested. We will take all of the commenters' recommendations into consideration as

we work on our packaging proposal for the CY 2007 OPPS.

However, in light of the commenters' concerns, we have decided to apply our equitable adjustment authority to establish several exceptions to the packaging threshold. We note that there were seven drugs and biologicals that we proposed to pay separately for in our proposed rule. However, when we recalculated their median costs per day using all of the hospital claims used for this final rule with comment period, their median costs per day were less than $50. We considered several payment options for these drugs and biologicals, such as packaging all of the items in CY 2005 or paying separately for all of them as we had proposed. However, after evaluating these drugs carefully, we decided to finalize the following payment policy for these items:

- Drugs and biologicals that were paid separately in CY 2004 and have median costs per day less than $50 based on the hospital claims data being used for the CY 2005 final rule with comment period would continue to receive separate payment in CY 2005.
- Those drugs and biologicals that are packaged in CY 2004 and that have median costs per day less than $50 based on the hospital claims data being used for the CY 2005 final rule with comment period would remain packaged in CY 2005.

We believe these policies are the most equitable for this particular set of drugs given the fluctuations in median hospital cost relative to the $50 threshold and their status in CY 2004.

Table 24 lists the seven drugs and biologicals to which this policy will apply along with their CYs 2004 and 2005 payment status indicator. The four items that will be separately paid under this policy meet the definition of sole source ''specified covered outpatient drugs'' and will be paid between 83 percent and 95 percent of their AWP in CY 2005.

Table 24.-- Drugs and Biologicals with Median Costs Per Day Less than $50[1] (Proposed for separate payment)

HCPCS	Description	CY 2004 Status Indicator	CY 2005 Status Indicator
J1450	Inj Fluconazole, 200 mg	N	N
J1730	Inj, Diazoxide, up to 300 mg	N	N
J3400	Inj, Trifluprom azine, Hcl, up to 20 mg	N	N
J0350	Inj, Anistreplase, per 30 units	K	K
J1830	Inj, Interferon beta-1B, 0.25 mg	K	K
J8510	Busulfan, oral, 2 mg	K	K
J9151	Daunorubicin citrate, liposomal formulation, 10 mg	K	K

[1]Median costs are based on CY 2003 final rule claims.

Comment: One commenter indicated that CMS was proposing a packaging policy that appeared to be different from the MMA requirement because a particular drug may be administered more than once per day. Therefore, the commenter added, a drug with a cost per administration of less than $50 that is administered more than once per day would qualify for separate payment under CMS' proposed policy, but would not qualify for separate payment under the MMA requirement. The commenter indicated that the overall impact of this discrepancy is that there will be less packaging of drugs under the OPPS than Congress intended. The commenter was unclear as to whether CMS had the authority to deviate from the statute in this way.

Response: We note that the hospital claims data do not indicate whether there were multiple administrations of the same drug on a single day. Accordingly, we must assume that for all cases there was only a single administration of each drug per day. For packaging purposes, the median cost per day for each drug and biological must, therefore, serve as a proxy for its cost per administration. We will, however, continue to explore ways to distinguish single versus multiple drug administrations for future OPPS updates.

Comment: Numerous commenters, including several manufacturers of pharmaceutical products, individual hospitals, and hospital associations, strongly supported CMS' proposed exception to exclude the six injectible and oral forms of 5HT3 anti-emetic products from the packaging threshold and allow separate payment for all of them. One commenter indicated that CMS' claims data used to determine median cost per day may not be a reliable source for accurate median costs for these products and may understate their actual acquisition and related costs. Another commenter stated that if the $50 threshold were applied to this class of drugs, it would have created an incentive for hospitals to choose therapies based on the opportunity for payment and not their appropriateness for each individual patient. The commenters agreed that this policy would help to ensure beneficiary access to the most appropriate anti-emetic drug for cancer care. Several commenters also urged CMS to give careful thought to the effects of packaging on patient access to other types of drugs and biological therapies. However, one commenter indicated that, in recent months, the

wholesale acquisition cost for one of the injectible anti-emetic drugs specified in the proposed exception was reduced by the manufacturer by seventy-three percent. If the proposed exception were applied to this drug, the payment would provide a margin of over one hundred dollars for each dose administered and the outcome would be contrary to the stated intent of the proposal. The commenter believed that CMS could not have anticipated the perverse payment situation that would result under such an exception and recommended that CMS reconsider and withdraw the exception to the packaging rule for this class of drugs.

Response: We appreciate the commenters' support of our proposal to pay for the six 5HT3 products separately. We also recognize the concerns raised by a commenter informing us of the price reduction for one of the injectible products. However, we firmly believe that packaging some of the 5HT3 anti-emetic products and paying separately for others may negatively impact a beneficiary's access to the particular anti-emetic that is most effective for him or her as determined by the beneficiary and his or her physician. Therefore, we are finalizing our policy to pay separately for all six injectible and oral forms of anti-emetic products in CY 2005. We note that this policy only affects drugs of a particular class (in this case, 5HT3 anti-emetic products) that vary in their payment status (that is, packaged or paid separately), and our intent is not to generally standardize payment methodologies for separately payable drugs of the same class.

Comment: One commenter expressed operational concerns about billing for oral anti-emetics associated with chemotherapy. The commenter indicated that it will be extremely difficult to bill for these drugs when the same HCPCS codes are used for the drugs' use in nausea not associated with chemotherapy and requested that CMS consider establishing a separate HCPCS code or an edit that will only allow payment when a cancer diagnosis is on the claim.

Response: The following HCPCS codes are those hospitals use to report the six 5HT3 products irrespective of their use: J1260 (Injection, Dolasetron, Mesylate, 10 mg), Q0180 (Dolasetron Mesylate, 100 mg, oral), J1626 (Injection, Graniestron Hydrochloride, 100 mcg), Q0166 (Granisetron Hydrochloride, 1 mg, oral), J2405 (Injection, Ondansetron Hydrochloride, per 1 mg), and Q0179 (Ondansetron Hydrochloride 8 mg, oral). The policy discussed above applies only to the packaging status of these products, not to their coverage status. Hospitals should continue billing in accordance with existing coverage rules.

Comment: We received comments on the packaging status of several drugs, biologicals, and radiopharmaceutical agents where the commenters indicated that the items were incorrectly packaged and should be paid separately as sole source ''specified covered outpatient drugs.'' Specific items mentioned in the comments were HCPCS codes A9524, Q3010, J2790, and J7525. The commenters asserted that the median cost per day calculations for these products were based on inaccurate and incomplete hospital claims data because the hospitals were not likely to have been charging appropriately for the products or billing the correct number of units. One of the commenters also cited changes in HCPCS code descriptors and the lag time in hospitals updating their charge masters to reflect revised code descriptors as possible reasons for why the hospital claims data may be skewed and may not be reflective of hospitals' actual acquisition costs. Another commenter asserted that since many of these drugs were packaged in CY 2003, the claims data did not capture the drugs' actual costs. Commenters urged CMS to review only the ''correctly coded'' claims when determining median cost per day for these products, use external data to help determine appropriate payment rates, or pay for the drugs separately as sole source ''specified covered outpatient drugs'' since these items meet that definition. Another commenter requested that CMS retain the CY 2004 payments until there is enough data to accurately determine payment rates.

Response: We understand commenters' concerns about the median cost per day for these particular items. To determine which claims for drugs, biologicals and radiopharmaceuticals are ''correctly coded'' would require that we attempt to assess which claims indicate that the number of units billed were or were not clinically reasonable. Given variations among patients with respect to the appropriate doses, the variety of indications with different dosing regimens for some agents, our lack of information about how many doses were administered on a given day, the possibility of off-label uses, and our desire not to question the clinical judgment of the prescribing providers on these issues, we do not believe that an approach that attempts to identify and use only ''correctly coded'' claims is feasible. The hospital claims database is the best and most complete source of data we have for establishing median hospital costs for the services and items paid for under the OPPS.

In section III.B. of this final rule with comment period, we discuss comments concerning our methodology for units trimming. It is possible that some other approaches to units trimming could increase the derived cost per day for some drugs but could also result in decreases for some. For others, it could result in no difference for the drug in relation to the $50 threshold. As a test, we applied several different unit trim approaches to one of the codes for which we received comments and still did not achieve a median cost per day above $50. Nevertheless, we appreciate the thoughtful comments we have received on this topic and will consider the issue of units trimming in later development of our OPPS payment rates. For our final policy for CY 2005, however, we retain the methodology that we proposed. We will also encourage hospitals to carefully consider the descriptions of each HCPCS code when determining the number of units to bill for drugs, biologicals and radiopharmaceuticals. We will consider special efforts related to particular items. We would note, also, that the payment hospitals receive for a particular drug is based on the number of units billed. If a hospital underreports the number of units administered to a patient due to a misunderstanding about the definition of the code, the hospital will not receive the full amount to which it is entitled. Conversely, hospitals should not report more units than appropriate based on the coding description and the amount required to treat the patient.

3. Payment for Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Status That Are Not Packaged

a. Payment for Specified Covered Outpatient Drugs

Section 621(a)(1) of Pub. L. 108–173 amended section 1833(t) of the Act by adding a new subparagraph (14) that requires special classification of certain separately paid radiopharmaceutical agents and drugs or biologicals and mandates specific payments for these items. Under section 1833(t)(14)(B)(i), a ''specified covered outpatient drug'' is a covered outpatient drug, as defined in section 1927(k)(2) of the Act, for which a separate APC exists and that either is a radiopharmaceutical agent or is a drug or biological for which payment was made on a pass-through basis on or before December 31, 2002.

Under section 1833(t)(14)(B)(ii) of the Act, certain drugs and biologicals are designated as exceptions and are not

included in the definition of ''specified covered outpatient drugs.'' These exceptions are:

• A drug or biological for which payment is first made on or after January 1, 2003, under the transitional pass-through payment provision in section 1833(t)(6) of the Act.

• A drug or biological for which a temporary HCPCS code has not been assigned.

• During CYs 2004 and 2005, an orphan drug (as designated by the Secretary).

Section 1833(t)(14)(A)(i) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, specifies payment limits for three categories of specified covered outpatient drugs in CY 2004. Section 1833(t)(14)(F) of the Act defines the three categories of specified covered outpatient drugs based on section 1861(t)(1) and sections 1927(k)(7)(A)(ii), (k)(7)(A)(iii), and (k)(7)(A)(iv) of the Act. The categories of drugs are ''sole source drugs,'' ''innovator multiple source drugs,'' and ''noninnovator multiple source drugs.'' The definitions of these specified categories for drugs, biologicals, and radiopharmaceutical agents under Pub. L. 108–173 were discussed in the January 6, 2004 OPPS interim final rule with comment period (69 FR 822), along with our use of the Medicaid average manufacturer price database to determine the appropriate classification of these products. Because of the many comments received on the January 6, 2004 interim final rule with comment period, the classification of many of the drugs, biologicals, and radiopharmaceuticals changed from that initially published. These changes were announced to the public on February 27, 2004, Transmittal 112, Change Request 3144. Additional classification changes were implemented in Transmittals 3154 and 3322.

We received 25 public comments associated with the January 6, 2004 interim final rule with comment period. These public comments are summarized under section V.B.4. of this preamble.

Section 1833(t)(14)(A) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, also provides that payment for these specified covered outpatient drugs is to be based on its ''reference average wholesale price,'' that is, the AWP for the drug, biological, or radiopharmaceutical as determined under section 1842(o) of the Act as of May 1, 2003 (section 1833(t)(14)(G) of the Act). Section 621(a) of Pub. L. 108–173 also amended the Act by adding section 1833(t)(14)(A)(ii), which requires that:

• A sole source drug must, in CY 2005, be paid no less than 83 percent and no more than 95 percent of the reference AWP.

• An innovator multiple source drug must, in CY 2005, be paid no more than 68 percent of the reference AWP.

• A noninnovator multiple source drug must, in CY 2005, be paid no more than 46 percent of the reference AWP.

Section 1833(t)(14)(G) of the Act defines ''reference AWP'' as the AWP determined under section 1842(o) as of May 1, 2003. We interpreted this to mean the AWP set under the CMS single drug pricer (SDP) based on prices published in the Red Book on May 1, 2003.

For CY 2005, we proposed to determine the payment rates for specified covered outpatient drugs under the provisions of Pub. L. 108–173 by comparing the payment amount calculated under the median cost methodology as done for procedural APCs (described previously in the preamble) to the AWP percentages specified in section 1833(t)(14)(A)(ii) of the Act.

Specifically, for sole source drugs, biologicals, and radiopharmaceuticals, we compared the payments established under the median cost methodology to their reference AWP. We proposed to determine payment for sole source items as follows: If the payment falls below 83 percent of the reference AWP, we would increase the payment to 83 percent of the reference AWP. If the payment exceeds 95 percent of the reference AWP, we would reduce the payment to 95 percent of the reference AWP. If the payment is no lower than 83 percent and no higher than 95 percent of the reference AWP, we would make no change.

Comment: A few commenters strongly opposed the decrease in the payment floor for sole source specified covered outpatient drugs from 88 percent of AWP in CY 2004 to 83 percent of AWP in CY 2005. The commenters believed that the decrease was inappropriate and lacked sound policy justification. The commenters recommended that for CY 2005 the payment floor for sole source specified covered outpatient drugs be maintained at 88 percent of AWP. One commenter, however, was concerned about the proposed payment rate for HCPCS code J9395 (Injection, Fulvestrant, 25 mg), which is based on 83 percent of AWP instead of 85 percent of AWP that is the CY 2004 payment level. The commenter asserted that CMS's use of median cost data to establish appropriate payment rates for specified covered outpatient drugs is faulty for this drug because of concerns about the accuracy of the hospital median cost data. The commenter also indicated that several payment changes affecting this drug were likely to have created a significant degree of confusion among hospitals that may have negatively skewed hospital median cost data and led CMS to correlate the data to an AWP-based payment percentage that is too low. Another commenter urged CMS to create an exceptions process that would provide for appropriate adjustments within the MMA-specified payment corridor upon submission of data documenting potential access problems or a payment rate significantly lower than the acquisition cost of the drug. The commenter indicated that creating such an approach would help to minimize disruption to patient access to drugs in the hospital outpatient setting. To the contrary, several commenters were pleased with the payment rates for certain products at 83 percent of their AWPs.

Response: Section 621(a) of Pub. L. 108–173 is very specific in requiring that a sole source drug must be paid no less than 83 percent and no more than 95 percent of the reference AWP in CY 2005. We used the 83 percent of AWP as the payment floor to set payment rates for sole source drugs, unless payments based on median costs were higher, as we lack any data to determine what would be the appropriate payment level between 83 percent and 95 percent of AWP for all sole source drugs. We set up a payment floor to avoid paying for these drugs at different arbitrarily determined payment levels. We note that if data show that the payment rate for a drug falls between the 83 percent floor and 95 percent ceiling, the drug is paid at the payment rate.

We have responded to comments about the relative hospital data from our claims above and in other sections of this preamble. While we certainly share the desire to provide beneficiaries with access to the drugs that are reasonable and necessary for the treatment of their conditions, we do not agree with the comments that we should pay above the 83 percent floor established by the MMA for sole source drugs if the median hospital cost falls below this floor. We believe the intent of the law is to use hospital cost data as the best available information in setting the payment rates for most items paid for under the OPPS. In the case of sole source specified covered outpatient drugs, the MMA provides for a floor of 83 percent of the reference AWP for those items for which the payment based on relative hospital costs would fall below 83 percent of the AWP and a ceiling of 95 percent of the reference AWP for items where the relative

hospital costs from our claims data exceed that amount. We are not convinced that the 83 percent AWP floor is a barrier to appropriate treatment.

Comment: One commenter, the manufacturer of AGGRASTAT®, requested that CMS convert the current temporary outpatient HCPCS code C9109 (Injection, Tirofiban HCl, 6.25 mg) to a permanent national HCPCS code with a base dose of 5 mg and continue to maintain the permanent national HCPCS code J3245 (Injection, Tirofiban HCl, 12.5 mg). The commenter asserted that HCPCS codes with units of 5 mg and 12.5 mg would properly reflect the actual doses of AGGRASTAT® that currently exist in the market.

Response: For 2005, the National HCPCS Panel decided to delete HCPCS codes C9109 and J3245 and create a new HCPCS code J3246 (Injection, Tirofiban HCl, 0.25 mg). We hope that the creation of this new HCPCS code will ameliorate the commenter's concerns about appropriate coding for this product.

Comment: We received a number of comments on the packaging status of HCPCS codes J7505 (Muromonab-CD3, parenteral, 5 mg) and J9266 (Pegaspargase, single dose vial). The commenters stated that these two products were incorrectly packaged because the data used to determine packaging status were flawed and requested that both products be paid separately as sole source drugs at a rate between 83 percent and 95 percent of their AWPs.

Response: There were several drugs and biologicals that we proposed to package in the proposed rule, including the two products mentioned in the comments. However, when we recalculated their median costs per day using all of the hospital claims from CY 2003 used for this final rule with comment period, we determined that their median costs per day were greater than $50. Therefore, for CY 2005, we will pay for these drugs and biologicals separately. Items that meet the definition of ''specified covered outpatient drugs'' (SCOD) will be paid according to the payment methodologies established in the MMA, and payment for items that do not meet the definition will be based on their median unit cost. Table 25 lists the drugs and biologicals that were proposed as packaged drugs and biologicals but will be paid separately in CY 2005. The table also indicates the methodology that will be used to determine their APC payment rates in CY 2005.

Table 25. - Drugs and Biologicals with Packaging above $50 Threshold (Proposed as packaged items but will be paid separately in CY 2005)

HCPCS	Description	CY 2005 Payment Methodology
J0743	INJ, CILASTATIN SODIUM; IMIPENEM, PER 250 MG	Median based
J0900	INJ, TESTOSTERONE ENANTHATE AND ESTRADIOL VALERATE, UP TO 1 CC	Median based
J1455	INJ, FOSCARNET SODIUM, PER 1000 MG	Median based
J2760	INJ, PHENTOLAMINE MESYLATE, UP TO 5 MG	Median based
J1325	INJ, EPOPROSTENOL, 0.5 MG	SCOD
J7505	MUROMONAB-CD3, PARENTERAL, 5 MG	SCOD
J9050	CARMUSTINE, 100 MG	SCOD
J9165	DIETHYLSTILBESTROL DIPHOSPHATE, 250 MG	SCOD
J9266	PEGASPARGASE, PER SINGLE DOSE VIAL	SCOD

Comment: One commenter was concerned about the proposed payment rates for HCPCS codes A9502 (Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m tetrofosmin, per unit dose) and Q3005 (Supply of radiopharmaceutical diagnostic imaging agent, technetium Tc-99m mertiatide, per mci). The commenter indicated that payment corrections made for these two products in the February 27, 2004 CMS Transmittal 113 resulted in significant payment reductions. The commenter was concerned that significant payment fluctuations and reductions were counter-productive to the provision of quality care and will negatively impact the operational viability of nuclear medicine departments. Therefore, the commenter urged CMS to reconsider their proposed payments for these two products.

Response: We understand the commenter's concern about the impact of fluctuations in payment rates for HCPCS codes A9502 and Q3005. However, we note that the payment rates that were listed in the January 6, 2004 interim final rule with comment period for these products were calculated using incorrect reference AWPs as indicated in the February 27, 2004 CMS Transmittal 113. Therefore, we made corrections to the AWPs for these products and recalculated their payment rates according to the payment methodology required by the MMA for sole source ''specified covered outpatient drugs''.

Comment: One commenter requested that CMS support a decision by the HCPCS Alpha-Numeric Editorial Panel to issue separate permanent and universal drug codes for echocardiography contrast agents for which applications have been submitted. Specifically, the commenter recommended that CMS support the application submitted for the creation of a J-code for Definity, which is currently being reported as HCPCS code C9112 (Injection, perflutren lipid microsphere, per 2 ml vial).

Response: Decisions regarding the creation of permanent HCPCS codes are coordinated by the National HCPCS Panel. Comments related to the HCPCS code creation process and decisions made by the National HCPCS Panel are

outside the scope of this rule; therefore, we will not respond to this comment. We note that until a J-code is established for this product, hospitals can continue to bill for this product using the HCPCS code C9112.

Comment: Several commenters expressed concern about the proposed payment for intravenous immune globulin. They were concerned that CMS calculated the reference AWP for this code using AWPs for one or more products that were no longer commercially available. For example, Carimune and Panglobulin were removed from the market and replaced with Carimune NF and Panglobulin NF, respectively. The commenters requested that CMS review the current pricing data on the brand products that are currently in the market place and recalculate payment for IVIG as a sole source specified covered outpatient drug. Another commenter was concerned about the proposed payment rate for HCPCS code J7198 (Anti-inhibitor, per IU). The commenter indicated CMS calculated the reference AWP for this code using an AWP for a product called Autoplex that was discontinued from the market in May 2004 and recommended that CMS calculate payment for this HCPCS code using cost data associated with the product Feiba VH that currently exists in the market.

Response: We agree with the comments and accordingly recalculated the base AWP for HCPCS code J1563 (Immune globulin, intravenous, 1 g) excluding AWPs for the two discontinued products, Panglobulin and Carimune. Similarly, we excluded the AWP for the discontinued product, Autoplex, when redetermining the base AWP for HCPCS code J7198 (Anti-inhibitor, per IU). We then recalculated their payment rates as sole source ''specified covered outpatient drugs.'' We note that these changes resulted in an increase in the base AWPs for both products.

Comment: One commenter, the maker of the product billed under HCPCS code C9201 (Dermagraft, 37.5 cm2), requested that CMS set its CY 2005 payment rate under the OPPS identical to the payment rate in the physician office setting. The commenter anticipated a payment rate of $574.41 (third quarter ASP plus 6 percent) when it is used in the physician office setting during CY 2005; however, the proposed payment rate as a sole source drug under the OPPS was $529.54. The commenter indicated that Dermagraft's cost to all customers is identical regardless of the site of service and establishing a payment rate under the OPPS below the cost of the product to hospitals would hinder their access to medical technologies for which they will not recover their costs. Additionally, we received comments from an association representing a group of specialty hospitals and a professional association expressing concern about the proposed payment level for HCPCS code J3395 (Injection, verteporfin, 15 mg). The commenters indicated that the payment rate for this product is significantly less than the acquisition cost for outpatient facilities and requested that CMS pay for it at a rate that covers the cost of acquiring the drug. The commenter also stated that accurate pricing information for the drug should be available when CMS receives final data from the manufacturer on October 31, 2004 and that the final OPPS payment rate should be reflective of the pricing data.

Response: The products described by HCPCS codes C9201 and J3395 meet the definition of sole source ''specified covered outpatient drugs.'' The MMA specifies the methodology that determines payment for this group of drugs under the OPPS where, for CY 2005, sole source drugs must be paid between 83 percent and 95 percent of their reference AWP. Since payments for these two products based on the median cost methodology were less than 83 percent of their AWPs, their CY 2005 payment levels were established at 83 percent of their AWP. In these cases, we believe the statute specifically addresses the payment methodology for these drugs.

Comment: A few commenters were concerned about the proposed payment rates for some separately payable drugs and biologicals that did not fall under the category of ''specified covered outpatient drugs.'' These products would be either paid as pass-through items or their payment rates were based on median cost data; however, the commenters requested that the products be paid as sole source ''specified covered outpatient drugs.'' One of the commenters requested that external data be used to correct the payment rate for their product. Several rationales were cited for this request to change the payment methodology, such as the use of inaccurate and incomplete hospital claims data to determine payment rates that are lower than actual hospital acquisition costs and eliminating payment differentials between drugs of the same class.

Response: We believe that the MMA defines the items that are to be considered ''specified covered outpatient drugs'' for payment purposes under the OPPS, and these drugs do not meet the definition. We also recognize that classifying these products as sole source ''specified covered outpatient drugs'' would increase their payments; however, we are not convinced that the payment rates for these products calculated under current methodologies are insufficient.

In developing our August 16, 2004 proposed rule, there was one sole source item, Co 57 cobaltous chloride (HCPCS code C9013), for which we could not find a reference AWP amount. However, we had CY 2003 claims data for HCPCS code C9013, and therefore, we proposed to derive its payment rate using its median cost per unit. We requested comments on our proposed methodology for determining the payment rate for HCPCS code C9013. We received a few comments in response to our proposal.

Comment: The manufacturer of the product billed under HCPCS code C9013 (Supply of Co 57 cobaltous chloride, radiopharmaceutical diagnostic imaging agent), Rubatrope, along with other commenters, indicated that Rubatrope is an FDA-approved radiopharmaceutical and a sole source drug that meets the definition of a ''specified covered outpatient drug;'' therefore, it should be paid between 83 percent and 95 percent of AWP. The manufacturer of Rubatrope indicated that it had experienced problems with the production of this product in the past 2 years and thus production was discontinued. However, the product will be commercially available from November 2004. The commenter also indicated that it would send CMS an AWP for this product once it becomes available. Therefore, for CY 2005, the commenters strongly urged CMS to establish payment for C9013 as a sole source drug at 83 percent of AWP.

Response: We understand the commenters' concern about the payment rate for this product and note that HCPCS code C9013 was considered a sole source ''specified covered outpatient drug'' in the proposed rule. However, as we were not able to determine a reference AWP for this product, we based its proposed payment rate on its median cost from the claims data. At the time of the publication of this final rule, we were still unable to find an AWP for this product, and thus, in the absence of an AWP for this product, as proposed we will use the product's median cost to base its CY 2005 payment rate. However, if we determine an AWP for HCPCS code C9013, we will issue a change to its payment accordingly in a quarterly update of the OPPS.

We note that there are three radiopharmaceutical products for which

we proposed a different payment policy in CY 2005. These products are represented by HCPCS codes A9526 (Ammonia N–13, per dose), C1775 (FDG, per dose (4–40 mCi/ml), and Q3000 (Rubidium–Rb–82). Radiopharmaceuticals are classified as a ''specified covered outpatient drug'' according to section 1833(t)(14)(B)(i)(I) of the Act and their payment is dependent on their classification as a single source, innovator multiple source, or noninnovator multiple source product as defined by sections 1927 (k)(7)(A)(iv), (ii), and (iii) of the Act. Upon further analysis of these items, we determined that these three products do not meet the statutory definition of a sole source item or a multiple source item. Pub. L. 108–173 requires us to pay for ''specified covered outpatient drugs'' using specific payment methodologies based on their classification and does not address how payment should be made for items that do not meet the definition of a sole source or multiple source item. Therefore, in the August 16, 2004 proposed rule, we proposed to set the CY 2005 payment rates for these three products based on median costs derived from CY 2003 hospital outpatient claims data, which would reflect hospital costs associated with these products. With regard to HCPCS code A9526, we have no hospital outpatient cost data for this HCPCS code. We received correspondence from an outside source stating that Rubidium–Rb–82 (HCPCS code Q3000) is an alternative product used for procedures for which Ammonia N–13 is also used and these two products are similar in cost. Therefore, we proposed to establish a payment rate for Ammonia N–13 that is equivalent to the payment rate for Rubdium Rb–82.

We listed the proposed CY 2005 payment rates for these three items in Table 25 of the proposed rule (69 FR 50507), requested comments on the proposed payment rates and invited commenters to submit external data if they believe the proposed CY 2005 payment rates for these items do not adequately represent actual hospital costs.

We received many public comments on the proposed payment rates for the three items.

Comment: Many commenters were concerned about the proposed reduction in the payment rate for FDG in CY 2005. They stated that FDG meets the definition of ''specified covered outpatient drugs,'' and the MMA requires that ''specified covered outpatient drugs'' be classified as sole source drugs, innovator multiple source drugs, or noninnovator multiple source drugs, and be reimbursed according to a percentage of the reference AWP during CY 2005. Several commenters understood the difficulty CMS had in classifying FDG into one of the three categories of ''specified covered outpatient drugs.'' However, one of the commenters was concerned that CMS abandoned the methodology prescribed by the MMA and created another payment category for ''specified covered outpatient drugs,'' which the commenter believed is outside the scope of the MMA.

A commenter suggested that CMS assign FDG to the category that most closely reflects the underlying regulatory and economic environment for the production of FDG, which is the innovator multiple source drug category. The commenter explained that the production and sale of FDG is unusual in that the FDA does not yet require an approved New Drug Application (NDA) or Abbreviated New Drug Application (ANDA). The commenter also stated that the FDA is currently drafting special criteria to govern NDAs and ANDAs for the production and marketing of FDG, and eventually, manufacturers will be required to submit either an NDA or ANDA in order to sell FDG. Right now, there are no approved ANDAs or ''generics'' for FDG, and none of the FDA approved products is therapeutically equivalent. The commenter indicated that FDG is sold commercially by at least three manufacturers and is produced by numerous hospitals and academic medical centers for their own use, thus making it a multiple source drug. However, until the FDA finalizes its requirements for NDAs and ANDAs for FDG and all manufacturers have an opportunity to comply with those regulations, all FDG marketed in the United States should be considered a ''brand'' version. Although the different FDG products distributed are not rated as equivalent by the FDA, FDG was originally marketed under an NDA, and currently there are multiple distributors. Thus, although FDG does not meet all aspects of the multiple source innovator drug definition, given the inaccuracies of the hospital outpatient claims data, this commenter, along with several others, recommended that FDG be paid under the MMA at 68 percent of its AWP. Alternatively, some commenters requested that CMS keep the CY 2005 payment for FDG at its CY 2004 level until the completion of the GAO hospital acquisition cost survey, which will allow for a more reliable basis for setting payment based on average acquisition cost. One commenter stated that CMS should use external data submitted by hospitals to determine the true costs of this product. External data from a survey of 2002 nuclear medicine costs reported by hospitals were submitted, and the results indicated that median cost to hospitals for one dose of FDG is $425. Another commenter stated that their current cost for administering one dose of FDG to patients receiving PET scans is $450 and that CMS should research real market costs for this product before reducing payment by $126 from the current CY 2004 payment rate

The commenters all agreed that CMS should not use CY 2003 hospital claims data to calculate payment for FDG in CY 2005 because the reported data fails to accurately capture the actual acquisition cost to hospitals along with all the reasonable costs needed to safely prepare, store, administer, and dispose of the product. Commenters indicated that the HCPCS code descriptor for C1775 is written in a way that requires hospitals to use the same code to report FDG with a concentration of 4mci/ml as they use to report FDG with a concentration of 40 mci/ml, thus making the claims data unreliable, and also, hospitals did not have clear billing and charging guidance. Thus, the commenters claimed that the FDG data from CY 2003 are a flawed basis upon which to make a payment determination and would significantly underpay hospitals. Commenters noted that a reduction in payment for FDG to the proposed payment rate would limit utilization and access to FDG PET because of the financial losses the providers will suffer.

Response: We appreciate these thoughtful comments on our proposed payment rate for FDG. Based on the unique regulatory processes that affect the manufacturing and marketing of FDG, we believe that it is reasonable for us to classify FDG as an innovator multiple source drug. Therefore, we will not reinstate the HCPCS code C9408 (FDG, brand, per dose), which we inadvertently deleted as stated in the October 2004 Update of the OPPS (CMS Transmittal 290). In CY 2005, hospitals should use C1775 to bill for all FDG products.

With respect to calculating payment for FDG in CY 2005, the MMA requires that an innovator multiple source drug must be paid no more than 68 percent of the reference AWP. The MMA sets forth a payment ceiling for the brand innovator multiple source drugs, but does not provide a payment floor for them. We believe that the intent of the statute is to use available hospital

claims to set payment rates for most items paid under OPPS; therefore, we apply the ceiling only when the payment for an item based on the median hospital cost for the drug exceeds the ceiling. As we described in section V.A.3.a. of this final rule with comment period, for innovator multiple source drugs, we set the payment rate at the lower of the payment rate calculated under the standard median cost methodology or 68 percent of the AWP. We have applied this methodology to all of the other innovator multiple source drugs; therefore, we do not believe that it would be appropriate for us to exempt FDG from this methodology and pay for it at 68 percent of AWP, the ceiling for innovator products. We believe that basing payment for this item on relative hospital costs, with the application as appropriate of the previously mentioned ceiling, not only meets the intent but also the requirements of the MMA. The payment rate for C1775 in CY 2005 will be $221.11.

Comment: The manufacturer of CardioGen–82, also known as Rubidium Rb–82, along with other commenters asserted that this product does meet the classification of a sole source drug as defined by the MMA. The commenters indicated that FDA approval for this product was received under an NDA, and there is currently only one manufacturer of the Cardiogen–82 generators used to produce Rubidium Rb–82. Also, there is no FDA-approved generic product for Rubidium Rb–82. One of the commenters indicated that a survey was conducted to obtain data on actual hospital costs for Rubidium Rb–82, which showed that the median per dose cost to hospitals was $244.73. Thus, the commenter believed that CMS hospital cost data were flawed and do not represent true hospital costs; therefore, the hospital claims cost data should not be used to set the payment rate for Rubidium Rb–82 in CY 2005. Other commenters indicated that median cost data used by CMS to calculate the payment rate for Rubidium Rb–82 underreport the actual and reasonable hospital costs needed to safely prepare, store, administer, and dispose of the product. The commenters urged CMS to recognize HCPCS code Q3000 (Supply of radiopharmaceutical diagnostic imaging agent, Rubidium Rb–82, per dose) as a sole source drug and set its payment at 83 percent of its AWP, or at minimum, retain the CY 2004 payment rate.

Response: We appreciate these comments. Based on further evaluation of the appropriate classification for this product, we agree with the commenters that Rubidium Rb–82 should be classified as a sole source product. Therefore, payment for Q3000 will be made at 83 percent of AWP as its payment based on the median cost methodology is less than 83 percent of AWP. The payment rate for Rubidium Rb–82 in CY 2005 will be $153.39 per dose.

Comment: Numerous commenters were concerned about the proposed payment rate for HCPCS code A9526 (Ammonia N–13, per dose). Some of the commenters stated that CMS proposed to treat HCPCS codes Q3000 (Rubidium Rb–82, per dose) and A9526 under a ''presumptive functional equivalence'' in setting the same payment rate for these products when they are not functionally equivalent. It was also stated that Rubidium Rb–82 and Ammonia N–13 are used for similar procedures, but they have different costs, clinical composition, and utilization patterns. Another commenter indicated that Rubidium Rb–82 significantly differs from the other PET radiopharmaceuticals as it is produced by a radionuclide generator system, compared to FDG and Ammonia N–13 that are made in cyclotrons. A commenter also stated that Ammonia N–13 has no commercial vendors; whereas, Rubidium Rb–82 is produced and distributed by one commercial vendor. Some commenters suggested that CMS pay for A9526 separately, similar to other ''specified covered outpatient drugs.'' On the other hand, other commenters recommended that, in the absence of reliable cost data or a published AWP, CMS should use the cost of FDG as a proxy for the cost of Ammonia N–13, since these products have equivalent production costs.

Response: We recognize the concerns raised by commenters about our proposal to pay for Ammonia N–13 at the same payment rate as Rubidium Rb–82. We acknowledge that Ammonia N–13 meets the definition of ''specified covered outpatient drugs;'' however, we have not been able to determine an AWP for this product. Thus, we cannot set a payment rate for this product based on a percentage of its AWP. While some of the commenters recommended that we set the payment rate for Ammonia N–13 at the same level as that for FDG, we are aware this would give rise to the same concerns raised by commenters regarding payment for Ammonia N–13 and Rubidium Rb–82. Therefore, we are not adopting our proposed payment policy for Ammonia N–13. Based on the complete CY 2003 hospital claims data that were used for this final rule with comment period, we were able to identify claims submitted for Ammonia N–13; therefore, for CY 2005, we will use median cost derived from the claims data to set the payment for this product. The CY 2005 payment rate for A9526 will be $109.86 per dose.

Comment: A number of commenters, including several cancer research centers and trade associations representing the radionuclide and radiopharmaceutical industry, biomedical science, and the biotechnology industry, as well as the manufacturers of Bexxar (billed using HCPCS codes C1080, C1081, and G3001) and Zevalin (billed using HCPCS codes C1082 and C1083), expressed concern that 83 percent of AWP is insufficient to reimburse hospitals for the cost of acquiring Zevalin and Bexxar. Several commenters, including the manufacturer of Zevalin, were concerned that the proposed payment rates for Zevalin are inadequate to facilitate patient access to this critical therapy. One commenter stated that, because Zevalin is a radioimmunotherapy, its purchase and use are subject to state regulatory safeguards that limit its availability in the oncology practices; therefore, its access in the hospital outpatient setting is crucial. The commenter urged CMS to maintain the 2004 payment rates for Zevalin, which are at 88 percent of AWP, into CY 2005, and indicated that this stability would make treatment with Zevalin more economically feasible for hospitals.

One commenter, the manufacturer of Bexxar, expressed concern about what they identified as several ''inequities'' in the coding and proposed payments for Bexxar and Zevalin. Specifically, the commenter pointed out that the payment proposed for Bexxar in CY 2005 is more than $1500 less than the payment proposed for Zevalin. This commenter further recommended that payment for Bexxar be set at its wholesale acquisition cost, which is $19,500, or 95 percent of the RAWP, which would be $22,230. Several commenters indicated that CMS has the option to exceed the floor of 83 percent of AWP established under the MMA for sole source specified covered outpatient drugs, which would enable CMS to set a rate for Bexxar and Zevalin commensurate with their cost.

Two commenters recommended that CMS consider external data where available to supplement its payment determinations for Bexxar and Zevalin.

Response: We share the commenters' concerns that Medicare payment rates not be a barrier to beneficiary access to radioimmunotherapy for the treatment of non-Hodgkins lymphoma. However, we do not agree with the comments that we should set the OPPS payment rates

for Zevalin and Bexxar based on their CY 2004 payment levels, on external data, on their WAC, or on any payment amount other than that which is consistent the designation of radiopharmaceuticals in the MMA as specified covered outpatient drugs.

Zevalin and Bexxar are radiopharmaceuticals, and the MMA includes them as ''specified covered outpatient drugs'' for the OPPS payment purposes. Each meets the definition of a sole source drug. We believe the intent of the law is that we set payment rates for most items paid for under the OPPS using hospital cost data from the best and most recent information available, unless the statute directs otherwise, as in the case of drugs with pass-through status or new drugs without HCPCS codes. The MMA provides a floor of 83 percent of the reference AWP in CY 2005 for sole source specified covered outpatient drugs for which payment based on relative hospital costs would be less. Similarly, the MMA provides a cap of 95 percent of the reference AWP in CY 2005 for sole source specified covered outpatient drugs for which payment based on relative hospital costs would be higher. The statute provides a payment floor and ceiling for sole source ''specified covered outpatient drugs,'' at no lower than 83 percent of AWP or higher than 95 percent of AWP; the statute does not require a payment at some intermediate level that falls between 83 percent and 95 percent of AWP.

Payment for Zevalin based on relative hospital costs drawn from CY 2003 claims data would fall below 83 percent of the reference AWP. As we did in the case of other sole source drugs for which payment based on hospital claims would be lower than 83 percent of AWP, we proposed to set payment for Zevalin at 83 percent of the reference AWP. We also proposed to set payment for Bexxar in CY 2005 as a sole source radiopharmaceutical at 83 percent of AWP because, like Zevalin, it is a radiopharmaceutical and, therefore, a sole source specified covered outpatient drug under the MMA. We discuss in section V.G. of this final rule with comment period that we are making final our proposal to treat radiopharmaceuticals the same as we treat drugs and biologicals for purposes of ratesetting, with two exceptions: We will set payment for new radiopharmaceuticals for which we have no claims data, and for new radiopharmaceuticals with pass-through status effective on or after January 1, 2005, based on the MMA CY 2005 payment requirements for specified covered outpatient drugs. We have no ASP for Bexxar because it is a radiopharmaceutical, and manufacturers have not been required to submit ASP for radiopharmaceuticals. We have no claims data from which to calculate relative hospital costs for Bexxar because of the newness of the product. Therefore, we are setting payment for Bexxar in accordance with the MMA requirement that a sole source specified covered outpatient drug be paid no less than 83 percent of AWP in CY 2005.

Comment: A number of commenters, including several cancer centers and a nuclear medicine trade association, asked that CMS provide payment to hospitals for the cost of compounding each patient-specific dose of Bexxar, noting that the compounding costs amount to several thousand dollars in addition to the cost of the drug itself. One of these commenters recommended that the cost of compounding Bexxar be included in the payment for the product and that C1080 and C1081 be assigned to a new technology APC to reflect the total cost of the product plus compounding. One commenter, the manufacturer of Bexxar, is concerned because the payment proposed for Bexxar in CY 2005 does not include payment for the cost of compounding that is required to prepare patient specific doses of diagnostic and therapeutic I–131 tositumomab, whether done by the hospital's own radiopharmacy or by a commercial radiopharmacy. The commenter estimates that hospitals incur a compounding cost of $2,000–$3,000 to furnish Bexxar to a single patient when a commercial radiopharmacy does the compounding. The commenter recommends that CMS either base payment for Bexxar on 95 percent of AWP, continue payment for Bexxar at the CY 2004 level, or establish a new code to enable hospitals to bill separately for Bexxar compounding costs.

Response: Because Zevalin and Bexxar are radiopharmaceuticals that fall under the category of sole source specified covered drugs established by the MMA, the payment rates for these products are based on AWP, as required by the MMA. To the extent that compounding costs are reflected in the AWP, the payment rate includes these costs. If hospitals incur additional compounding costs for the radiolabeled monoclonal antibodies, those costs could be reported as a separate line item charge with an appropriate revenue code or packaged into the charge for CPT codes 78804 and 79403, which could result in an outlier payment if the outlier threshold for those services was exceeded. The MMA requires that MedPAC submit a report to the Secretary by July 1, 2005 on adjustment of payment for ambulatory payment classifications for specified covered outpatient drugs to take into account overhead and related expenses, such as pharmacy services and handling costs. We look forward to receiving this report in anticipation that the data collected by MedPAC will enable us to address drug-related overhead costs in future OPPS updates.

Comment: Several commenters expressed concerns that the payment rates proposed for Bexxar could result in clinicians having to make treatment decisions based upon payment considerations rather than medical considerations, and could result in physicians having to deny patients a potential life-saving therapy. The same commenters were concerned that the payment proposed for Zevalin and Bexxar does not recognize all of the additional costs associated with the provision of radiolabeled antibody therapy or radioimmunotherapy (RIT) for the treatment of non-Hodgkins lymphoma. These commenters urged CMS to consider all of the costs associated with this therapy when setting payment rates for each component of the regimen and recommended that CMS ensure that total payment to hospitals be commensurate with all of the actual costs that hospitals incur to acquire, prepare, and administer radiolabeled antibodies and to perform all of the additional procedures associated with RIT, thereby ensuring that patient access to these vital therapies will not be jeopardized.

Response: We share the commenters' concerns about the extent to which payment considerations influence treatment decisions. However, we believe that to the extent that radioimmunotherapy proves to be an efficacious treatment for patients with certain forms of non-Hodgkins lymphoma, payment in the aggregate for the full array of procedures and services associated with this new form of treatment affords hospitals sufficient flexibility to ensure that payment is not a barrier to beneficiary access when it is deemed reasonable and necessary.

Table 26 below lists the final APC payment rates for sole source drugs, biologicals, and radiopharmaceuticals effective January 1, 2005 to December 31, 2005.

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Table 26. – CY 2005 APC Payment Rates for Sole Source Drugs, Biologicals, and Radiopharmaceuticals

HCPCS	Status Indicator	APC	Short Description	CY 2005 Payment Rate
A4642	K	0704	Satumomab pendetide per dose	$1,390.25
A9500	K	1600	Technetium TC 99m sestamibi	$106.32
A9502	K	0705	Technetium TC99M tetrofosmin	$104.58
A9504	K	1602	Technetium tc 99m apcitide	$415.00
A9507	K	1604	Indium/111 capromab pendetid	$1,915.23
A9508	K	1045	Iobenguane sulfate I-131, pe	$996.00
A9511	K	1095	Technetium TC 99m depreotide	$37.79
A9521	K	1096	Technetiumtc-99m exametazine	$778.13
A9605	K	0702	Samarium sm153 lexidronamm	$907.33
C1079	K	1079	CO 57/58 per 0.5 uCi	$221.78
C1080	K	1080	I-131 tositumomab, dx	$2,241.00
C1081	K	1081	I-131 tositumomab, tx	$19,422.00
C1082	K	9118	Indium111ibritumomabtiuxetan	$2,419.78
C1083	K	9117	Yttrium90ibritumomabtiuxetan	$20,948.25
C1091	K	1091	IN111 oxyquinoline,per0.5mCi	$373.50
C1092	K	1092	IN 111 pentetate per 0.5 mCi	$224.10
C1122	K	1122	Tc 99M ARCITUMOMAB PER VIAL	$1,079.00
C1178	K	1178	BUSULFAN IV, 6 Mg	$24.35
C1201	K	1201	TC 99M SUCCIMER, PER Vial	$118.52

HCPCS	Status Indicator	APC	Short Description	CY 2005 Payment Rate
C1305	K	1305	Apligraf	$1,130.88
C9003	K	9003	Palivizumab, per 50 mg	$576.51
C9008	K	9008	Baclofen Refill Kit-500mcg	$10.21
C9009	K	9009	Baclofen Refill Kit-2000mcg	$37.64
C9013	K	9013	Co 57 cobaltous chloride	$142.45
C9105	K	9105	Hep B imm glob, per 1 ml	$118.32
C9112	K	9112	Perflutren lipid micro, 2ml	$129.69
C9200	K	9200	Orcel, per 36 cm2	$991.85
C9201	K	9201	Dermagraft, per 37.5 sq cm	$529.54
C9202	K	9202	Octafluoropropane	$129.48
J0130	K	1605	Abciximab injection	$448.22
J0207	K	7000	Amifostine	$395.75
J0287	K	9024	Amphotericin b lipid complex	$19.09
J0288	K	0735	Ampho b cholesteryl sulfate	$15.20
J0289	K	0736	Amphotericin b liposome inj	$31.27
J0350	K	1606	Injection anistreplase 30 u	$2,353.53
J0583	K	9111	Inj, bivalirudin, 1 mg	$1.52
J0585	K	0902	Botulinum toxin a per unit	$4.32
J0587	K	9018	Botulinum toxin type B	$7.68
J0637	K	9019	Caspofungin acetate	$28.78
J0850	K	0903	Cytomegalovirus imm IV /vial	$622.13
J1260	K	0750	Dolasetron mesylate	$14.38
J1325	K	7003	Epoprostenol injection	$15.78
J1327	K	1607	Eptifibatide injection	$11.21
J1438	K	1608	Etanercept injection	$135.56
J1440	K	0728	Filgrastim 300 mcg injection	$162.41
J1441	K	7049	Filgrastim 480 mcg injection	$274.40
J1563	K	0905	IV immune globulin	$80.68
J1564	K	9021	Immune globulin 10 mg	$0.75
J1565	K	0906	RSV-ivig	$16.55
J1626	K	0764	Granisetron HCl injection	$16.20
J1745	K	7043	Infliximab injection	$57.40
J1830	K	0910	Interferon beta-1b / .25 MG	$58.73
J1950	K	0800	Leuprolide acetate /3.75 MG	$451.98
J2020	K	9001	Linezolid injection	$32.15
J2324	K	9114	Nesiritide	$132.47
J2353	K	1207	Octreotide injection, depot	$69.44
J2354	K	7031	Octreotide acetate injection, 25 mcg	$3.72
J2405	K	0768	Ondansetron hcl injection	$5.54
J2505	K	9119	Injection, pegfilgrastim	$2,448.50

HCPCS	Status Indicator	APC	Short Description	CY 2005 Payment Rate
J2788	K	9023	Rho d immune globulin 50 mcg	$30.38
J2792	K	1609	Rho(D) immune globulin h, sd	$17.95
J2820	K	0731	Sargramostim injection	$25.39
J2941	K	7034	Somatropin injection	$280.87
J2993	K	9005	Reteplase injection	$1,192.09
J3100	K	9002	Tenecteplase injection	$2,350.98
J3246	K	7041	Tirofiban hydrochloride	$8.24
J3305	K	7045	Inj trimetrexate glucoronate	$142.50
J3396	K	1203	Verteporfin injection	$8.49
J3487	K	9115	Zoledronic acid	$197.87
J7190	K	0925	Factor viii	$0.76
J7191	K	0926	Factor VIII (porcine)	$1.78
J7192	K	0927	Factor viii recombinant	$1.10
J7193	K	0931	Factor IX non-recombinant	$0.98
J7194	K	0928	Factor ix complex	$0.32
J7195	K	0932	Factor IX recombinant	$0.98
J7198	K	0929	Anti-inhibitor	$1.29
J7320	K	1611	Hylan G-F 20 injection	$203.70
J7504	K	0890	Lymphocyte immune globulin	$243.50
J7505	K	7038	Monoclonal antibodies	$747.31
J7507	K	0891	Tacrolimus oral per 1 MG	$3.05
J7511	K	9104	Antithymocyte globuln rabbit	$312.41
J7517	K	9015	Mycophenolate mofetil oral	$2.46
J7520	K	9020	Sirolimus, oral	$6.23
J8510	K	7015	Oral busulfan	$2.08
J8520	K	7042	Capecitabine, oral, 150 mg	$2.96
J8700	K	1086	Temozolomide	$6.42
J9001	K	7046	Doxorubicin hcl liposome inj	$343.78
J9020	K	0814	Asparaginase injection	$54.71
J9031	K	0809	Bcg live intravesical vac	$139.90
J9045	K	0811	Carboplatin injection	$129.96
J9151	K	0821	Daunorubicin citrate liposom	$56.44
J9170	K	0823	Docetaxel	$312.69
J9178	K	1167	EPIRUBICIN HCL, 2 mg	$24.14
J9185	K	0842	Fludarabine phosphate inj	$311.09
J9201	K	0828	Gemcitabine HCl	$105.73
J9202	K	0810	Goserelin acetate implant	$390.09
J9206	K	0830	Irinotecan injection	$127.33
J9213	K	0834	Interferon alfa-2a inj	$30.48
J9214	K	0836	Interferon alfa-2b inj	$13.00

HCPCS	Status Indicator	APC	Short Description	CY 2005 Payment Rate
J9215	K	0865	Interferon alfa-n3 inj	$8.17
J9217	K	9217	Leuprolide acetate suspnsion	$543.72
J9219	K	7051	Leuprolide acetate implant	$4,717.72
J9245	K	0840	Inj melphalan hydrochl 50 MG	$367.03
J9266	K	0843	Pegaspargase/singl dose vial	$1,247.08
J9268	K	0844	Pentostatin injection	$1,683.24
J9270	K	0860	Plicamycin (mithramycin) inj	$93.80
J9293	K	0864	Mitoxantrone hydrochl / 5 MG	$313.96
J9310	K	0849	Rituximab cancer treatment	$437.83
J9350	K	0852	Topotecan	$697.76
J9355	K	1613	Trastuzumab	$50.79
J9390	K	0855	Vinorelbine tartrate/10 mg	$95.23
J9600	K	0856	Porfimer sodium	$2,274.78
Q0136	K	0733	Non esrd epoetin alpha inj	$11.09
Q0137	K	0734	Darbepoetin alfa, 1 mcg[1]	$3.66
Q0166	K	0765	Granisetron HCl 1 mg oral	$39.04
Q0179	K	0769	Ondansetron HCl 8mg oral	$26.12
Q0180	K	0763	Dolasetron mesylate oral	$63.28
Q0187	K	1409	Factor viia recombinant	$1,410.34
Q2002	K	7022	Elliotts b solution per ml	$1.50
Q2003	K	7019	Aprotinin, 10,000 kiu	$12.51
Q2005	K	7024	Corticorelin ovine triflutat	$353.70
Q2006	K	7025	Digoxin immune fab (ovine)	$332.00
Q2007	K	7026	Ethanolamine oleate 100 mg	$63.29
Q2008	K	7027	Fomepizole, 15 mg	$10.04
Q2009	K	7028	Fosphenytoin, 50 mg	$5.31
Q2011	K	7030	Hemin, per 1 mg	$6.47
Q2013	K	7040	Pentastarch 10% solution	$131.99
Q2017	K	7035	Teniposide, 50 mg	$224.94
Q2018	K	7037	Urofollitropin, 75 iu	$56.59
Q2021	K	9057	Lepirudin	$130.30
Q2022	K	1618	VonWillebrandFactrCmplxperIU	$0.83
Q3000	K	9025	Rubidium-Rb-82	$153.39
Q3002	K	1619	Gallium ga 67	$27.10
Q3003	K	1620	Technetium tc99m bicisate	$370.60
Q3005	K	1622	Technetium tc99m mertiatide	$31.13
Q3007	K	1624	Sodium phosphate p32	$94.98
Q3008	K	1625	Indium 111-in pentetreotide	$1,079.00
Q3011	K	1628	Chromic phosphate p32	$147.25
Q3012	K	1089	Cyanocobalamin cobalt co57	$85.49
Q3025	K	9022	IM inj interferon beta 1-a	$74.44

[1] Equitable adjustment applied to payment rate

In order to determine the payment amounts for innovator multiple source and noninnovator multiple source forms of the drug, biological, or radiopharmaceutical, we compared the payments established under the median cost methodology to their reference AWP. For innovator multiple source items, we proposed to set payment rates at the lower of the payment rate calculated under our standard median cost methodology or 68 percent of the reference AWP. For noninnovator multiple source items, we proposed to set payment rates at the lower of the

payment rate calculated under our standard median cost methodology or 46 percent of the reference AWP. We followed this same methodology to set payment amounts for innovator multiple source and noninnovator multiple source ''specified covered outpatient drugs'' that were implemented by the January 6, 2004 interim final rule with comment period. We listed the proposed payment amounts in Table 26 of the proposed rule.

Comment: One commenter, an association of cancer centers, indicated that CMS proposed the same payment rate for both the brand name and generic versions of a drug. Given that CMS does not have separate HCPCS code level data for brand versus generic drugs in the CY 2003 claims data, the commenter indicated that it did not understand how CMS could use claims data to justify equivalent payment levels for both brand and generic versions of a drug. The commenter was also concerned about the adequacy of using the CY 2003 claims data to calculate the costs of these products and making comparisons to the payment rate ceilings set forth by the MMA for multi-source drugs, especially for the brand name drugs. Therefore, the commenter requested that CMS pay for all brand name drugs at 68 percent of AWP and pay for generics by comparing the calculated cost using the claims data to the 46 percent of AWP threshold and selecting the lower of the two as the payment rate.

Response: For CY 2005, as for the current year, the MMA sets forth different payment ceilings for the brand and generic versions of the drug. The MMA does not provide a payment floor for either the brand or generic versions of such items. Only sole source drugs have a payment floor and ceiling. As stated elsewhere in this final rule with comment period, the CY 2005 payment rate for innovator multiple source (brand name) drugs may not exceed 68 percent of the reference AWP. The payment for noninnovator multiple source (generic) drugs may not exceed 46 percent of the reference AWP. In determining payment rates, we apply those ceilings only when the payment for an item based on the median hospital cost for the drug exceeds one of these ceilings. In some cases, the payment based on the median hospital cost falls below the 46 percent ceiling for generic drugs. In such cases, the payment rate would be the same for brand and generic versions. However, we believe that basing payment for these items on relative hospital costs, with the application as appropriate of the previously mentioned ceilings not only meets the intent but also the requirements of the MMA.

Comment: A few commenters indicated that the proposed payment rate of $410.45 for HCPCS code A9600 (Supply of therapeutic radiopharmaceutical, Strontium-89, per mci) would underpay hospitals for this product since the payment rate was based on flawed CMS median cost data that do not accurately reflect the real acquisition cost of this drug by hospitals. The commenters believed that hospital costs for A9600 are approximately $800 per mci and requested that CMS adjust the payment accordingly. One commenter, who was the manufacturer of this product, asserted that the product is expensive and difficult to manufacture since it is produced in small quantities. The commenter also indicated that the reduction in the payment rate for this product is driving the underutilization of this product and increasing the use of costly narcotic analgesics, thus resulting in a decrease in quality of life and a rise in the cost of health care. Another commenter stated that the HCPCS codes for diagnostic and therapeutic iodine products (C1064, C1065, C1188, C1348, A9528, A9529, A9530, A9531, A9517 and A9518) all describe in various years and forms diagnostic and therapeutic Iodine 131 and that these codes have had varying descriptions that have resulted in flawed cost data. The commenter submitted data indicating that the cost for I–131 in the capsule form is higher than for solution, and recommended that CMS use external data to restore and correct payment rates for the Iodine 131 product so that the payment more accurately reflects actual hospital costs.

Response: We understand the commenters' concerns about establishing appropriate payment rates for these products. We believe that the intent of the statute is to use available hospital claims to set payment rates for most items paid under the OPPS. In the case of multiple source drugs such as these products, the MMA requires that innovator and noninnovator multiple source drugs be paid no more than 68 percent and 46 percent of their AWP, respectively.

As previously stated, for innovator multiple source drugs, we set the payment rate at the lower of the payment rate calculated under the standard median cost methodology or 68 percent of the AWP; and for noninnovator multiple source drugs, we set the payment rate at the lower of the payment rate calculated under the standard median cost methodology or 46 percent of the AWP. Using the most recent available data, we determined that the payment rates based on median cost for these drugs were lower than both 68 percent and 46 percent of their AWPs; therefore, the payment rates for both the innovator and noninnovator forms of these products were based on their median costs.

Comment: One commenter, the maker of one of the viscosupplement drugs, was concerned that the proposed payment rates for the four competitive products are inequitable and will harm beneficiary access to these therapies. The commenter indicated that currently two of the products, Hyalgan and Supartz, are billed using HCPCS code J7317 (Sodium Hyaluronate, per 20 to 25 mg dose for intra-articular injection), and this HCPCS code has been classified as a multi-source drug. The commenter assumed that another product, Orthovisc, would also be billed under HCPCS code J7317. However, the fourth product, Synvisc, is classified as a sole source drug and billed under HCPCS code J7320 (Hylan G–F20, 16 mg, for intra-articular injection). The commenter strongly believed that classifying these products differently resulted in payment rates that will create significant payment inequities and unjustified market distortions. To correct the payment inequity across the class of viscosupplements, the commenter recommended that CMS create separate HCPCS codes for these products and treat each product as a sole source drug. Another commenter strongly recommended that Orthovisc, a new product, be recognized as a pass-through under the OPPS, and be assigned a separate C-code for payments under that system.

Response: We recognize the commenter's concern about payment for these viscosupplement drugs under the OPPS. The National HCPCS Panel coordinates decisions regarding the creation of permanent HCPCS codes; therefore, comments related to the HCPCS creation process and decisions made by the National HCPCS Panel are outside the scope of this rule. However, we note that the product Orthovisc received approval for pass-through status under the OPPS effective January 1, 2005, and a new temporary C-code has been established to allow hospitals to receive pass-through payments for this product.

Comment: A commenter requested that CMS show three separate tables for the nonpass-through drugs; that is, one for sole source drugs, one for innovator multiple source drugs, and one for noninnovator multiple source drugs.

Response: We have accepted the commenter's suggestion and created three distinct tables listing the sole source drugs, innovator multiple sources drugs, and noninnovator multiple source drugs.

Tables 27 and 28 below list the final payment amounts for innovator and noninnovator multiple source drugs, biologicals, and radiopharmaceuticals, respectively, effective January 1, 2005 to December 31, 2005.

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Table 27. – CY 2005 APC Payment Rates for Multiple Source Innovator Drugs, Biologicals, and Radiopharmaceuticals

HCPCS	Status Indicator	APC	Short Description	CY 2005 Payment Rate
C1775	K	1775	FDG, per dose (4-40 mCi/ml)	$221.11
C9400	K	9400	Thallous chloride, brand	$21.19
C9401	K	9401	Strontium-89 chloride, brand	$406.16
C9402	K	9402	Th I131 so iodide cap, brand	$6.57
C9403	K	9403	Dx I131 so iodide cap, brand	$6.57
C9404	K	9404	Dx I131 so iodide sol, brand	$9.73
C9405	K	9405	Th I131 so iodide sol, brand	$9.73
C9410	K	9410	Dexrazoxane HCl inj, brand	$123.93
C9411	K	9411	Pamidronate disodium, brand	$160.65
C9413	K	9413	Sodium hyaluronate inj, brand	$53.94
C9414	K	9414	Etoposide oral, brand	$25.71
C9415	K	9415	Doxorubic hcl chemo, brand	$6.94
C9417	K	9417	Bleomycin sulfate inj, brand	$130.56
C9418	K	9418	Cisplatin inj, brand	$11.42
C9419	K	9419	Inj cladribine, brand	$36.72
C9420	K	9420	Cyclophosphamide inj, brand	$4.10
C9421	K	9421	Cyclophosphamide lyo, brand	$3.50
C9422	K	9422	Cytarabine hcl inj, brand	$2.28
C9423	K	9423	Dacarbazine inj, brand	$8.15
C9424	K	9424	Daunorubicin, brand	$53.14
C9425	K	9425	Etoposide inj, brand	$1.22
C9426	K	9426	Floxuridine inj, brand	$97.92
C9427	K	9427	Ifosfomide inj, brand	$90.80
C9428	K	9428	Mesna injection, brand	$23.79
C9429	K	9429	Idarubicin hcl inj, brand	$66.58
C9430	K	9430	Leuprolide acetate inj, brand	$21.41
C9431	K	9431	Paclitaxel inj, brand	$93.50
C9432	K	9432	Mitomycin inj, brand	$45.70
C9433	K	9433	Thiotepa inj, brand	$66.98
C9435	K	9435	Gonadorelin hydroch, brand	$17.08
C9436	K	9436	Azathioprine parenteral,brnd	$44.61
C9437	K	9437	Carmus bischl nitro inj	$79.42
C9438	K	9438	Cyclosporine oral, brand	$1.78
C9439	K	9439	Diethylstilbestrol injection	$10.32

Table 28. – CY 2005 Payment Amounts for Noninnovator Multiple Source Drugs, Biologicals, and Radiopharmaceuticals

HCPCS	Status Indicator	APC	Short Description	CY 2005 Payment Rate
A9505	K	1603	Thallous chloride TL 201/mci	$18.29
A9517	K	1064	Th I131 so iodide cap millic	$6.57
A9528	K	1064	Dx I131 so iodide cap millic	$6.57
A9529	K	1065	Dx I131 so iodide sol millic	$9.73
A9530	K	1065	Th I131 so iodide sol millic	$9.73
A9600	K	0701	Strontium-89 chloride	$406.16
J1190	K	0726	Dexrazoxane HCl injection	$113.28
J1620	K	7005	Gonadorelin hydroch/ 100 mcg	$17.08
J2430	K	0730	Pamidronate disodium /30 MG	$128.74
J7317	K	7316	Sodium hyaluronate injection	$53.94
J7501	K	0887	Azathioprine parenteral	$30.18
J7502	K	0888	Cyclosporine oral 100 mg	$1.78
J8560	K	0802	Etoposide oral 50 MG	$21.91
J9000	K	0847	Doxorubic hcl 10 MG vl chemo	$4.69
J9040	K	0857	Bleomycin sulfate injection	$88.32
J9050	K	0812	Carmus bischl nitro inj	$65.94
J9060	K	0813	Cisplatin 10 MG injection	$7.73
J9065	K	0858	Inj cladribine per 1 MG	$24.84
J9070	K	0815	Cyclophosphamide 100 MG inj	$2.77
J9093	K	0816	Cyclophosphamide lyophilized	$2.36
J9100	K	0817	Cytarabine hcl 100 MG inj	$1.55
J9130	K	0819	Dacarbazine 100 mg inj	$6.14
J9150	K	0820	Daunorubicin	$35.94
J9165	K	0822	Diethylstilbestrol injection	$6.98
J9181	K	0824	Etoposide 10 MG inj	$0.83
J9200	K	0827	Floxuridine injection	$66.24
J9208	K	0831	Ifosfomide injection	$72.81
J9209	K	0732	Mesna injection	$17.66
J9211	K	0832	Idarubicin hcl injection	$66.58
J9218	K	0861	Leuprolide acetate injeciton	$14.48
J9265	K	0863	Paclitaxel injection	$79.04
J9280	K	0862	Mitomycin 5 MG inj	$30.91
J9340	K	0851	Thiotepa injection	$45.31

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b. Treatment of Three Sunsetting Pass-Through Drugs as Specified Covered Outpatient Drugs

As we discussed in the August 16, 2004 proposed rule, there are 13 drugs and biologicals whose pass-through status will expire on December 31, 2004. Table 29 below lists these drugs and biologicals.

Pass-through payment was made for 10 of these 13 items as of December 31, 2002. Therefore, these 10 items now qualify as specified covered outpatient drugs under section 1833(t)(14) of the Act, as added by section 621(a) of Pub. L. 108–173, as described above. However, pass-through status for three of the pass-through drugs and biologicals that will expire on December 31, 2004 (C9121, Injection, Argatroban; J9395, Fulvestrant; and J3315, Triptorelin pamoate), was first made effective on January 1, 2003. These items are specifically excluded from the definition of ''specified covered outpatient drugs'' in section 1833(t)(14)(B)(ii) of the Act, because they are not drugs or biologicals for which pass-through payment was first made on or before December 31, 2002. Pub. L. 108–173 does not address how

to set payment for items whose pass-through status expires in CY 2004, but for which pass-through payment was not made as of December 31, 2002.

Therefore, we proposed to pay for the three expiring pass-through items for which payment was first made on January 1, 2003, rather than on or before December 31, 2002 using the methodology described under section 1833(t)(14) of the Act for specified covered outpatient drugs. We believed that this methodology would allow us to determine appropriate payment amounts for these products in a manner that is consistent with how we pay for drugs and biologicals whose pass-through status was effective as of December 31, 2002, and that does not penalize those products for receiving pass-through status beginning on or after January 1, 2003 and expiring December 31, 2004. In Table 27 in the proposed rule, we listed the CY 2005 OPPS payment rates that we proposed for these three drugs and biologicals.

Of the 13 products for which we proposed that pass-through status expire on December 31, 2004, we proposed to package two of them (C9113, Inj. Pantoprazole sodium and J1335, Ertapenum sodium) because their median cost per day falls below the $50 packaging threshold. We proposed to pay for the remaining 11 drugs and biologicals as sole source items according to the payment methodology for sole source products described above.

We note that darbepoetin alfa (Q0137) will be considered a ''specified covered outpatient drug'' in CY 2005. Payment for these drugs is governed under section 1833(t)(14) of the Act. Specifically, we proposed that darbepoetin alfa would be paid as a sole source drug at a rate between 83 percent and 95 percent of its reference AWP. Accordingly, we specifically solicited comments on whether we should again apply an equitable adjustment, made pursurant to section 1833(t)(2)(E) of the Act, to the price for this drug.

Comment: Numerous commenters applauded CMS for proposing a fair and consistent payment methodology for drugs and biologicals whose pass-through status expires on December 31, 2004, and supported the proposal to treat these three therapies as specified covered outpatient drugs. They also encouraged CMS to expand this treatment to all separately paid drugs and biologicals in the future. A few commenters, including MedPAC, disagreed with our proposal to pay for the three expiring pass-through items for which payment was first made on January 1, 2003, as ''specified covered outpatient drugs.'' One commenter indicated that because these three drugs were excluded from the statutory definition of ''specified covered outpatient drug,'' it did not believe that CMS had the authority to treat newer drugs expiring out of pass-through status as specified covered outpatient drugs. Therefore, the commenter believed that CMS should pay for newer drugs expiring from pass-through status at 106 percent ASP, the rate applicable to the physician setting. MedPAC expressed concern about treating these 3 expiring pass-through drugs differently from the older, historically packaged drugs that are now eligible for separate payment and whose payments will be based on the median cost from the claims data. MedPAC indicated that the purpose of the pass-through payments is to allow time to accumulate data on costs and that there seemed to be no reason to believe that claims data are more accurate for one category of drugs that the other. Therefore, the drugs coming off pass-through, which do not fall under the SCOD category, and the older drugs should be paid consistently.

Response: We appreciate the commenters' support for our proposal to treat the three items for which pass-through status expires on December 31, 2004, but that were approved for pass-through status effective January 1, 2003, similar to the other drugs and biologicals whose pass-through status expires December 31, 2004, but that were approved for pass-through status on or before December 31, 2002. The statute does not address payment for drugs and biologicals that had pass-through status effective on January 1, 2003, but not on or before December 31, 2002. These items are newer drugs than the older products that never received pass-through status. We have accumulated cost data for these three drugs throughout the same 2-year period during which we accumulated cost data for the other drugs and biologicals whose pass-through status expires on December 31, 2004. Therefore, noting that the statute does not address drugs whose pass-through status likewise expires on December 31, 2004, but was approved on January 1, 2003, we believe it is reasonable to pay for these three drugs in a manner consistent with how we pay for the other drugs whose pass-through status likewise sunsets on December 31, 2004.

Comment: We received a number of comments concerning our proposal to pay for both epoetin alfa (marketed under trade name of Procrit) and darbepoetin alfa (marketed under the trade name of Aranesp®) based on 83 percent of their individual reference AWPs. A number of commenters also wrote in response to our solicitation for comments concerning the application of our equitable adjustment authority in determining the payment rate for darbepoetin alfa. Commenters acknowledged that both biologicals meet the MMA definition of specified covered outpatient drug (SCOD) and that the pass-through status of darbepoetin alfa ends on January 1, 2005. One of the commenters supported the proposal to establish payment for darbepoetin alfa as a SCOD, to base CY 2005 payment on its reference AWP, and to discontinue the application of an equitable adjustment to reduce the statutorily mandated payment for any product paid under the OPPS in CY 2005. This commenter stated the proposed payment for darbepoetin alfa as a sole source SCOD is fully consistent with section 621 of the MMA and that this is consistent with the method of payment for all other sole source SCODs. The commenter further stated that when drafting the language for section 622 of the MMA, Congress intended to ensure that considerations of functional equivalence were not applied to darbepoetin alfa after its pass-through status expired. This commenter acknowledges that section 1833(t)(2)(E) of the Act permits CMS to make ''adjustments as determined to be necessary to ensure equitable payments.'' However, this commenter stated that payments for the two products are already inherently equitable at the proposed rates because they are comparably priced and because CMS proposed to set the payment rates for the two products using the same methodology. The commenter noted that when CMS first applied the equitable adjustment for darbepoetin alfa, in CY 2003, CMS had only three choices for establishing drug payments under the OPPS: (1) Packing payment with related services; (2) using charges from outpatient claims to derive median cost; and (3) paying separately under the pass-through provisions, at 95 percent of AWP. The commenter notes the new payment methodology for all sole source ''specified covered outpatient drugs'' and argues that by applying this methodology to both of these biologicals, CMS would establish a level playing field and assure that market-based forces remain operable. This commenter also provided data concerning the clinical efficacy of darbepoetin alfa.

Many of the other commenters stated that CMS' application of its equitable adjustment authority deviated from the MMA's intent to pay for sole source

products and multi-source products under separate payment methodologies. The commenters were concerned about the significant impact that application of such authority may have on a company's decision to continue developing innovator products. The commenters also argued that applying such a policy could inject CMS into clinical decisions based solely on economic considerations and create payment incentives that distort patient decisions properly entrusted to treating physicians. One commenter recommended that if CMS plans to utilize this authority again, then CMS should hold a public forum and provide interested parties with an opportunity to submit written comments about the standards that will be used to determine equitable adjustment. Other commenters argued that CMS should comply with the MMA and protect patient access to innovative therapies by not applying functional equivalence or a similar standard to any drug in 2005 or future years.

One commenter on this topic also provided detailed results of clinical studies that the commenter believes support the necessity of a continuation of the equitable payment adjustment. This commenter further stated that the clinical data support the use of a particular conversion ratio in making such an adjustment. The commenter noted that without an equitable adjustment policy, both drugs would be paid at 83 percent of each product's AWP. The commenter estimated weekly payments for the two drugs under four scenarios: an equitable adjustment based on three different conversion ratios and the proposed policy of treating each drug independently without application of an equitable adjustment. According to this commenter, overall Medicare expenditures and beneficiary coinsurance payments would increase for the treatment of chemotherapy-induced anemia in the absence of an equitable payment adjustment. The commenter's estimates assume a 50 percent market share for each of the two drugs and estimated 2005 spending based on 2003 OPPS claims data with anemia market unit growth assumptions of 35 percent in 2004 and 22 percent in 2005. The commenter also noted that the MMA did not remove the Secretary's authority to establish adjustments to ensure equitable payments and that the Secretary retains the authority to determine the CY 2005 payment rate for darbepoetin alfa using the equitable payment policy applied in CY 2003 and CY 2004. This commenter also argued that the MMA prohibition on the use of a functional equivalence standard applies only to pass-through drugs and only to future implementation.

A comment from MedPAC on this issue indicated that as costs to the Medicare program continue to grow, the program will need to examine tools for obtaining value in its purchasing. MedPAC believed that, absent evidence that the CMS' use of its equitable adjustment to set equivalent payment rates for Procrit and Aranesp® denied beneficiaries' access to needed treatments, CMS should pursue value-based purchasing where possible.

Response: As the commenters noted, while we proposed a payment rate for darbepoetin alfa as a sole source SCOD based on its reference AWP, we also specifically solicited comments on whether we should again apply an equitable adjustment, made pursuant to section 1833(t)(2)(E) of the Act, to establish the payment for this drug in CY 2005. After careful consideration of the thoughtful and well-documented comments concerning this issue, we have concluded that it is still appropriate to apply an adjustment to the payment for darbepoetin alfa under our authority in section 1833(t)(2)(E) of the Act to ensure that equitable payments for these two products under the OPPS continue in CY 2005. We agree with those commenters that argued that section 1833(t)(2)(E) of the Act was not affected by the provisions of the MMA and that we retain our authority to make such adjustments to payments under the OPPS. As we have done previously, we will reassess the need to exercise our adjustment authority when we next review the payment rates under the OPPS.

To apply an equitable adjustment for CY 2005, we reviewed the analysis we conducted during 2003 and the additional data we received in 2004. As we discussed in further detail in our November 7, 2003 final rule with comment period for the 2004 update to the OPPS (68 FR 63455) and our November 1, 2002 final rule with comment period for the 2003 update (67 FR 66758), because darbepoetin alfa has two additional carbohydrate side-chains, it is not structurally identical to epoetin alfa. The addition of these two carbohydrate chains affects the biologic half-life of the compound. This change in turn affects how often the biological can be administered, which yields a different dosing schedule for darbepoetin alfa by comparison to epoetin alfa. Amgen has FDA approval to market darbepoetin alfa under the trade name ® for treatment of anemia related to chronic renal failure (including patients on and not on dialysis) and for treatment of chemotherapy-related anemia in cancer patients. Epoetin alfa, which is marketed by Ortho Biotech under the trade name Procrit, is approved by FDA for marketing for the following conditions: (1) Treatment of anemia of chronic renal failure (including for patients on and not on dialysis); (2) treatment of Zidovudine-related anemia in HIV patients; (3) treatment of anemia in cancer patients on chemotherapy; and (4) treatment of anemia related to allogenic blood transfusions in surgery patients.

The two biologicals are dosed in different units. Epoetin alfa is dosed in Units per kilogram (U/kg) of patient weight and darbepoetin alfa in micrograms per kilogram (mcg/kg). The difference in dosing metric is due to differences in the accepted convention at the time of each product's development. At the time epoetin alfa was developed, biologicals (such as those like epoetin alfa that are produced by recombinant DNA technology) were typically dosed in International Units (or Units for short), a measure of the product's biologic activity. They were not dosed by weight (for example, micrograms) because of a concern that weight might not accurately reflect their standard biologic activity. The biologic activity of such products can now be accurately predicted by weight, however, and manufacturers have begun specifying the doses of such biologicals by weight. No standard formula exists for converting amounts of a biologic dosed in Units to amounts of drug dosed by weight.

The process that we used in 2003 to define the payment conversion ratio between the two biologicals for CY 2004 is described in the November 7, 2003 final rule with comment period. We refer readers to that discussion, found at 68 FR 63455, for more complete details on that process and the data received and reviewed by CMS during the process. At the conclusion of the 2003 process, we established a conversion ratio of 330 Units of epoetin alfa to 1 microgram of darbepoetin alfa (330:1) for establishing the CY 2004 payment rate for darbepoetin alfa.

During the comment period, each company presented additional data concerning their products. Based upon our analysis to date, we continue to believe that the conversion ratio used for CY 2004 is appropriate for purposes of establishing equitable payment under the OPPS for both epoetin alfa and darbepoetin alfa for CY 2005. Initial review of new information submitted by the commenters provides no compelling

evidence that the conversion ratio of 330:1 is unreasonable. Therefore, for this final rule with comment period, we have established payment for darbepoetin alfa by applying the conversion ratio of 330:1 to 83 percent of the AWP for epoetin alfa. The resulting payment rate for darbepoetin alfa is $3.66 per microgram. We will continue to assess the data we have received thus far and invite the submission of additional information. In order to fully evaluate and assess this issue in determining whether any further adjustment of the conversion ratio is necessary, additional analysis will be required. If, after additional review and analysis, we determine that a different conversion ratio is more appropriate, we will make a change in the payment rate for darbepoetin alfa to reflect the change in ratio as soon as possible.

We do not believe that our application of an equitable adjustment will create a barrier to treatment for the conditions for which these products are prescribed or to the product of choice of the beneficiary and his or her treating physician. According to the most recent average sales price (ASP) information collected by CMS and available in time for this final rule with comment period, 106 percent of ASP for darbepoetin alfa is $3.69 per microgram. This amount would have been the basis for payment under the OPPS on January 1, 2005 if pass-through status did not expire and if we did not apply an equitable adjustment. Furthermore, as we have emphasized in prior rulemaking on this topic, our conversion of amounts of a biologic dosed in Units to amounts of a drug dosed by weight strictly for the purpose of calculating a payment rate should not in any way be viewed as a statement regarding the clinical use of either product. The method we use to convert Units to micrograms in order to establish equitable payments is not intended to serve as a guide for dosing individual patients in clinical practice. By using a conversion ratio solely for the purpose of establishing equitable payments, CMS is not attempting to establish a lower or upper limit on the amount of either biological that a physician should prescribe to a patient. We expect that physicians will continue to prescribe these biologicals based on their own clinical judgment of the needs of individual patients.

Table 29 below lists the final CY 2005 OPPS payment rates for the three sunsetting pass-through drugs and biologicals that will be treated as specified covered outpatient drugs.

Table 29. -- CY 2005 APC Payment Rates for Three Expiring Pass-Through Drugs and Biologicals That Will Be Treated As Specified Covered Outpatient Drugs

HCPCS Code	Status Indicator	Short Description	APC	CY 2005 Payment Rate
J9395	K	Injection, Fulvestrant	9120	$79.65
J3315	K	Triptorelin pamoate	9122	$362.78
C9121	K	Injection, argatroban	9121	$12.45

c. CY 2005 Payment for Nonpass-through Drugs, Biologicals, and Radiopharmaceuticals With HCPCS Codes, But Without the OPPS Hospital Claims Data

Pub. L. 108–173 does not address the OPPS payment in CY 2005 for new drugs and biologicals that have assigned HCPCS codes, but that do not have a reference AWP or approval for payment as pass-through drugs or biologicals. Because there is no statutory provision that dictates payment for such drugs and biologicals in CY 2005, and because we have no hospital claims data to use in establishing a payment rate for them, we investigated other possible options to pay for these items in CY 2005. Clearly, one option is to continue packaging payment for these new drugs and biologicals that have their own HCPCS codes until we accumulate sufficient claims data to calculate median costs for these items. Another option is to pay for them separately using a data source other than our claims data. The first option is consistent with the approach we have taken in prior years when claims data for new services and items have not been available to calculate median costs. However, because these new drugs and biologicals may be expensive, we are concerned that packaging these new drugs and biologicals may jeopardize beneficiary access to them. In addition, we do not want to delay separate payment for a new drug or biological solely because a pass-through application was not submitted.

Therefore, for CY 2005, we proposed to pay for these new drugs and biologicals with HCPCS codes but which do not have pass-through status at a rate that is equivalent to the payment they would receive in the physician office setting, which would be established in accordance with the methodology described in the CY 2005 Medicare Physician Fee Schedule proposed rule (69 FR 47488, 47520 through 47524). We noted that this payment methodology is the same as the methodology that will be used to calculate the OPPS payment amount that pass-through drugs and biologicals will be paid in CY 2005 in accordance with section 1842(o) of the Act, as amended by section 303(b) of Pub. L. 108–173, and section 1847A of the Act. Thus, we proposed to treat new drugs and biologicals with established HCPCS codes the same, irrespective of whether pass-through status has been determined. We also proposed to assign status indicator ''K'' to HCPCS codes for new drugs and biologicals for which we have not received a pass-through application.

In light of our August 16, 2004 proposal, we understood that manufacturers might be hesitant to apply for pass-through status. However, we did not believe there would be many instances in CY 2005 when we would not receive a pass-through application for a new drug or biological that has an HCPCS code. To avoid delays in setting an appropriate payment amount for new drugs and biologicals and to expedite the processing of claims, we strongly encouraged manufacturers to continue submitting pass-through applications for new drugs and biologicals when FDA

approval for a new drug or biological is imminent to give us advance notice to begin working to create an HCPCS code and APC. The preliminary application would have to be augmented by FDA approval documents and final package inserts once such materials become available. However, initiating the pass-through application process as early as possible would enable us to expedite coding and pricing for the new drugs and biologicals and accelerate the process for including them in the next available OPPS quarterly release.

In the August 16, 2004 proposed rule, we discussed how we proposed to pay in CY 2005 for new drugs and biologicals between their FDA approval date and assignment of an HCPCS code and APC. We shared the desire of providers and manufacturers to incorporate payment for new drugs and biologicals into the OPPS as expeditiously as possible to eliminate potential barriers to beneficiary access and to minimize the number of claims that must be processed manually under the OPPS interim process for claims without established HCPCS codes and APCs, and we solicited public comments on our proposal.

Comment: Several commenters commended CMS's proposal to set payment rates for new drugs with HCPCS codes using the same methodology proposed to set payment for drugs with pass-through status, regardless of whether a pass-through application has been submitted for the new drug. They applauded CMS for acknowledging that packaging payment for these new therapies might jeopardize beneficiary access to them. However, a comment from MedPAC indicated that CMS's proposal to pay 106 percent of ASP for this particular group of drugs and biologicals represented a change in policy where drugs of this nature were previously packaged until sufficient claims data were accumulated to calculate payment rates, unless they received pass-through status via an application process. MedPAC was concerned that the newly approved drugs and biologicals that do not go through the pass-through payment mechanism will be added to the OPPS system without any control on spending since this policy does not have a budget neutrality provision, similar to pass-through payments. Given that the pass-through policy existed as a controlled mechanism for introducing new drugs into the OPPS, these drugs should either be treated through the pass-through process or continue to be packaged under the previous policy.

Response: We appreciate the commenters' support for our proposal to pay for new drugs with HCPCS codes, but without pass-through status and hospital claims data under the same methodology that will be used to pay for them in the physician office setting. We also understand MedPAC's concern about budget neutrality associated with this policy. Our intent in paying for new drugs and biologicals with HCPCS codes, but without pass-through status and hospital claims data, separately, was that we recognized that some of these new products would be important new therapies in treatment of such diseases as cancer. We also believe that the MMA provision that requires CMS to pay for new drugs and biologicals before a code is assigned indicates that Congress intended for us to pay separately for new items until we have hospital claims data that would allow us to determine whether the product should be packaged. We are concerned that packaging their payments may prevent hospitals from acquiring these products and in turn harm beneficiaries' access to them. We do not expect the volume of new drugs and biologicals to which we would apply this policy in CY 2005 to be so significant as to have an effect on budget neutrality. Moreover, we would not expect this policy to have a differential impact on budget neutrality any more than payment for the drugs would affect pass-through spending had the drugs been approved for pass-through status. We also believe (and strongly encourage) that stakeholders will continue to apply for pass-through status for new drugs, biologicals and radiopharmaceuticals as a means of ensuring that we have all of the information required to establish accurate payments for these items as quickly as possible. At the same time, if we were to package all such items, we are concerned that it would provide a disincentive for manufacturers to come forward and request codes for new items. Under the MMA provision described above, we are required to pay for new drugs and biologicals without HCPCS code at 95 percent of AWP, which we would expect to generally be higher than 106 percent of ASP. We also believe the MMA provision regarding drugs without HCPCS codes indicates that Congress clearly intended that we pay separately for new drugs and biologicals. Therefore, for CY 2005 we will finalize the policy that we proposed to pay separately for new drugs and biologicals with HCPCS codes but without pass-through status and hospital claims data based on the payment for the same new products in a physician office.

We will, however, monitor this carefully during the course of CY 2005 and reassess the policy for CY 2006. In CY 2005, payment for these new drugs and biologicals will be based on 106 percent of ASP. In the absence of ASP data, we will use wholesale acquisition cost (WAC) for the product to establish the initial payment rate. If WAC is also unavailable, then we will calculate payment at 95 percent of the May 1, 2003 AWP or the first reported AWP for the product. We have used the second quarter ASP data from CY 2004 because those were the most recent numbers available to us in time for the publication for this rule. To be consistent with the ASP-based payments that will be made when these drugs and biologicals are furnished in the physician offices, we plan to make any appropriate adjustments to the amounts shown in Addendum A and B if later quarter ASP submissions indicate that adjustments to the payment rates are necessary. We will announce such changes in our program instructions to implement quarterly releases and post any revisions to the addenda on the *www.cms.hhs.gov* Web site. We will similarly adjust payment for items for which we used AWP or WAC because ASP was not available if ASP becomes available from later quarter submissions.

For CY 2005, we will apply this policy to three drugs and biologicals that are new effective January 1, 2005 and do not have pass-through status and hospital claims data. These drugs will be separately payable under the OPPS, and thus, we have assigned them to status indicator ''K''. Table 30 below lists these drugs and biologicals and the payment methodologies used to calculate their APC payments listed in Addendum A and B of this rule.

Table 30. -- New CY 2005 HCPCS Codes for Drugs and Biologicals without Pass-Through Status and Hospital Claims Data

HCPCS Code	APC	Short Descriptor	CY 2005 Payment Methodology
J0135	1083	Injection, Adalimumab, 20 mg	95% AWP
J1457	1085	Injection, Gallium nitrate, 1 mg	WAC
J7674	0867	Methacholine Chloride, neb	95% AWP

We have also identified several drugs and biologicals with new HCPCS codes created effective January 1, 2004, that do not meet the definition of ''specified covered outpatient drugs'' and for which we would not have CY 2003 hospital claims data. These items are packaged in CY 2004, and we also proposed to package them for CY 2005 in the proposed rule. To avoid negatively impacting beneficiary access to these new products by packaging them, we will be paying for these drugs in CY 2005 under the same methodology that will be used to pay for them in the physician office setting. The rules for determining payment for these drugs will be the same as the rules for new drugs with HCPCS codes but without pass-through status in CY 2005. In CY 2005, these drugs will be separately payable under the OPPS, and thus, we have assigned status indicator ''K'' to these drugs. Table 31 below lists these drugs and biologicals and the payment methodologies used to calculate their APC payments listed in Addendum A and B of this rule.

We note that CPT 90715 (Tdap vaccine > 7 im) was newly created in 2004; however, we will not apply this payment policy to this code because all of the vaccines similar to this product are packaged in CY 2004 and will remain packaged in CY 2005. This payment policy also will not apply to new radiopharmaceuticals since all radiopharmaceuticals meet the definition of ''specified covered outpatient drugs''. Therefore, payment for new radiopharmaceuticals will be made according to the payment methodologies established for ''specified covered outpatient drugs'' under section 1833(t)(14)(A)(ii) of the Act.

Table 31. - New 2004 HCPCS Codes for Drugs and Biologicals without Pass-Through Status and Hospital Claims Data

HCPCS	APC	Description	CY 2005 Payment Methodology
J0595	0703	Butorphanol tartrate 1 mg	106 % ASP
J2185	0729	Meropenem	106% ASP
J2280	1046	Inj, moxifloxacin 100 mg	WAC
J3411	1049	Thiamine hcl 100 mg	WAC
J3415	1050	Pyridoxine hcl 100 mg	WAC
J3465	1052	Injection, voriconazole	106% ASP
Q4075	1062	Acyclovir, 5 mg	106% ASP
Q4076	1070	Dopamine hcl, 40 mg	106% ASP
Q4077	1082	Treprostinil, 1 mg	106% ASP

Comment: One commenter noted that CMS historically had declined to process pass-through applications prior to FDA approval, consequently many manufacturers have ceased submitting early applications. The commenter stated that manufacturers may be uncomfortable submitting the detailed information required for the pass-through application prior to securing FDA approval. The commenter suggested that a more realistic expectation of the timeframe for pass-through application would be at or subsequent to FDA approval, when the product launch is imminent.

Response: We recognize that some manufacturers may be concerned about submitting detailed information for pass-through application in advance of FDA's approval for their product. However, we reiterate that we strongly encourage manufacturers to continue submitting pass-through applications when FDA approval for a new drug or biological is imminent to give us advance notice to begin working to create a HCPCS code and an APC for their product. While we will not be able to give final approval to the pass-through application prior to FDA approval, early notification about the product prior to FDA approval can expedite the granting of a new product-specific code and implementation of

that code and appropriate payment rate within our system.

d. Payment for Separately Payable NonPass-Through Drugs and Biologicals

As discussed in section V.B.2. of the August 16, 2004 proposed rule, for CY 2005, we used CY 2003 claims data to calculate the proposed median cost per day for drugs, biologicals, and radiopharmaceuticals that have an assigned HCPCS code and are paid either as a packaged or separately payable item under the OPPS. Section 1833(t)(14) of the Act, as added by section 621(a) of Pub. L. 108–173, specified payment methodologies for most of these drugs, biologicals, and radiopharmaceuticals. However, this provision did not specify how payment was to be made for separately payable drugs and biologicals that never received pass-through status and that are not otherwise addressed in section 1833(t)(14) of the Act. Some of the items for which such payment is not specified are (1) those that have been paid separately since implementation of the OPPS on August 1, 2000, but are not eligible for pass-through status, and (2) those that have historically been packaged with the procedure with which they are billed but, based on the CY 2003 claims data, their median cost per day is above the legislated $50 packaging threshold. Because Pub. L. 108–173 does not address how we are to pay for such drugs and biologicals (any drug or biological that falls into one or the other category and that has a per day cost greater than $50), we proposed to set payment based on median costs derived from the CY 2003 claims data. Because these products are generally older or low-cost items, or both, we believe that the payments will allow us to provide adequate payment to hospitals for furnishing these items. In the proposed rule, we listed in Table 28 the drugs and biologicals to which the proposed payment policy would apply.

We received numerous public comments on our proposal.

Comment: A commenter expressed concern about the proposed payment rate for HCPCS code J7342 (Dermal tissue, of human origin, with or without other bio-engineered or processed elements, with metabolically active elements, per square centimeter) when billed by Maryland-based hospitals and comprehensive outpatient rehabilitation facilities (CORFs).

Response: We understand the commenter's concern; however, Maryland-based hospitals and CORFs are excluded from payment under the OPPS and the OPPS payment rates do not apply to them. This final rule with comment period addresses only the providers that are paid under the OPPS. Therefore, this comment is outside the scope of this rule.

Comment: An association for manufacturers of contrast agents supported CMS' proposal to pay separately for certain MRI contrast agents (for example, HCPCS codes A4643 and A4647). However, the commenter was concerned that the payment rates for these products were based on CY 2003 hospital claims data and that the overall accuracy of the hospital median cost data is questionable; therefore, the commenter recommended that CMS review the proposed payment rates for MRI contrast agents and requested that such review include a confirmation that the median cost data used as the basis for calculating the payment rates are correct. The commenter also indicated that the proposed rule did not have unit descriptors for the HCPCS codes A4643 and A4647 and requested that CMS add the unit descriptor, ''up to 20 ml'' to HCPCS codes A4643 and A4647 in order to provide further clarity and facilitate more accurate coding and billing by hospitals.

Response: We understand the commenter's concern about setting appropriate payment rates for these products. These products do not meet the definition of ''specified covered outpatient drugs'' as defined in the MMA; however, we do have a significant number of CY 2003 hospital claims data for these products. It is our general policy under the OPPS to use the most recent available hospital claims data in setting the OPPS payment rates. For CY 2005, both of these products will be separately payable items. The payment rate for A4643 will be based on approximately 14,200 claims for approximately 27,000 services, and payment for A4647 will be based on approximately 87,600 claims for approximately 155,000 services.

We believe that the CY 2003 claims data contain a sufficiently robust set of claims for both products on which to base the payment rates for these items using the methodology that will be used for other separately payable non-pass-through drugs and biologicals. With respect to adding unit descriptors to A4643 and A4647, we suggest that the commenter pursue these changes through the process set up by the National HCPCS Panel.

Comment: A commenter expressed concern that CMS may have inappropriately packaged low osmolar contrast material (LOCM) drugs into APCs based on a determination that the drugs do not meet CMS's packaging rule because they are below the $50 threshold required for separate payment. The commenter questioned the accuracy of the median cost data used as the basis for CMS's decision as CMS' paid claims files for LOCM do not include unit descriptors for the HCPCS codes A4644, A4645, and A4646. The commenter is concerned that this makes it difficult to interpret the data in any meaningful way for purposes of determining what the payment rates for these drugs should be and whether they should be paid separately, in particular, because the dose administered per procedure can range from 10 ml to 200 ml. The commenter also believed that CMS should pay for LOCM drugs separately in the hospital outpatient setting because they are paid as such in the physician office setting. Therefore, the commenter recommended that CMS exercise its discretion to apply an exception to the packaging rule to LOCM as it did with the anti-emetics and allow separate payment for LOCM drugs in CY 2005. The commenter also suggested that CMS assign the unit descriptor ''per 10 ml'' to HCPCS codes A4644, A4645, and A4646.

Response: We recognize that the commenter is concerned about the packaging of the three LOCM products. Based on the methodology used to calculate median cost per day for drugs and biologicals, as explained in section V.B.2. of the preamble, we determined that the per day costs of these products were below $50. Therefore, these items were packaged. We note that the LOCM products are a unique class of drugs that have always been packaged from the beginning of the OPPS in August 1, 2000, and this is the first year that we looked into the cost data for these drugs to determine whether they should be paid separately. We realize that for CY 2005 these drugs will be packaged under the OPPS, but will receive separate payment in the physician office setting. However, based upon the statutory packaging threshold for drugs and biologicals as per administration cost less than $50, we believe that it is appropriate for us to package the LOCM drugs under the OPPS. With respect to adding unit descriptors to HCPCS code A4644, A4645, and A4646, we suggest that the commenter pursue these changes through the process set up by the National HCPCS Panel.

Comment: We received comments concerning the new Part D prescription drug benefit mandated by the MMA and the intersection between drugs covered by Part D and Part B.

Response: Because such issues are not within the scope of this CY 2005 OPPS

final rule with comment period, we will not respond to those comments in this document.

Comment: We received many comments from makers of drug and biological products, national trade associations, and an association for cancer centers suggesting that CMS should expand the future rate-setting methodology for ''specified covered outpatient drugs'' to include all drugs and biologicals that either are or were previously paid separately under the OPPS, regardless of whether the drugs meet or exceed the $50 threshold. The commenters also recommended that CMS also work with GAO and MedPAC to ensure that their respective studies of the acquisition costs and pharmacy service and overhead costs include all of these drugs and biologicals and that the studies are thorough and will contain all the information CMS needs to set proper payment rates in the future. Many of these commenters were concerned about CMS' use of claims, other data, and the methodologies used to establish the OPPS payments for drugs and biologicals that do not meet the definition of ''specified covered outpatient drugs'' and therefore, are not statutorily required to be included in these studies. The commenters suggested that CMS should not implement different methodologies for ''specified covered outpatient drugs'' and other separately paid drugs in CY 2006; instead, CMS should ensure appropriate payment for all Medicare covered drugs by applying the acquisition cost-based payment methodology to all separately paid drugs. One commenter believed that Congress fully intended for all separately paid drugs and biologicals to be paid based on hospital acquisition costs, as informed by these studies. Another commenter recommended that CMS continue to accept external cost data that may be submitted by knowledgeable stakeholders, such as manufacturers, providers, or patients to provide verification of hospital acquisition costs for specific drugs and biologicals. One commenter indicated that it would like to work with CMS as it prepares the hospital acquisition cost survey for the CY 2006 rates.

Response: We appreciate the interest expressed by many of the commenters regarding the MMA-mandated surveys that will be conducted by the GAO and MedPAC of hospital acquisition cost for drugs and biologicals and their overhead and related costs, respectively. However, we note that these provisions of the MMA affect payment for drugs and biologicals in CY 2006, and thus, these comments fall outside the scope of this rule. Therefore, we will not be responding to these comments at this time.

Comment: A commenter requested that CMS examine every HCPCS J-code for drugs to ensure that the dosage definitions for the HCPCS codes are set at the lowest available manufacturers' dosage and match the customary dispensing packaging.

Response: Changes to the HCPCS J-codes are made by the National HCPCS Panel; therefore, this comment is outside the scope of this OPPS final rule. We suggest that the commenter pursue these changes through the process established by the National HCPCS Panel.

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Table 32. – CY 2005 APC Payment Rates for Drugs, Biologicals, and Radiopharmaceuticals (Based on Median Cost)

HCPCS	Status Indicator	APC	Short Description	CY 2005 Payment Rate
A4643	K	9026	High dose contrast MRI	$26.24
A4647	K	9027	Supp- paramagnetic contr mat	$35.59
J0120	K	9028	Tetracyclin injection	$99.99
J0150	K	0379	Injection adenosine 6 MG	$12.33
J0152	K	0917	Adenosine injection	$8.71
J0282	K	9029	Amiodarone HCl	$11.00
J0285	K	9030	Amphotericin B	$20.64
J0395	K	9031	Arbutamine HCl injection	$68.08
J0475	K	9032	Baclofen 10 MG injection	$10.68
J0740	K	9033	Cidofovir injection	$407.58
J0743	K	0846	Cilastatin sodium injection	$11.37
J0900	K	0848	Testosterone enanthate inj	$38.27
J0945	K	9034	Brompheniramine maleate inj	$59.01
J1051	K	9035	Medroxyprogesterone inj	$17.56
J1212	K	9036	Dimethyl sulfoxide 50% 50 ML	$53.34
J1230	K	9037	Methadone injection	$13.32
J1245	K	0380	Dipyridamole injection	$11.70
J1410	K	9038	Inj estrogen conjugate 25 MG	$45.51
J1452	K	9040	Intraocular Fomivirsen na	$939.79
J1455	K	0866	Foscarnet sodium injection	$11.80
J1460	K	9041	Gamma globulin 1 CC inj	$31.63
J1610	K	9042	Glucagon hydrochloride/1 MG	$46.16
J1742	K	9044	Ibutilide fumarate injection	$123.79
J1750	K	9045	Iron dextran	$14.78
J1756	K	9046	Iron sucrose injection	$0.53
J1835	K	9047	Itraconazole injection	$42.10
J2260	K	7007	Inj milrinone lactate / 5 MG	$8.22
J2597	K	9048	Inj desmopressin acetate	$4.52
J2725	K	9049	Inj protirelin per 250 mcg	$40.81
J2760	K	0845	Phentolaine mesylate inj	$20.82
J2916	K	9050	Na ferric gluconate complex	$6.03
J2995	K	0911	Inj streptokinase /250000 IU	$43.41
J2997	K	7048	Alteplase recombinant	$18.04
J3350	K	9051	Urea injection	$69.74
J3365	K	7036	Urokinase 250,000 IU inj	$124.64
J3530	K	9053	Nasal vaccine inhalation	$92.41
J7342	K	9054	Metabolically active tissue	$7.15
J7350	K	9055	Injectable human tissue	$8.05
P9041	K	0961	Albumin (human),5%, 50ml	$18.82
P9045	K	0963	Albumin (human), 5%, 250 ml	$60.54
P9046	K	0964	Albumin (human), 25%, 20 ml	$13.01
P9047	K	0965	Albumin (human), 25%, 50ml	$52.32

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e. CY 2005 Change in Payment Status for HCPCS Code J7308

Since implementation of the OPPS on August 1, 2000, HCPCS code J7308 (Aminolevulinic acid HCI for topical administration, 20 percent single unit dosage form) has been treated as a packaged item and denoted as such using status indicator ''N''. Thus, historically we have not allowed separate payment for this drug under the OPPS and it does not meet the statutory definition of a specified covered outpatient drug. For CY 2005, we proposed to allow separate payment for this drug at 106 percent of ASP, which is equivalent to the payment rate that it would receive under the Medicare Physician Fee Schedule. We proposed a CY 2005 ASP and payment under the OPPS for HCPCS code J7308 of $88.86. We solicited comments on our proposed payment methodology for HCPCS code J7308 for CY 2005.

We did not receive any comments on our proposed policy. However, we did receive a comment on this policy in response to the January 6, 2004 interim final rule with comment period, which we discuss below.

Comment: One commenter requested that HCPCS code J7308 be paid separately under the OPPS because its cost is in excess of the $50 median cost per day threshold, and the drug is also paid separately under the Medicare Physician Fee Schedule in CY 2004.

Response: We agree with the commenter and will finalize our policy to pay separately for J7308 at the payment rate that it would receive under the Medicare Physician Fee Schedule. The payment rate listed in Addenda A and B of the August 16, 2005 proposed rule was based on the second quarter ASP submission for CY 2004. As stated in section V.A. 3. of this final rule with comment period, we plan to make any appropriate adjustments to the amount shown in Addenda A and B if later quarter ASP submissions indicate that adjustments to the payment rate for this drug is necessary.

4. Public Comments Received on the January 6, 2004 Interim Final Rule With Comment Period and Departmental Responses

As discussed in section V.B.3. of this final rule with comment period, on January 6, 2004, we published in the **Federal Register** an interim final rule with comment period (69 FR 822) that implemented section 621(a)(1) of Pub. L. 108–173. Section 621(a)(1) specified payment limits on three categories of specific covered outpatient drugs and defined these three categories of drugs.

We received many pieces of correspondence that contained public comments associated with the January 6, 2004 interim final rule with comment period. Many of the comments expressed concerns about the following issues: treating radiopharmaceuticals as ''drugs;'' establishing mechanisms to pay for drugs without HCPCS codes at 95 percent of AWP; correcting the classification of specific items to sole source ''specified covered outpatient drugs;'' eliminating the use of ''equitable adjustments'' to the OPPS payment for drugs and biologicals or applying any functional equivalence standards; paying separately for drugs that are either packaged or whose payment is based on median cost as ''specified covered outpatient drugs''; expanding the list of items that will be studied in the MMA-mandated GAO and MedPAC surveys of certain OPD services; using the cost-to-charge methodology and the hospital outpatient claims data to set payment rates for certain drugs and biologicals; identifying and establishing appropriate payment rates for innovator and noninnovator multiple source drugs; and changing HCPCS code descriptors for radiopharmaceuticals to reflect the products as administered to patients.

We will not address these comments separately in this section because these issues are discussed in detail throughout this entire section (section V.) of this final rule with comment period. However, for those public comments that are not specifically addressed in section V., a summary of them and our responses to those comments follow:

Comment: A commenter suggested that CMS create separate HCPCS codes for Neoral, Sandimmune, and the other cyclosporine products. The commenter indicated that currently all of these products are being billed using HCPCS code J7502 (Cyclosporine, oral, 100 mg). The commenter stated that the payment rates for the brand name products should not be linked to the payment rates for the non-innovator products because this situation creates access issues to the branded products, and CMS should not limit patient access to the specific formulation deemed medically appropriate for the individual needs of the specific patients.

Response: We note that for both CYs 2004 and 2005, hospitals can use HCPCS code C9438 to bill for the brand name forms of oral cyclosporine. As stated V.A.3.a. of this final rule with comment period, the MMA set forth different payment ceilings for the brand and generic versions of a drug where the CY 2005 payment rate for innovator multiple source (brand name) drugs may not exceed 68 percent of the reference AWP and the payment for generic versions may not exceed 46 percent of the reference AWP. We explained previously that we apply those ceilings only where the payment for an item based on the median hospital cost for the drug exceeds one of these ceilings. In some cases, the payment based on the median hospital cost falls below the 46 percent ceiling for generic drugs. In such cases, the payment rate would be the same for brand and generic versions. We believe that basing payment for these items on relative hospital costs, with the application as appropriate of the previously mentioned ceilings not only meets the intent but also the requirements of the MMA.

Comment: A commenter recommended that CMS consider pricing information from several authoritative sources when determining the reference AWP, including Red Book and First Data Bank, on a case-by-case basis since such pricing information can be used to resolve outstanding payment issues and ensure greater accuracy in calculating the OPPS payment rates.

Response: We appreciate this comment and will consider this recommendation when we reassess the OPPS payment rates.

Comment: Several commenters noted that CMS changed the classification for many of the biologicals products to sole source ''specified covered outpatient drugs'' in the February 27, 2004 CMS Transmittal 113 without discussing why the changes were made. One of the commenters indicated that the definition for sole source ''specified covered outpatient drugs'' in the MMA is different from the Medicaid rebate definition. The commenter stated that the MMA defined sole source drugs as: (1) A biological product (as defined under section 1861(t)(1) of the Act); or (2) a single source drug (as defined in section 1927(k)(7)(A)(iv) of the Act). The commenters requested that CMS clarify that it intends to treat all biological products as sole source drugs in the future as the law requires.

Response: We agree with the commenters that biologicals products are defined as sole source ''specified covered drugs'' in the MMA, and we will determine payment rates for these products accordingly.

Comment: We received several comments on the mechanism for establishing payment rates for innovator and noninnovator multiple source drugs. One commenter urged CMS to set the payment rates closer to the actual

costs for all products and services and provide differential reimbursement for innovator multiple source products only if their actual acquisition costs were markedly higher than that for the noninnovator multiple source products. Another commenter indicated that innovator and noninnovator multiple source drugs were discounted very similarly, and therefore, differential payments were not necessary. A commenter also requested that CMS obtain legislative approval to price these innovator and noninnovator multiple source drugs using a blended payment rate set halfway between 46 percent and 68 percent of their reference AWPs.

Response: We appreciate these suggestions and note that the methodology that will be used to determine payment rates for innovator and noninnovator multiple source drugs in CY 2005 is described in detail in section V.A.3.a. of this final rule with comment period.

C. Coding and Billing for Specified Outpatient Drugs

As discussed in the January 6, 2004 interim final rule with comment period (69 FR 826), hospitals were instructed to bill for sole source drugs using the existing HCPCS code, which were priced in accordance with the provisions of newly added section 1833(t)(14)(A)(i) of the Act, as added by Pub. L. 108–173. However, at that time, the existing HCPCS codes did not allow us to differentiate payment amounts for innovator multiple source and noninnovator multiple source forms of the drug. Therefore, effective April 1, 2004, we implemented new HCPCS codes via Program Transmittal 112 (Change Request 3144, February 27, 2004) and Program Transmittal 132 (Change Request 3154, March 30, 2004) that providers were instructed to use to bill for innovator multiple source drugs in order to receive appropriate payment in accordance with section 1833(t)(14)(A)(i)(II) of the Act. Providers were also instructed to continue to use the current HCPCS codes to bill for noninnovator multiple source drugs to receive payment in accordance with section 1833(t)(14)(A)(i)(III). In this manner, drugs, biologicals, and radiopharmaceuticals will be appropriately coded to reflect their classification and be paid accordingly. In the August 16, 2004 proposed rule, we proposed to continue this coding practice in CY 2005 with payment made in accordance with section 1833(t)(14)(A)(ii) of the Act.

We received a few public comments on our proposal.

Comment: Several commenters urged that CMS delete certain newly created C codes (C9400,Thallous Chloride, brand; C9401 Strontium–89 chloride, brand; C9402 Th I131 so iodide cap, brand; C9403 Dx I131 so iodide cap, brand; C9404 Dx So iodide sol, brand; C9405 Th I131 so iodide, sol. brand) because radiopharmaceuticals are better characterized as either sole source or innovator multiple source drugs. The commenters indicated that the creation of the new codes implied that some radiopharmaceuticals are generic products and others are brand, but there was no identification of which product falls within which code. Further, there was no payment difference between some of the radiopharmaceutical brand products versus generics. The commenters believed these products did not fit the conventional brand versus generic distinctions, and should all be recognized as brand drugs until the GAO report provides additional data. Also, the commenters recommended that the current A-codes be retained at the payment levels CMS proposes for ''brand'' drugs and believed that deletion of these codes should result in payment for the corresponding radiopharmaceuticals based on their status as a sole source or innovator multi-source drug and would significantly lessen hospital administrative burden and confusion. Another commenter indicated that hospitals needed further clarification on which manufacturers' products can be billed under the HCPCS codes created for the brand and generic forms of a product.

Response: As stated in section V.A.3.a. of this final rule with comment period, section 621(a) of Pub. L. 108–173 sets forth different payment ceilings for the brand and generic versions of a drug where the CY 2005 payment rate for innovator multiple source (brand name) drugs may not exceed 68 percent of the reference AWP and the payment for generic versions may not exceed 46 percent of the reference AWP. We explained previously that we apply those ceilings only where the payment for an item based on the median hospital cost for the drug exceeds one of these ceilings. In some cases, the payment based on the median hospital cost falls below the 46 percent ceiling for generic drugs. In such cases, as the commenters indicate, the payment rate would be the same for brand and generic versions.

We will not be providing a list of brand name and generic products for hospitals to use in determining whether their product is a brand name or generic product. We believe that hospitals are in the best position to correctly determine which type of products they are using. We refer the commenter to the definitions of innovator and noninnovator multiple source drugs stated in the January 6, 2004 interim final rule with comment period (69 FR 822). Hospitals can also use the FDA's Orange Book in determining whether an item they use is a brand name product.

D. Payment for New Drugs, Biologicals and Radiopharmaceuticals Before HCPCS Codes Are Assigned

1. Background

Historically, hospitals have used a code for an unlisted or unclassified drug, biological, or radiopharmaceutical or used an appropriate revenue code to bill for drugs, biologicals, and radiopharmaceuticals furnished in the outpatient department that do not have an assigned HCPCS code. The codes for not otherwise classified drugs, biologicals, and radiopharmaceuticals are assigned packaged status under the OPPS. That is, separate payment is not made for the code, but charges for the code would be eligible for an outlier payment and, in future updates, the charges for the code are packaged with the separately payable service with which the code is reported for the same date of service.

Drugs and biologicals that are newly approved by the FDA and for which an HCPCS code has not yet been assigned by the National HCPCS Alpha-Numeric Workgroup could qualify for pass-through payment under the OPPS. An application must be submitted to CMS in order for a drug or biological to be assigned pass-through status, along with a temporary C-code for billing purposes, and an APC payment amount. Pass-through applications are reviewed on a flow basis, and payment for drugs and biologicals approved for pass-through status is implemented throughout the year as part of the quarterly updates of the OPPS.

In the November 7, 2003 final rule with comment period (68 FR 63440), we explained how CMS generally pays under the OPPS for new drugs and biologicals that are assigned HCPCS codes, but that are not approved for pass-through payment, and for which CMS had no data upon which to base a payment rate. These codes do not receive separate payment, but are assigned packaged status. Hospitals were urged to report charges for the new codes even though separate payment is not provided. Charges reported for the new codes are used to determine hospital costs and payment rates in future updates. For CY 2004, we again

noted that drugs that were assigned an HCPCS code effective January 1, 2004, and that were assigned packaged status, remain packaged unless pass-through status is approved for the drug. If pass-through status is approved for these drugs, pass-through payments are implemented prospectively in the next available quarterly release.

2. Provisions of Pub. L. 108–173

Section 621(a)(1) of Pub. L. 108–173 amended section 1833(t) of the Act by adding paragraph (15) to provide for payment for new drugs and biologicals until HCPCS codes are assigned under the OPPS. Under this provision, we are required to make payment for an outpatient drug or biological that is furnished as part of covered OPD services for which a HCPCS code has not been assigned in an amount equal to 95 percent of AWP. This provision applies only to payments under the OPPS, effective January 1, 2004. However, we did not implement this provision in the January 6, 2004 interim final rule with comment period because we had not determined at that time how hospitals would be able to bill Medicare and receive payment for a drug or biological that did not have an identifying HCPCS code.

As stated earlier, at its February 2004 meeting, the APC Panel heard presentations suggesting how to make payment for a drug or biological that did not have a code. The APC Panel recommended that we work swiftly to implement a methodology to enable hospitals to file claims and receive payment for drugs that are newly approved by the FDA. The APC Panel further recommended that we consider using temporary or placeholder codes that could be quickly assigned following FDA approval of a drug or biological to facilitate timely payment for new drugs and biologicals.

We explored a number of options to make operational the provisions of section 1833(t)(15) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, as soon as possible. One of the approaches that we considered was to establish a set of placeholder codes in the Outpatient Code Editor (OCE) and the PPS pricing software for the hospital OPPS (PRICER) that we would instruct hospitals to use when a new drug was approved. Hospitals would be able to submit claims using the new code but would receive no payment until the next quarterly update. By that time, we would have installed an actual payment amount and descriptor for the code into the PRICER, and would mass-adjust claims submitted between the date of FDA approval and the date of installation of the quarterly release. A second option that we considered was to implement an APC, a C-code, and a payment amount as part of the first quarterly update following notice of FDA approval of a drug or biological. Hospitals would hold claims for the new drug or biological until the quarterly release was implemented and then submit all claims for the drug or biological for payment using the new C-code to receive payment on a retroactive basis. We also considered instructing hospitals to bill for a new drug or biological using a ''not otherwise classified'' code for which they would receive an interim payment based on charges converted to cost. Final payment would then be reconciled at cost report settlement. While each of these approaches might enable hospitals to begin billing for a newly approved drug or biological as soon as it received FDA approval, each approach had significant operational disadvantages, such as increased burden on hospitals or payment delays, or the risk of significant overpayments or underpayments that could not be resolved until cost report settlement.

We adopted an interim approach that we believe balances the need for hospitals to receive timely and accurate payment as soon as a drug or biological is approved by the FDA with minimal disruption of the OPPS claims processing modules that support the payment of claims. On May 28, 2004 (Transmittal 188, Change Request 3287), we instructed hospitals to bill for a drug or biological that is newly approved by the FDA by reporting the National Drug Code (NDC) for the product along with a new HCPCS code C9399, Unclassified drug or biological. When C9399 appears on a claim, the OCE suspends the claim for manual pricing by the fiscal intermediary. The fiscal intermediary prices the claim at 95 percent of its AWP using Red Book or an equivalent recognized compendium, and processes the claim for payment. This approach enables hospitals to bill and receive payment for a new drug or biological concurrent with its approval by the FDA. The hospital does not have to wait for the next quarterly release or for approval of a product-specific HCPCS to receive payment for a newly approved drug or biological or to resubmit claims for adjustment. Hospitals would discontinue billing C9399 and the NDC upon implementation of an HCPCS code, status indicator, and appropriate payment amount with the next quarterly update.

In the August 16, 2004 proposed rule, we proposed to formalize this methodology for CY 2005 and to expand it to include payment for new radiopharmaceuticals to which a HCPCS code is not assigned (see section V.G. of this preamble). We solicited comments on the methodology and expressed particular interest in the reaction of hospitals to using this approach to bill and receive timely payment under the OPPS for drugs, biologicals, and radiopharmaceuticals that are newly approved by the FDA, prior to assignment of a product-specific HCPCS code.

We received a number of public comments on our proposal.

Comment: One commenter, a state hospital association, is concerned about the ability of hospitals to correctly code for newly approved drugs and biologicals without HCPCS codes using the NDC codes. The commenter indicates that typically only pharmacy systems within hospitals can properly handle the assignment and reporting of a drug's NDC, not the hospital billing systems. Additionally, the use of the Remarks field to report the NDC creates payment delays as it requires manual review and pricing by the fiscal intermediaries. Several commenters, including a national hospital association and several state hospital associations, recommended that CMS adopt a new revenue code subcategory for hospitals to use when reporting these newly FDA-approved drugs and biologicals on UB–92 paper claims. The hospital could use the new revenue code along with the reported NDC in the revenue-code description field. Establishing a new revenue code field, to be used with the description field, allows clearinghouses to scan the paper UB–92 and then convert the data into the appropriate HIPAA standard for auto adjudication. The FI would then no longer have to suspend these paper claims for manual pricing, because it would build logic into the system to auto-adjudicate these claims. The hospital would then continue to report C9399 (HCPCS code indicating Unclassified drug or biological) in the HCPCS field, the units in the Unit field, the date the drug was administered in the date field, and finally, the price of these drugs in the Total Charges field. These commenters believed that this alternative policy would greatly improve the current process for both hospitals and fiscal intermediaries.

Response: We read the hospital associations' recommendation for an alternative approach to report NDCs on UB–92 paper claims with interest and will explore its feasibility with the different components within CMS that are responsible for claims processing, information technology and systems,

and HIPAA standards. It appears that time-consuming systems changes could be required were we to adopt such an approach, which could delay implementation, but we will consider the proposal carefully.

Comment: A maker of pharmaceuticals commends CMS for implementing the mechanism where hospitals can bill and be paid for new drugs without HCPCS codes. However, the commenter is concerned that the use of a miscellaneous code may result in significant payment delays and potentially prevent patient access to new therapies. The commenter suggests that CMS monitor claims submission, timely processing, and payments more closely so that patient access to new therapies is not impeded. Another commenter suggested that CMS should modify this mechanism if necessary to ensure patients have access to cutting-edge drugs. One commenter suggested that CMS explore with its contractors the feasibility of automating processing of these claims by including the NDC number as a claims processing field when the miscellaneous C code appears on a claim since such a process would eliminate the additional costs of manual claim review and expedite provider payment.

Response: We share the commenters' concerns that claims processing systems not impede beneficiary access to new drug therapies. However, we believe the approach that we implemented in CY 2004 and that we proposed to adopt permanently beginning in CY 2005, which requires the use of HCPCS code C9399 to be reported with an appropriate NDC, will result in hospitals receiving payment for new drugs more quickly compared to the process that we followed previously, even though some manual handling of claims is required. We agree with the commenter who suggested that CMS closely monitor claims submission, timely processing, and payments for new drugs, and we intend to do so.

Comment: One commenter encouraged CMS to reconsider the payment policy that requires the reporting of the NDC for new drugs as ''mandatory'' and consider making the NDC ''optional.'' For providers unable to automate the reporting of the NDC number due to software limitations, it suggested that CMS consider allowing providers the option of listing the NDC number in the detailed drug name as reported on the itemized statement of charges that can be requested along with the UB reporting the C9399 code.

Response: As we have indicated in previous responses to commenters' suggestions regarding ways to implement the payment requirement for new drugs and biologicals that have not been assigned a HCPCS code, we will also consider this commenter's recommendation to determine its feasibility.

Comment: Several commenters urged CMS to reconsider the policy of preloading several new codes into CMS' computer system and assigning them to new drugs and biologicals as the Food and Drug Administration approved them, rather than requiring manual processing of claims using a single miscellaneous code. If CMS determines that the current policy is imposing too great an administrative burden on hospitals and delays in processing claims that harm hospitals' ability to provide new drugs and biologicals to Medicare beneficiaries, the commenters urged CMS to reconsider its proposal and to explore preloading placeholder codes instead.

Response: Preloading placeholder codes was one of the options that we considered before we implemented C9399, but we found that this approach had its disadvantages, most of which stemmed from concerns about delays related to the dissemination of new codes to providers and installing prices into the claims processing modules in a timely manner. We propose to monitor throughout CY 2005 the use of HCPCS code C9399 and NDC codes to evaluate whether this approach is an improvement over how hospitals were previously paid for new drugs to which a HCPCS code had not been assigned and to determine if changes in the process would be beneficial.

Comment: One commenter indicated that requiring hospitals to submit the National Drug Code on claims imposes an enormous administrative burden on hospitals because there is no field for NDCs on the claims form and, therefore, NDCs cannot be entered on the claim automatically. Rather, claims must be flagged and adjusted manually. The commenter suggested that the best solution is to close the lag time between FDA approval and HCPCS assignment of a new drug. By creating a seamless execution of approval and code assignment, CMS can ensure that the MMA mandate is fulfilled in the least burdensome manner and that providers are adequately paid for providing these new drugs.

Response: While the use of NDCs may impose a degree of reporting burden on hospitals, we believe that, in spite of the inconvenience of manual reporting and claims processing, this approach is the most efficient way to expedite payment to hospitals for newly approved drugs to which a HCPCS code has not been assigned.

Comment: One commenter, an association for cancer centers, supported CMS' proposal for reporting new drugs without HCPCS codes using C9399 and any other necessary data. However, the commenter requested clarification from CMS on whether C9399 can only be used for injectible drugs or whether this code can also be used to report all newly approved FDA drugs (including oral drugs). The commenter believed that C9399 can be used for all Medicare-covered drugs, including oral anti-emetics and oral chemotherapeutics with IV equivalents, but requested that CMS clarify this issue to ensure that fiscal intermediaries correctly process this new code.

Response: Our instructions regarding how hospitals may report a new drug using C9399 and NDCs only indicate the method by which hospitals can bill Medicare for payment if the new drug is covered by the Medicare program. These instructions do not represent a determination that the Medicare program covers a new drug for which a hospital submits a bill using C9399. In addition to determining payment, fiscal intermediaries must determine whether a drug billed with C9399 meets all program requirements for coverage. For example, they must assess whether the drug is reasonable and necessary to treat the beneficiary's condition and whether the drug is excluded from payment because it is usually self-administered. The same rules, regulations, and policies that apply to coverage of drugs, biologicals, and radiopharmaceutical agents that already have a HCPCS code also apply to newly approved items for which a HCPCS code has not yet been assigned.

Comment: Two commenters urged CMS to publish the approved drugs and radiopharmaceuticals that may be submitted under HCPCS code C9399, as well as the appropriate units of measure applicable for each drug or biological and the payment amount for the drug based on 95 percent of the AWP. One commenter indicated that hospitals are concerned that they will not identify all of the drugs that are eligible for this payment and are also concerned that they may inappropriately assign the HCPCS code to drugs that are not eligible for this payment. Additionally, there is an administrative burden placed both on providers and the fiscal intermediaries when CMS does not publish the payment rates for these drugs.

Response: We understand that use of C9399 and NDCs is a departure from how hospitals have become accustomed

to preparing Medicare claims for the OPPS services. However, the MMA mandates that hospitals be paid 95 percent of AWP for new drugs until a HCPCS code is assigned to that drug. We believe this MMA provision is intended to ensure that hospitals can receive timely payment for new drugs, biologicals, and radiopharmaceuticals without having to wait for a HCPCS code to be created and disseminated or for an OPPS payment amount to be implemented in a quarterly OPPS update. Generally, CMS learns of FDA approval of a new product at approximately the same time the public learns of the approval. Hospitals may wish to look to their advocacy associations for assistance in monitoring the FDA Web site to identify new products as they are approved, as a supplemental information source. We also intend to explore ways hospitals could systematically receive timely reports of newly approved drugs by means other than checking the FDA Web site. However, how to report a product rests with the hospital, as it does for any drug, biological, radiopharmaceutical agent, procedure, or service, with or without a HCPCS code. Therefore, we are not accepting the commenters' suggestion that we publish the approved drugs and radiopharmaceuticals that may be submitted under HCPCS code C9399, as well as the appropriate units of measure applicable for each drug or biological and the payment amount for the drug based on 95 percent of the AWP. Rather, we prefer to focus our resources on updating the OPPS on a quarterly basis with codes, APC assignments, and payment amounts for drugs, biologicals, and radiopharmaceuticals newly approved by the FDA during the prior quarter.

We have carefully considered commenters' recommendations and concerns, and we believe that our proposed methodology for using C9399 and NDC codes to bill for drugs, biologicals, and radiopharmaceutical agents newly approved by FDA to which a HCPCS code is not assigned is the most efficient and practicable approach at this time to ensure timely, appropriate Medicare payment for these new products. Therefore, we are making final for CY 2005 our proposed methodology, without modification.

E. Payment for Vaccines

Outpatient hospital departments administer large numbers of immunizations for influenza (flu) and pneumococcal pneumonia (PPV), typically by participating in immunization programs. In recent years, the availability and cost of some vaccines (particularly the flu vaccine) have fluctuated considerably. As discussed in the November 1, 2002 final rule (67 FR 66718), we were advised by providers that the OPPS payment was insufficient to cover the costs of the flu vaccine and that access of Medicare beneficiaries to flu vaccines might be limited. They cited the timing of updates to the OPPS rates as a major concern. They indicated that our update methodology, which uses 2-year-old claims data to recalibrate payment rates, would never be able to take into account yearly fluctuations in the cost of the flu vaccine. We agreed with this concern and decided to pay hospitals for influenza and pneumococcal pneumonia vaccines based on a reasonable cost methodology. As a result of this change, hospitals, home health agencies (HHAs), and hospices, which were paid for these vaccines under the OPPS in CY 2002, have been receiving payment at reasonable cost for these vaccines since CY 2003. We are aware that access concerns continue to exist for these vaccines. However, we continue to believe that payment other than on a reasonable cost basis would exacerbate existing access problems. Therefore, in the August 16, 2004 proposed rule, we proposed to continue paying for influenza and pneumococcal pneumonia vaccines under the reasonable cost methodology in CY 2005.

Comment: Several commenters applauded CMS' proposal to continue to pay for vaccines under the reasonable cost methodology. The commenters indicated that payment on a reasonable cost basis helps ensure that the OPPS rates are adequate to cover hospitals' costs of providing vaccines to Medicare beneficiaries, protecting their health, and reducing Medicare's costs of treating influenza and other preventable illnesses.

Response: We appreciate the commenters' continued support of our policy to pay for influenza and pneumococcal pneumonia vaccines at reasonable cost and finalize our proposal in this final rule with comment period. We note that for CY 2005 a new CPT code for an influenza vaccine was created. The new CPT code 90656 (Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years and above, for intramuscular use) will be paid at reasonable cost in CY 2005. We have assigned status indicator ''L'' (Not Paid under OPPS. Paid at reasonable cost) to this new CPT code.

F. Changes in Payment for Single Indication Orphan Drugs

Section 1833(t)(1)(B)(i) of the Act gives the Secretary the authority to designate the hospital outpatient services to be covered. The Secretary has specified coverage for certain drugs as orphan drugs (section 1833(t)(14)(B)(ii)(III) of the Act as added by section 621(a)(1) of Pub. L. 108–173). Section 1833(t)(14)(C) of the Act as added by section 621(a)(1) of Pub. L. 108–173, gives the Secretary the authority in CYs 2004 and 2005 to specify the amount of payment for an orphan drug that has been designated as such by the Secretary.

We recognize that orphan drugs that are used solely for an orphan condition or conditions are generally expensive and, by definition, are rarely used. We believe that if the cost of these drugs were packaged into the payment for an associated procedure or visit, the payment for the procedure might be insufficient to compensate a hospital for the typically high cost of this special type of drug. Therefore, in the August 16, 2004 proposed rule, we proposed to continue making separate payments for orphan drugs based on their currently assigned APCs.

In the November 1, 2002 final rule (67 FR 66772), we identified 11 single indication orphan drugs that are used solely for orphan conditions by applying the following criteria:

- The drug is designated as an orphan drug by the FDA and approved by the FDA for treatment of only one or more orphan conditions(s).
- The current United States Pharmacopoeia Drug Information (USPDI) shows that the drug has neither an approved use nor an off-label use for other than the orphan condition(s).

Eleven single indication orphan drugs were identified as having met these criteria and payments for these drugs were made outside of the OPPS on a reasonable basis.

In the November 7, 2003 final rule with comment period (68 FR 63452), we discontinued payment for orphan drugs on a reasonable cost basis and made separate payments for each single indication orphan drug under its own APC. Payments for the orphan drugs were made at 88 percent of the AWP listed for these drugs in the April 1, 2003 single drug pricer, unless we were presented with verifiable information that showed that our payment rate did not reflect the price that is widely available to the hospital market. For CY 2004, Ceredase (alglucerase) and Cerezyme (imiglucerase) were paid at 94 percent of AWP because external data

submitted by commenters on the August 12, 2003 proposed rule caused us to believe that payment at 88 percent of AWP would be insufficient to ensure beneficiaries' access to these drugs.

In the December 31, 2003 correction of the November 7, 2003 final rule with comment period (68 FR 75442), we added HCPCS code J9017, arsenic trioxide (per unit) to our list of single indication orphan drugs. As of the time of our August 16, 2004 proposed rule, the following were the 12 orphan drugs that we have identified as meeting our criteria: J0205 Injection, alglucerase, per 10 units; J0256 Injection, alpha 1-proteinase inhibitor, 10 mg; J9300 Gemtuzumab ozogamicin, 5 mg; J1785 Injection, imiglucerase, per unit; J2355 Injection, oprelvekin, 5 mg; J3240 Injection, thyrotropin alpha, 0.9 mg; J7513 Daclizumab parenteral, 25 mg; J9015 Aldesleukin, per vial; J9017 Arsenic trioxide, per unit; J9160 Denileukin diftitox, 300 mcg; J9216 Interferon, gamma 1-b, 3 million units and Q2019 Injection, basiliximab, 20 mg. In the August 16, 2004 proposed rule, we did not propose any changes to this list of orphan drugs for CY 2005.

In the proposed rule, we noted that had we not classified these drugs as single indication orphan drugs for payment under the OPPS, they would have met the definition as a single source specified covered outpatient drug and been paid lower payments which could impede beneficiary access to these unique drugs dedicated to the treatment of rare diseases. Instead, for CY 2005, under our authority at section 1833(t)(14)(C) of the Act, we proposed to pay for all 12 single indication orphan drugs, including Ceredase and Cerezyme, at the rate of 88 percent of AWP or 106 percent of the ASP, whichever is higher. However, for drugs where 106 percent of the ASP would exceed 95 percent of AWP, payment would be capped at 95 percent of AWP, which is the upper limit allowed for sole source specific covered outpatient drugs. For example, Ceredase and Cerezyme would each be paid at 95 percent of the AWP because payment at ASP plus 6 percent for these two drugs not only exceeds 88 percent of the AWP but also exceeds 95 percent of the AWP. We proposed to pay the higher of 88 percent of AWP or 106 percent of ASP capped at 95 percent of AWP to ensure that beneficiaries will continue to have access to such important drugs.

We received the following comments to our August 16, 2004 proposed rule on single indication orphan drugs.

Comment: A few commenters recommended that CMS adopt the FDA's definition of an orphan drug as under the Orphan Drug Act. The commenters indicated that CMS should expand the current list of 12 single-indication orphan drugs that receive special treatment to include several other FDA-designated orphan drugs. One commenter requested that CMS adopt a utilization threshold to identify orphan drugs that would receive the special treatment rather than using its current criteria.

Response: Using the statutory authority in section 1833(t)(1)(B)(i) of the Act, which gives the Secretary broad authority to designate covered OPD services under the OPPS, we have established criteria which distinguish single-indication orphan drugs from other drugs designated as orphan drugs by the FDA under the Orphan Drug Act. Our determination to provide special payment for these drugs neither affects nor deviates from FDA's classification of any drugs as orphan drugs. The special treatment given to this subset of FDA-designated orphan drugs is intended to ensure that beneficiaries have continued access to these life-saving therapies given that these drugs have a relatively low volume of patient use, lack any other non-orphan indication and are typically very costly. Although we are not expanding our criteria to identify orphan drugs that will receive special payment for CY 2005, we will consider the commenters' recommendation of a utilization threshold in future changes to the OPPS orphan drug list.

Comment: We received comments from different drug manufacturers separately requesting that Campath (J9010, Alemtuzumab), Elitek (J2783, Rasburicase), Vidaza (C9218, Azacitidine for injectable suspension), and Botox (J0585, Botulinum toxin type A) be included in the list of single-indication orphan drugs that will receive special payment for CY 2005.

Response: After careful review of the requests for these four drugs to be included in the list of single-indication orphan drugs, we have determined that Campath (J9010) and Vidaza (C9218) do meet our criteria for inclusion in the list. Thus, effective for January 1, 2005, J9010 and C9218 will be paid in accordance with the payment policy for single indication orphan drugs for CY 2005. However, we have determined that Elitek (J2783) and Botox (J0585) do not meet the criteria for inclusion in the list because these drugs have an off-label use as indicated by the 2004 United States Pharmacopoeia Drug Information (USPDI).

Comment: Several commenters, including manufacturers of alpha-1 proteinase inhibitor (J0256) sold under the brand names Prolastin, Aralast and Zemaira, submitted comments expressing concern over the decrease in the payment rate for HCPCS J0256 from the CY 2004 level to the CY 2005 proposed rate. The majority of commenters requested that the payment rate for J0256 be frozen at the CY 2004 levels, rather than based on the AWP of Prolastin, the least expensive drug among the three name brands. As some commenters explained, Prolastin has experienced supply shortages in the past and if the payment rate for the alpha-1 therapy did not take into account the higher AWPs of Aralast or Zemaira, it would be inadequate to cover the actual acquisition costs of the drugs to hospitals.

The manufacturer of Aralast requested that CMS exclude pricing information associated with Prolastin when setting the payment rate for J0256. The commenter stated that although Prolastin is currently available and used in greater quantities than either Aralast or Zemaira , it has experienced supply shortages in the past. Therefore, according to the commenter, the payment rate for J0256 needs to be such that patients will have continued access to all three brand names. Alternatively, the commenter recommended that new HCPCS codes could be created so each brand name could be paid appropriately or CMS could freeze the payment rate for J0256 at the CY 2004 levels, as the majority of commenters recommended.

The manufacturer of Zemaira expressed concern that the proposed payment rate does not meet the actual hospital acquisition cost for this brand name, which is the newest of the three brand names to come on the market to be used in alpha-1 therapy.

We received a comment from an organization representing voluntary health organizations and individual patients that stated that the proposed payments for CY 2005 were adequate to avoid problems with access to the orphan drugs that patients with rare diseases need. In addition, the commenter requested that CMS take actions to monitor any changes in beneficiaries' access to orphan drugs as a result of payment changes, to review the claims database for changes in utilization patterns, to seek input from beneficiaries about access problems, and to inform beneficiaries about payment changes and the potential impact of such changes on their access.

We also received recommendations from a patient advocacy organization requesting that CMS work with the manufacturers of the alpha-1 therapy to obtain the data necessary to raise the proposed OPPS rate of $2.46 (per 10 mg) or to establish the ASP rate which may

enhance patient access to care. The commenter also recommended that CMS base the payment rate for J0256 on all available brands.

Response: After careful evaluation of the issues and concerns raised by commenters in response to our proposed rule, we recognize that our proposed payment rate for HCPCS code J0256 may create an unanticipated access problem during periods of short supply. Therefore, in order to ensure continued beneficiaries' access to this important drug, we will base the payment rate for HCPCS code J0256 on all three brands of the alpha-1 proteinase inhibitor currently available on the market. The adjusted AWP of HCPCS code J0256 will be based on the volume-weighted average of the three drugs. The adjusted AWP will be updated each quarter, as necessary, to reflect any changes in the individual AWP or relative weight of each drug in the calculation of the AWP for HCPCS code J0256. We would expect that as the volume and/or individual AWP increases or decreases for a brand, these changes will be captured in its relative weight and will be reflected in the adjusted AWP for HCPCS code J0256.

We share the commenters' concern for protecting beneficiaries' access to these therapies used for rare disease conditions. As part of our process of developing special payment rates for single indication orphan drugs in CY 2005, our analysis of CY 2003 claims data does not indicate a decrease in utilization of any orphan drugs that may signify barriers to beneficiaries' access to these drugs.

Comment: Several commenters recommended that CMS eliminate the 95 percent AWP cap on single-indication orphan drugs whose ASP plus 6 percent would exceed their 88 percent AWP. According to the commenters, these drugs would not be subject to the 95 percent AWP cap when administered in the physician's office. They argued that CMS should pay for these drugs at the same rate, irrespective of the site of service.

We received a request from the drug manufacturer of Ontak to increase the payment rate for the drug from 88 percent of the May 2004 AWP to 92 percent of the current AWP. Alternatively, the commenter requested that CMS remove the 95 percent AWP cap for J9160 (Ontak).

Response: We believe that access to these life-saving therapies is extremely important and after careful consideration, we will not implement the cap of 95 percent of AWP for any of the single-indication orphan drug for those drugs whose 106 percent ASP exceeds 88 percent of AWP. Effective for CY 2005, payment for all single-indication orphan drugs will be set at the higher of 106 percent of the most current ASP or 88 percent of the most current AWP.

Comment: A few commenters recommended that CMS update the payment rates quarterly, based on the latest ASP and AWP data available. They argue that to lock in the rates for a year based on outdated information could impede patient access to these drugs.

Response: We agree with the commenters and will base payments for single-indication orphan drugs on a quarterly comparison of ASP and AWP data. Appropriate adjustments to the payment amounts shown in Addendum A and B will be made if ASP submissions and AWP data in a later quarter indicate that adjustments to the payment rates are necessary. These changes to the Addenda will be announced in our program instructions released on a quarterly basis and posted on our Web site at *http://www.cms.hhs.gov.*

Comment: We also received a comment from the manufacturer of Fabrazyme requesting that CMS consider making payment for Fabrazyme (C9208, agalsidase beta) as a single-indication orphan drug. The commenter believes that by statute, CMS is required to pay for the drug at 106 percent of ASP; however, the commenter stated that if CMS were to somehow reach a different conclusion, it would request to be treated as a single-indication orphan drug.

Response: We agree with the commenter that the statute requires that payment for Fabrazyme (C9208), a drug that currently has pass-through status, be made at 106 percent of ASP for CY 2005.

In summary, we have set payment rates for single-indication orphan drugs according to the following policy, effective January 1, 2005:

- We are using the same criteria that we implemented in CY 2003 to identify single indication orphan drugs used solely for an orphan condition for special payment under the OPPS; and,
- We are setting payment under the CY 2005 OPPS for single indication orphan drugs at the higher of 88 percent of the AWP or the ASP plus 6 percent, updated quarterly to reflect the most current AWP and ASP data.

While we are not implementing the 95 percent AWP cap on single-indication orphan drugs in CY 2005, we will monitor this decision and may apply the cap in future OPPS updates.

G. Change in Payment Policy for Radiopharmaceuticals

In the November 1, 2002 OPPS final rule (67 FR 66757), we determined that we would classify any product containing a therapeutic radioisotope to be in the category of benefits described under section 1861(s)(4) of the Act. We also determined that the appropriate benefit category for diagnostic radiopharmaceuticals is section 1861(s)(3) of the Act. We stated in the November 1, 2002 final rule that we will consider neither diagnostic nor therapeutic radiopharmaceuticals to be drugs as defined in 1861(t) of the Act (67 FR 66757). Therefore, beginning with the CY 2003 OPPS update, and continuing with the CY 2004 OPPS update, we have not qualified diagnostic or therapeutic radiopharmaceuticals as drugs or biologicals.

As we stated in the August 16, 2004 proposed rule, when we analyzed the many changes mandated by Pub. L. 108–173 that affect how we would pay for drugs, biologicals, and radiopharmaceuticals under the OPPS in CY 2005, we revisited the decision that we implemented in CY 2003 not to classify diagnostic and therapeutic radiopharmaceuticals as drugs or biologicals. In our analysis, we noted that although we did not consider radiopharmaceuticals for pass-through payment in CYs 2003 and 2004, we did apply to radiopharmaceuticals the same packaging threshold policy that we applied to other drugs and biologicals, and which we proposed to continue in CY 2005. In addition, for the CY 2004 OPPS update, we applied the same adjustments to median costs for radiopharmaceuticals that we applied to separately payable drugs and biologicals that did not have pass-through status (68 FR 63441).

In our review of this policy, we noted that section 1833(t)(14)(B)(i) of the Act, as amended by section 621(a) of Pub. L. 108–173, does include ''radiopharmaceutical'' within the meaning of the term ''specified covered outpatient drugs,'' although neither section 621(a)(2) nor section 621(a)(3) of Pub. L. 108–173 includes a reference to radiopharmaceuticals.

In an effort to provide a consistent reading and application of the statute, we proposed to apply to radiopharmaceuticals certain provisions in section 621 of Pub. L. 108–173 which affect payment for drugs and biologicals billed by hospitals for payment under the OPPS. We believed it was reasonable to include radiopharmaceuticals in the general category of drugs in light of their

inclusion as specified covered outpatient drugs in section 1833(t)(14)(B) of the Act, as added by section 621(a)(1) of Pub. L. 108–173.

Section 621(a)(1) of Pub. L. 108–173, which amends section 1833(t) of the Act by adding a new subparagraph (14) affecting payment for radiopharmaceuticals under the OPPS, is unambiguous. This provision clearly requires that separately paid radiopharmaceuticals be classified as ''specified covered outpatient drugs.'' Therefore, in CY 2005, we proposed to continue to set payment for radiopharmaceuticals in accordance with these requirements, which are discussed in detail in section V.B.3. of this preamble.

Section 1833(t)(16)(B) of the Act, as added by section 621(a)(2) of Pub. L. 108–173, requires us to reduce the threshold for the establishment of separate APCs with respect to drugs and biologicals to $50 per administration for drugs and biologicals furnished in 2005 and 2006. We proposed to apply the $50 packaging threshold methodology discussed in section V.B.2. of this final rule with comment period to radiopharmaceuticals as well as to drugs and biologicals.

Section 1833(t)(15) of the Act, added by section 621(a)(1) of Pub. L. 108–173, requires us to make payment equal to 95 percent of the AWP for an outpatient drug or biological that is covered and furnished as part of covered OPD services for which a HCPCS code has not been assigned. We proposed, beginning in CY 2005, to extend to radiopharmaceuticals the same payment methodology discussed in section V.D. of this preamble for new drugs and biologicals before HCPCS codes are assigned. That is, we proposed to pay for newly approved radiopharmaceuticals, as well as newly approved drugs and biologicals, at 95 percent of AWP prior to assignment of a HCPCS code.

Section 1833(t)(5)(E) of the Act, as added by section 621(a)(3) of Pub. L. 108–173, excludes separate drug and biological APCs from outlier payments. Beginning in CY 2005, we proposed to apply section 621(a)(3) of Pub. L. 108–173 to APCs for radiopharmaceuticals. That is, beginning in CY 2005, radiopharmaceuticals would be excluded from receiving outlier payments.

Consistent with our proposed policy to apply to radiopharmaceutical agents payment policies that apply to drugs and biologicals, we further proposed, beginning in CY 2005, to accept applications for pass-through status for certain radiopharmaceuticals. That is, we proposed on a prospective basis to consider for pass-through status those radiopharmaceuticals to which a HCPCS code is first assigned on or after January 1, 2005. As we explain in section V.A.3. of this final rule with comment period, section 1833(t)(6)(D)(i) of the Act sets the payment rate for pass-through eligible drugs and biologicals as the amount determined under section 1842(o) of the Act. In the August 16, 2004 proposed rule, we proposed to pay for drugs and biologicals with pass-through status in CY 2005 consistent with the provisions of section 1842(o) of the Act as amended by Pub. L. 108–173, at a rate that is equivalent to the payment these drugs and biologicals would receive in the physician office setting and set in accordance with the methodology described in the Medicare Physician Fee Schedule Proposed Rule for CY 2005 (69 FR 47488, 47520 through 47524).

We issued an interim final rule with comment period entitled ''Medicare Program: Manufacturer Submission of Manufacturer's Average Sales Price (ASP) Data for Medicare Part B Drugs and Biologicals'' in the April 6, 2004 **Federal Register**, related to the calculation and submission of manufacturer's ASP data (69 FR 17935). We need these data in order to determine payment for drugs and biologicals furnished in a physician office setting in accordance with the methodology described in the Medicare Physician Fee Schedule Proposed Rule (69 FR 47488, 47520 through 47524). However, the April 6, 2004 interim final rule with comment period excludes radiopharmaceuticals from the data reporting requirements that apply to Medicare Part B covered drugs and biologicals paid under sections 1842(o)(1)(D), 1847A, or 1881(b)(13)(A)(ii) of the Act (69 FR 17935). As a consequence, we would not have the same type of data available to determine payment for a new radiopharmaceutical approved for pass-through status after January 1, 2005 that would be available to determine payment for a new drug or biological with pass-through status in CY 2005.

Therefore, in order to set payment for a new radiopharmaceutical approved for pass-through status in accordance with 1842(o) of the Act and in a manner that is consistent with how we proposed to set payment for a pass-through drug or biological, we proposed a methodology that would apply solely to new radiopharmaceuticals for which payment would be made under the OPPS and for which an application for pass-through status is submitted after January 1, 2005. That is, in order to receive pass-through payment for a new radiopharmaceutical under the OPPS, a manufacturer would be required to submit data and certification for the radiopharmaceutical in accordance with the requirements that apply to drugs and biologicals under section 303 of Pub. L. 108–173 as set forth in the interim final rule with comment period issued in the April 6, 2004 **Federal Register** (66 FR 17935) and described on the CMS Web site at *http://cms.hhs.gov.* We proposed that payment would be determined in accordance with the methodology applicable to drugs and biologicals that is discussed in the CY 2005 Medicare Physician Fee Schedule proposed rule (69 FR 47488, 47520–47524). In the event the manufacturer seeking pass-through status for a radiopharmaceutical does not submit data in accordance with the requirements specified for new drugs and biologicals, we proposed to set payment for the new radiopharmaceutical as a specified covered outpatient drug, under section 1833(t)(14)(A) as added by section 621(a)(1) of Pub. L. 108–173.

We received many public comments on our proposals.

Comment: Many commenters applauded CMS for proposing to treat radiopharmaceuticals as drugs and encouraged CMS to continue to pay for these products as ''specified covered outpatient drugs'' under the OPPS, consistent with section 621(a) of the MMA. They indicated that this policy ensures consistent treatment of drugs and radiopharmaceuticals, eliminates confusion related to the prior differences in their treatment under the OPPS, and facilitates patient access to these important therapies in clinically appropriate settings. One of the commenters also supported the proposal to exclude radiopharmaceuticals from receiving outlier payments in CY 2005.

Response: We appreciate the commenters' support of our policy to treat radiopharmaceuticals as drugs and will finalize this policy for CY 2005.

Comment: Several commenters opposed our proposal to require manufacturers to submit ASP data for radiopharmaceutical agents with pass-through status. One manufacturer of radiopharmaceuticals stated that there are significant practical problems and legal barriers to reporting ASP for radiopharmaceuticals. The commenter indicated that manufacturers often sell the components of a radiopharmaceutical to independent radiopharmacies. These radiopharmacies then sell unit doses to many hospitals; however, some hospitals also purchase the components

of the radiopharmaceutical and prepare the radiopharmaceutical through in-house radiopharmacies. This commenter asserted that the end result is that there is very often no ASP for the finished radiopharmaceutical product. For example, there may only be manufacturer pricing for the components; however, the price set by the manufacturer for one component of a radiopharmaceutical does not directly translate into the acquisition cost of the ''complete'' radiopharmaceutical, which may result from the combination of several components. This commenter recommended that CMS be consistent and not require ASP in the OPPS, as CMS does not require ASP for radiopharmaceuticals in the Medicare Physician Fee Schedule. The commenter thus urged CMS to determine payment for pass-through radiopharmaceuticals as specified covered outpatient drugs, based on AWP or acquisition costs. Another commenter recommended that CMS set payment for all pass-through radiopharmaceuticals in CY 2005 using the AWP-based ''specified covered outpatient drugs'' payment methodology, regardless of whether ASP data are available for the drug and stated that this methodology is more appropriate for these products, because it will be more likely to ensure adequate payment as use of the product is adopted, and thus will provide for robust cost data for future rate-setting purposes.

Response: We appreciate these comments and understand the concerns commenters stated regarding our proposal to require manufacturers of radiopharmaceutical agents with pass-through status to submit ASP data. We recognize the complexities of determining ASP for radiopharmaceuticals because of their unique preparation processes; therefore, we agree with the commenters' concerns about finalizing the proposed policy. Because radiopharmaceuticals are not paid on ASP in the physician office setting, manufacturers of these agents will not be required to report ASPs for payment purposes under the OPPS. Therefore, payment for radiopharmaceuticals with pass-through status will be made in accordance with their status as sole source ''specified covered outpatient drugs.'' That is, in the absence of both ASP data and hospital claims data, we will set payment for new radiopharmaceuticals approved for pass-through status beginning in CY 2005 at the floor for sole source ''specified coveraged outpatient drugs,'' which is 83 percent of the AWP.

Comment: A few commenters urged CMS to revise the HCPCS code descriptors for radiopharmaceutical products that do not currently have ''per dose'' or ''per study'' descriptors and indicated that ''per dose'' or ''per study'' code descriptors will facilitate the collection of more accurate charge and cost data which are necessary to establish equitable payment for radiopharmaceutical agents.

Response: We recognize the concerns expressed by these commenters. As we have stated in the November 7, 2003 OPPS final rule with comment period (68 FR 63451), we continue to believe that in changing descriptors to ''per dose'' or ''per study'', we will lose specificity with respect to the data we will receive from hospitals. We are not convinced that there is a programmatic need to change the radiopharmaceutical code descriptors to ''per dose'' or that claims data based on the current code descriptors are problematic for setting payment rates for these products. However, we will continue to work with industry representatives to ensure that the current HCPCS descriptors are appropriate and review this issue in the future, if needed. Furthermore, we stress the importance of proper coding by providers so that we can obtain accurate data for future rate setting.

Comment: A commenter strongly supported CMS requiring that hospitals report all HCPCS codes for drugs including those that are packaged and indicated that this will enable CMS to track costs and help to ensure that only correctly coded claims (those with radiopharmaceuticals) are used in setting payment rates for nuclear medicine procedures. Therefore, the commenter recommended that CMS require continued reporting of HCPCS codes for all radiopharmaceuticals (packaged and non-packaged products).

Response: We will continue to strongly encourage hospitals to report charges for all drugs using the correct HCPCS codes for the items used, including the drugs that have packaged status in CY 2005. We agree with the commenter that it is most useful to us when we have a robust set of claims for each item paid for under the OPPS. We would note, however, that with just a very few exceptions, hospitals do appear to be reporting charges for drugs, biologicals and radiopharmaceuticals using the existing HCPCS codes, even when such items have packaged status. At this time, we do not believe it is necessary to institute a requirement for drugs as we are doing for the device category codes. However, we will continue to monitor this through our annual analysis of claims data and will reconsider this in the future, if we determine that it is necessary.

H. Coding and Payment for Drug Administration

Since implementation of the OPPS, Medicare OPPS payment for administration of cancer chemotherapy drugs and infusion of other drugs has been made using the following HCPCS codes:

- Q0081, Infusion therapy other than chemotherapy, per visit
- Q0083, Administration of chemotherapy by any route other than infusion, per visit
- Q0084, Administration of chemotherapy by infusion only, per visit
- Q0085, Administration of chemotherapy by both infusion and another route, per visit

In the CY 2004 proposed rule, we proposed to change coding and payment for these services to enable us to pay more accurately for the wide range of services and the drugs that we package into these per visit codes. (Background discussion on these codes is included in the August 12, 2003 OPPS proposed rule (68 FR 47998). Commenters on the CY 2004 proposed rule recommended that we use the CPT codes for drug administration. One commenter provided a crosswalk from the CPT codes for drug administration to the Q codes that we could use in a transition. We did not implement this in the final rule for CY 2004 OPPS but indicated that we would consider it for CY 2005 and would discuss it with the APC Panel at its February 2004 meeting.

Commenters and the APC Panel recommended that we discontinue use of code Q0085 for CY 2004 because codes Q0083 and Q0084 could be used together to report the services described by code Q0085. We did implement this change for CY 2004 and made code Q0085 nonpayable for CY 2004 OPPS.

At the February 2004 APC Panel meeting, we presented a proposal from an outside organization that matched CPT codes for chemotherapy and nonchemotherapy infusions to the Q codes currently used to pay for these services under the OPPS. We asked the APC Panel for their perspective on the potential benefit of using the proposed coding approach as the basis for billing and determining the OPPS payment for administering these drugs. The APC Panel recommended that CMS continue to review the organization's proposed coding crosswalk with the goal of using it to transition from the use of Q-codes

to that of CPT codes to bill for administration of these drugs.

In the August 16, 2004 proposed rule, for CY 2005, we proposed to use the CPT codes for drug administration but to crosswalk the CPT codes into APCs that reflect how the services would have been paid under the Q codes. Although hospitals would bill the CPT codes and include the charges for each CPT code on the claim, payment would be made on a per visit basis, using the cost data from the per visit Q codes (Q0081, Q0083 and Q0084) to set the payment rate for CY 2005. See Table 29 of the proposed rule for the proposed crosswalk of CPT codes into APCs based on the Q codes (69 FR 50521). The only change from the crosswalk that was submitted by the outside organization is that we proposed a Q code and APC crosswalk for CPT code 96549 (Unlisted chemotherapy procedure), rather than bundling that service. We believe that Q0083 is the code that would have previously been reported by hospitals to describe the unlisted service. In addition, this would place the unlisted service in our lowest resource utilization APC for chemotherapy, consistent with our policy for other unlisted services.

We proposed to establish the Q code and APC crosswalk for CPT code 96549 because there is no CPT specific charge or frequency data on which to set payments. The CY 2005 OPPS is based on CY 2003 claims data which used the Q codes. Therefore, the only cost data available to us for establishment of median costs is the data based on the Q codes for drug administration. Moreover, the only frequency data that are available for use in calculating the scalar for budget neutrality of payment weights are the frequency data for the Q codes. Therefore, the payments set for the CPT codes must use the cost data for the Q codes and must result in the same payments that would have been made had the Q codes been continued.

Under this proposed methodology, hospitals would report the services they furnish with the CPT codes and would show the charges that they assign to the CPT codes on the claim. The Medicare OCE would assign the code to an APC whose payment is based on the per visit Q code that would have been used absent coding under CPT. In most cases, the OCE would collapse multiple codes or multiple units of the same CPT code into a single unit to be paid a single APC amount. This approach is needed because the data for the Q codes is reported on a per visit basis and more than one unit of a CPT code can be provided in a visit.

For example, CPT code 96410 (Chemotherapy administration infusion technique, up to 1 hour) is for infusion of chemotherapy drugs for the first hour, and CPT code 96412 is for chemotherapy infusion up to 8 hours, each additional hour. The claims data used to set the APC payment rate for these codes is for a per visit amount (taken from CY 2003 data for Q0084 a per visit code). The frequency data on the claim are also on a per visit basis. For CY 2005, we proposed that CPT code 96410 would be paid one unit of APC 0117 (to which CPT code 96410 would be crosswalked) and no separate payment would be made for CPT code 96412, regardless of whether one unit or more than one unit is billed. CPT code 96412 would be a packaged code for CY 2005. Under the Q code data on which the payment weight for APC 0117 is based, the per visit amount would represent a payment that is appropriate for all drug administration services in a visit (that is, one unit of CPT code 96410 and as many units of CPT code 96412 as were furnished in the same visit).

Similarly, we proposed that when a hospital bills 3 units of CPT code 96400 (Chemotherapy administration, subcutaneous or intramuscular, with or without local anesthesia), the OCE would assign one unit of APC 0116 for that code. (APC 0116 is the APC to which CPT code 96400 would be crosswalked.) The payment would be based on Q0083, a per visit code, because, absent the ability to be paid based on CPT codes, the hospital would have billed one unit of Q0083 (for the 3 injections) had we not discontinued the Q codes for CY 2005. The OCE would assume that there was one and only one visit in which there were 3 injections and would pay accordingly (that is, one unit of APC 0116).

We noted that if we adopt the CPT codes for drug administration to ensure accurate payment in the future, it would be critical for hospitals to bill the charges for the packaged CPT codes for drug administration for CY 2005 (that is, the CPT codes with SI=N), even though there would be no separate payment for them in CY 2005. For CY 2007 OPPS, CY 2005 claims data would be used as the basis for setting median costs for each CPT code, based on the reported charges reduced to cost, and would determine what APC configuration ensures most appropriate payment for the CPT drug administration codes. If hospitals do not bill charges in CY 2005 for the packaged drug administration CPT codes such as CPT codes 96412, 96423, 96545, or 90781, they would jeopardize our ability to make accurate payments for services billed and paid under these codes in CY 2007 when we use the CY 2005 data to set the payment weights.

Comment: Most commenters supported our proposal to code drug administration using CPT codes instead of the HCPCS codes. They indicated that it would be less burdensome for hospitals to code services using just one method for Medicare and all other payers. Some commenters opposed the use of CPT codes unless CMS pays an amount for each use of the CPT code, as CMS does under the Medicare Physician Fee Schedule.

Response: We cannot pay an amount for each use of each CPT code because all of our drug administration cost data are on a per visit (not a per code) basis as charges for each of the following three HCPCPS codes, Q0081, Q0083, and Q0084, are reported for a visit and not a service.

We agree that billing for drug administration using the CPT codes will be less burdensome to hospitals and will also facilitate development of more accurate payment rates for drug administration services in future years. For CY 2005 OPPS, we will collapse the CPT codes billed for drug administration into a single unit of the applicable APC for payment as we do not have the CPT code specific claims data for use in establishing a CPT code specific payment. However, we anticipate that we would have the necessary claims for CY 2007 OPPS to set an appropriate APC payment rate for the services described by the CPT codes.

Comment: Several commenters asked that we affirm that hospitals may report CPT codes 90780 (intravenous infusion for therapy/diagnosis administered by physician or under direct supervision of physician; up to one hour) and 90781 (each additional hour up to (8) hours), notwithstanding that the administration is not done by a physician or under the direct supervision of a physician. The commenters stated that such services are typically administered in hospitals by nurses without direct physician supervision and that if hospitals report these codes only when the full definition of the code is met, they would not be able to report the infusion services they furnish.

Response: We do not view the language of these CPT codes' definitions as being an obstacle to or inconsistent with the use of the codes by hospitals for billing Medicare. We view our general requirements regarding physician supervision (with respect to payment for services that are incident to a physician's service in the outpatient hospital setting) as meeting the

physician supervision aspect of the codes and thus, do not believe that use of the codes in the hospital outpatient setting would be prevented by the inclusion of the language in the code definition.

Comment: A commenter asked that we change the status indicator for CPT code 90780 and 90781 to ''X'' from ''T'' thereby eliminating the multiple procedure reduction for these codes, which in CY 2005 will replace HCPCS code Q0081 in billing for the administration of infusion therapy. The commenter stated that there is no situation in which the time and resources involved in infusion care should be reduced in the case of an observation patient.

Response: We disagree. The costs of space, utilities and staff attendance are duplicated when the beneficiary is receiving another service at the same time as infusion therapy, in particular when the patient is in observation. Hence it is appropriate to apply a multiple procedure reduction to infusion therapy particularly when the patient is in observation status. We believe it is necessary to understand how the OCE multiple procedure discounting logic functions. Line-items with a service indicator of ''T'' are subject to multiple procedure discounting unless modifiers 76, 77, 78, and/or 79 are present on the claim. The ''T'' line-item with the highest payment amount will not be discounted but all other ''T'' line items will be discounted as multiple procedures. All line-items that do not have a service indicator of ''T'' will be ignored in determining the discount. Therefore, if the only other services reported with infusion therapy are an emergency department or other visit code, or diagnostic tests and services assigned status indicator ''S,'' the infusion therapy code would not be subject to the multiple procedure discounting.

Comment: Several commenters stated that multiple visits per day for antibiotic infusion are common and the drug administration policies should permit such visits to be paid separately. The commenters stated that multiple visits for chemotherapy are possible and that provisions should be made for billing and paying them when they occur.

Response: We agree with the commenters on this issue. The reporting and payment for these multiple visits and services will not be an issue once payment for drug administration under the OPPS is made based on CPT code-specific data. However, until such time, hospitals will need to use modifier 59 (distinct procedure) when billing charges for services furnished during multiple visits that follow the initial visit. For CPT codes 90780 and 90781, where there are multiple visits for infusion on the same day, the hospital should report CPT code 90780 with modifier 59 and CPT code 90781, if appropriate, with modifier 59 for each separate visit for infusion. With modifier 59 appended to CPT codes 90780 and 90781, the OCE will allow up to 4 units of APC 0120 (Infusion of nonchemotherapy drugs) to be paid. Similarly, for the chemotherapy administration codes, where there is no modifier 59 reported, the OCE will collapse all codes that map to a particular APC into one unit of that APC and will pay one unit of each applicable APC. The system will assume that all services were furnished in one single encounter. Where the chemotherapy services are provided in multiple encounters, the hospital will need to show modifier 59 on the service furnished in the second encounter. The OCE will map those services into an additional unit of each applicable APC and will pay for each visit. The OCE will not, for a single date of service, pay more than 4 units of APC 120, nor more than 2 units of APCs 116 and 117 (chemotherapy by route other than infusion and infusion of chemotherapy drugs). We intend to reassess these limits based on provider feedback and our review of later claims data.

Comment: One commenter asked that CMS ensure that the costs for CPT code 90780 (Infusion therapy one hour) are included in payment for CPT codes 67221 (Ocular photodynamic therapy) and 67225 (Eye photodynamic therapy add-on) because CPT code 90780 is bundled into both of these procedure codes.

Response: The procedure code definition for CPT code 67221 specifies that intravenous infusion is included, and CPT code 67225 is to be listed separately in addition to CPT code 67221, if a second eye is treated. Therefore, the National Correct Coding Initiative (NCCI) edits preclude payment for CPT code 90780 with CPT codes 67221 and 67225 because the charges for the procedure CPT codes 67221 and 67225 are presumed to include all costs of administering the drug. Correct coding would not include reporting CPT code 90780 for the same visits when photodynamic therapy was provided. We expect that hospitals will include their charges for the necessary infusion in their charges for the procedure codes when they bill CPT codes 67221 or 67225, so that our claims data reflect the costs of all resources necessary to perform the services.

Comment: Several commenters urged CMS to adopt the new and revised AMA definitions for drug administration, which will be HCPCS G-codes in the CY 2005 Medicare Physician Fee Schedule, because the existing CPT codes do not adequately capture the costs of the range of drug administrations. They also urged CMS to educate providers on the correct use of the new CPT codes. The commenters indicated that implementing the new CPT codes for drug administration will be more difficult in hospitals than in physicians' offices because the services are typically provided in more places in hospitals than in physicians' offices.

Response: For CY 2005 OPPS, we are implementing the existing CPT codes for drug administration rather than the new G-codes that will be used for the Medicare Physician Fee Schedule payments. We do not intend to use the new HCPCS G-codes for the OPPS drug administration services until such time as the new CPT codes for those services are issued in CY 2006. We believe that it would be disruptive to hospitals if we required them to implement the HCPCS alphanumeric codes for drug administration in CY 2005 and then switch to the new CPT codes in CY 2006. While only a subset of the physician community administers anti-neoplastic drugs in their offices, we believe that most hospitals do so on an outpatient basis and hence most hospitals would have to change to the new HCPCS codes for CY 2005, only to change again to new CPT codes for CY 2006. However, we are told that all hospitals use the current CPT codes to bill other payers and crosswalk from the current CPT codes to the Q codes to bill Medicare. Thus, using the current CPT codes should be easier for hospitals than their current method for billing Medicare. This would not be the case if we were to require that they use the new HCPCS codes for drug administration.

Comment: One commenter indicated that CMS should revise the OPPS to mirror the policy under the Medicare Physician Fee Schedule that pays separately for each drug administered to permit the payment of one unit of each APC for each and every drug administered. The commenter stated that since CMS acknowledged that there are additional resources used with each administration of a drug, it should apply the same policy to hospitals since all of these services are furnished by nurses, whether in a physician's office setting or a hospital setting.

Response: We are moving to the use of CPT codes for CY 2005 OPPS. However, we will not be paying an APC amount for each unit of each CPT code.

The APC rate is, by necessity, based on historic data for a code that was billed and reported on a per visit basis. Therefore, to pay each unit of a CPT code an APC amount would not accurately reflect the resources used and would result in an overpayment of the costs of the services provided.

Comment: A commenter asked CMS to permit hospitals to continue billing HCPCS codes Q0081, Q0083 and Q0084 for drug administration until April 1, 2005 so that hospitals that do not currently bill the CPT codes for drug administration may have a transition period to convert to CPT code billing.

Response: The three cited Q-codes will be deactivated for the OPPS effective January 1, 2005 and therefore cannot be used up to April 1, 2005. As discussed in our proposed rule, we are eliminating the 90-day grace period for deleted codes effective January 1, 2005. We are adopting this policy because the Health Insurance Portability and Accountability Act (HIPAA) transaction and code set rules require usage of the medical code that is valid at the time that the service is provided. Details regarding elimination of the 90-day grace period for billing deleted codes were issued to our contractors on February 4, 2004, in Transmittal 89, Change Request 3093. Moreover, we are not aware that there are any hospitals that do not bill the CPT codes for drug administration, as hospitals have told us that all payers other than Medicare require that they use the CPT codes and will not accept the Q-codes.

Comment: A commenter asked that CMS use the first two quarters of the CY 2005 claims to set the median costs for drug administration in CY 2006 OPPS so that the transition to the more accurate payments under the CPT codes could begin earlier than CY 2007.

Response: As the CY 2005 claims data will be the basis for the CY 2007 payment weights, we regret that we are unable to transition to the new payments earlier than CY 2007 because of the time required to access the CY 2005 claims data and to process and construct our database for ratesetting and impact analyses. The second quarter of CY 2005 data will not be available to us until at least August 15, 2005, which is far too late for us to have developed and published any CY 2006 proposed rule.

After carefully reviewing all comments received, we are adopting as final our proposal to use the CPT codes for drug administration, effective January 1, 2005. We will collapse the CPT codes billed into a single unit of the applicable APC for payment. In addition, we are establishing the Q-code and APC crosswalk for CPT code 96549 and will be paying 1 unit of APC 0117 for CPT code 96410 (to which CPT code 96410 will be crosswalked). We will not make a separate payment for CPT code 96412 regardless of whether 1 unit or more units are billed. For CY 2005, CPT code 96412 will be a packaged and not paid separately. Further, when a hospital bills 3 units of CPT code 96400 (Chemotherapy administration, subcutaneous or intramuscular, with or without local anesthesia), the OCE will assign 1 unit of APC 0116 for that code and the payment will be based on HCPCS code Q0083, a per visit code. Modifier 59 may be used with codes in APCs 0116, 0117, and 0120 to signify additional encounters on the same date of service for which additional APC payments may be made.

Table 33 below contains the crosswalk of CPT codes for drug administration to drug administration APCs for CY 2005. The last two columns of this table indicate the maximum number of units of the APC that the OCE will assign without or with modifier 59, respectively.

BILLING CODE 4120–01–P

Table 33.--Crosswalk from CPT Codes for Drug Administration to Drug Administration APCs

CPT Code	Description	SI	APC	Corresponding HCPCS Code	OCE Maximum APC Units without Modifier 59	OCE Maximum APC Units with Modifier 59
96400	Chemotherapy, sc/im	S	116	Q0083	1	2
96405	Intralesional chemo admin	S	116	Q0083	1	2
96406	Intralesional chemo admin	S	116	Q0083	1	2
96408	Chemotherapy, push technique	S	116	Q0083	1	2
96410	Chemotherapy,infusion method	S	117	Q0084	1	2
96412	Chemo, infuse method add-on	N	--	--	0	0
96414	Chemo, infuse method add-on	S	117	Q0084	1	2
96420	Chemotherapy, push technique	S	116	Q0083	1	2
96422	Chemotherapy,infusion method	S	117	Q0084	1	2
96423	Chemo, infuse method add-on	N	--	--	0	0
96425	Chemotherapy,infusion method	S	117	Q0084	1	2
96440	Chemotherapy, intracavitary	S	116	Q0083	1	2
96445	Chemotherapy, intracavitary	S	116	Q0083	1	2
96450	Chemotherapy, into CNS	S	116	Q0083	1	2
96542	Chemotherapy injection	S	116	Q0083	1	2
96545	Provide chemotherapy agent	N	--	--	0	0
96549	Chemotherapy, unspecified	S	116	Q0083	1	2
90780	IV infusion therapy, 1 hour	T	120	Q0081	1	4
90781	IV infusion, additional hour	N	--	--	0	0

BILLING CODE 4120–01–C

I. Payment for Blood and Blood Products

Since the OPPS was first implemented in August 2000, separate payments have been made for blood and blood products in APCs rather than packaging them into payment for the procedures with which they were administered. Administrative costs for processing and storage specific to the transfused blood product are included in the blood product APC payment, which is based on hospitals' charges. Payment for the collection, processing, and storage of autologous blood, as described by CPT code 86890, is made

through APC 0347 (Level III Transfusion Laboratory Procedures).

In CY 2000, payments for bloods were established based on external data provided by commenters due to limited Medicare claims data. From CY 2000 to CY 2002, blood and blood product payment rates were updated for inflation. For CY 2003, as described in the November 1, 2002 final rule (67 FR 66773), we applied a special dampening methodology to blood and blood products that had significant reductions in payment rates from CY 2002 to CY 2003, when median costs were first calculated from hospital claims. Using the dampening methodology, we limited the decrease in payment rates for blood and blood products to approximately 15 percent. For CY 2004, as recommended by the APC Panel, we froze payment rates for blood and blood products at CY 2003 levels. This allowed us to undertake further study of the issues raised by commenters and presenters at the August 2003 and February 2004 APC Panel meetings.

In the August 16, 2004 proposed rule for CY 2005 OPPS, we proposed to continue to pay separately for blood and blood products. We also proposed to establish new APCs that would allow each blood product to be in its own separate APC, as several of the blood product APCs currently contained multiple blood products with no clinical homogeneity or whose product-specific median costs may not have been similar. Thus, we also proposed to reassign some of these HCPCS codes already contained in certain APCs to new APCs. (*See* Table 30 of the proposed rule (69 FR 50523.)

Other than for autologous blood products, hospital reimbursement for the costs of collection, processing, and storage of blood and blood products are made through the OPPS payments for specific blood product APCs. Wastage and other administrative costs for blood are attributable to overhead and distributed across all hospital services linked to cost centers in the Medicare cost report, through the standard process of converting charges to costs using hospitals' CCRs for each cost center on the cost report.

In the August 16, 2004 proposed rule, we noted that comments to previous OPPS rules had stated that the CCRs that we used to adjust claim charges to costs for blood in past years were too low, resulting in underestimation of the true hospital costs for blood and blood products. In response, we conducted a thorough analysis of the OPPS claims to compare CCRs between hospitals with a blood-specific cost center and hospitals defaulting to the overall hospital CCR. Our past methodology for determining CCRs for blood products included a default to the overall CCR when any given provider had chosen not to report costs and charges in a blood-specific cost center on the cost report. After matching the two blood-specific cost centers to the 38X and 39X revenue codes, we observed a significant difference in CCRs utilized for conversion of blood product charges to costs for those hospitals with and without blood-specific cost centers. The median CCR for those hospitals with a blood-specific cost center was 0.66 for revenue code 38X and 0.64 for revenue code 39X, and for those defaulting to the overall hospital CCR, the result was a CCR of 0.34 for revenue code 38X and 0.33 for revenue code 39X. The median overall CCR for all hospitals in the CY 2005 analysis was 0.33.

In light of this information, we applied the methodology described in our August 16, 2004 proposed rule to calculate simulated medians for each blood and blood product based on our CY 2003 claims data. We assumed that those hospitals not reporting costs and charges in a blood-specific cost center on their annual cost report, in general, face similar costs and engage in comparable charging practices for blood as those reporting a blood-specific cost center. For those hospitals not reporting a blood-specific cost center, we simulated a blood-specific CCR, which we then applied to convert charges to costs for blood products. Overall, this methodology increased the estimated median costs of blood and blood products by 25 percent for CY 2005 relative to the median costs used to set CY 2004 APC rates. For example, the estimated median for HCPCS code P9016 (Red blood cells, leukocyte reduced), the most frequently billed blood product, increased by 32 percent relative to the CY 2004 median.

As discussed in the proposed rule, in reviewing the simulated medians calculated using the methodology described above relative to those medians used to set CY 2004 payment rates, we noticed that some low-volume blood products (< 1,000 units) demonstrated significant decreases in median costs utilizing our general methodology. Overall, the simulated median costs for low-volume blood products declined by 14 percent for CY 2005. Because a small sample size can lead to great variability in point estimates, we sought to increase the number of units of low-volume blood products by combining CY 2002 and CY 2003 claims data for the low-volume products. We used the simulated CCRs to calculate costs from charges from CY 2002 and CY 2003 claims data. To ensure that we combined comparable costs, we updated the simulated costs on the CY 2002 claims to the base year of CY 2003 using the Producer Price Index (PPI) for blood and derivatives for human use (Commodity Code #063711). This is the PPI used to update blood and blood product prices in the market basket (67 FR 50039, August 1, 2002). We recognize that not all of the low-volume blood products had claims in CY 2002.

After combining the 2 years of claims data, we were able to raise the volume of blood units billed for several of these products above 1,000 units. Since the publication of the proposed rule, additional claims data from the last quarter of CY 2003 have become available to us. The data showed that a few of the blood products had utilization in CY 2003 that exceeded the 1,000 unit low-volume threshold and will not be subject to the low-volume blood product payment adjustment described below, that we are adopting for CY 2005. The low-volume blood products that we are adopting as final are listed below in Table 31 of this final rule with comment period.

The DHHS Advisory Committee on Blood Safety and Availability has recommended that CMS establish payment rates for blood and blood products based on current year acquisition costs and actual total costs of providing such blood products. At the February 2004 APC Panel meeting, the APC Panel recommended that CMS use external data to derive costs of blood and blood products in order to establish payment rates. At the September 2004 APC Panel meeting, the APC Panel recommended that CMS freeze payment rates for low-volume blood products for CY 2005 at CY 2004 levels. The Panel also recommended that CMS consider using external data for setting payment rates for blood and blood products in the future.

We received the following comments on our August 16, 2004 proposed rule regarding payment for blood and blood products.

Comment: A few commenters expressed strong support for payment rates developed using hospital data rather than blood industry data. The commenters urged CMS to exercise caution in using blood industry data and to consider evaluating the data for their validity, reliability and consistency with geographic variations in costs, in addition to being publicly available and subject to audit.

Response: We agree with the commenters that the OPPS payment rates should be based on the most

recently available and accurate hospital claims data. However, in rare circumstances when accurate hospital claims data capturing the full costs of services may not be available, we evaluate all external data very carefully to make sure that they meet our external data criteria. As discussed above, in setting all blood and blood product payment rates for CY 2005, we have relied upon data from hospital claims submitted to CMS.

Comment: Several commenters expressed concern about the proposed payment rates for blood and blood products. The commenters indicated that despite increases in the CY 2005 proposed payment rates for blood and blood products, the proposed payment rates still do not meet the actual costs to hospitals of acquiring these products. Some commenters stated that, in addition to hospital coding and billing problems, only a small number of hospitals were actually reporting blood costs, and that lack of reporting explains why the payment rates are still significantly below hospital acquisition costs. The commenters expressed concerns that this would create barriers to access to a safe blood supply for Medicare beneficiaries.

The commenters also expressed concerns about reductions in payment rates for low-volume blood products. They recommended that CMS either freeze payment rates at the CY 2004 OPPS levels for low-volume blood products that experienced a decrease in their proposed rates or use external data in setting payment rates for these products.

Response: We appreciate the commenters' concerns and share the same concern for protecting beneficiaries' access to a safe blood supply. As with all of the OPPS services, we prefer to rely on our claims data whenever possible. Comments received for previous rules also suggested that current hospital blood costs are not captured because hospitals underreport blood on their claims because it is too costly to bill for blood. However, our thorough analysis of billing for blood from CY 2003 claims data indicated that 81 percent of all hospitals included in our ratesetting and modeling for CY 2005 billed at least one unit of blood or blood product in CY 2003. Of these hospitals however, only 47 percent reported separate costs and charges in the two cost centers specific to blood on their most recent annual cost reports. It may be that those hospitals billing for blood but not reporting costs and charges on their cost reports for either of the two blood-specific cost centers reported their blood costs and charges under other cost centers, such as operating room. As discussed in the proposed rule, we simulated blood-specific hospital CCRs to account for these reporting differences and used these simulated CCRs to develop proposed median costs for blood products for CY 2005. Our claims data clearly show that the vast majority of hospitals do bill the OPPS for blood and blood products. In addition, the distribution of costs for individual products provides no evidence of significant coding problems.

As explained in the preamble of this section, we estimate that by using our new methodology of simulating medians and implementing the proposed payment rates for blood and blood products, excluding low-volume blood products, there would be a 25 percent increase in payment for blood and blood products overall. This includes a 32 percent increase in payment from CY 2004 for leukocyte reduced red blood cells (HCPCS code P9016), the highest volume blood product in the hospital OPD, and a 25 percent increase in payment for each unit of red blood cells (HCPCS code P9021), the second highest volume blood product.

After carefully reviewing all of the public comments received timely regarding low-volume blood products, we are convinced that due to the low utilization of these products, in addition to possible hospital coding and billing problems for these low-volume products, the claims data may not have captured the complete costs of these products to hospitals as fully as possible. We believe it is imperative that Medicare beneficiaries have full access to all medically necessary blood and blood products, including products that are infrequently utilized. Therefore, for blood products that would have experienced a decrease in median cost from CY 2004 to CY 2005 based on our proposed methodology, we are establishing CY 2005 payment rates that are adjusted to a 50/50 blend of CY 2004 product-specific OPPS median costs and our proposed CY 2005 simulated medians. This adjustment methodology will allow us to undertake further study of the issues raised by commenters and by presenters at the September 2004 APC Panel meeting, without putting beneficiary access to these low-volume blood products at risk.

Comment: One commenter suggested that CMS survey all hospitals across the country to investigate direct and indirect costs for blood. The commenter expressed concern that our proposed rates were insufficient to cover the costs of blood and its testing and storage. The commenter also expressed the need for continued increases in payments for blood products.

Response: We appreciate the commenter's recommendation and will take it into consideration as needed, when we reassess the payment rates for blood and blood products. While we believe our payment rates are appropriate and adequate for the provision of blood and blood product services, we are aware of the increasing number of tests required to ensure the safety of the nation's blood supply, which could possibly add to the costs of processing blood and blood products. The APC payment rates for blood and blood products are intended to cover the costs of medically necessary testing by community blood banks or blood banks operated by hospitals. However, the APC payment rates are not meant to include costs of tests requiring a specific patient's blood, such as cross-matching in preparation for transfusion, because these tests are separately payable under the OPPS.

Comment: Several commenters, including a hospital association, recommended that CMS issue more specific guidance to hospitals for billing of blood-related services in order to improve hospital claims data. Specifically, commenters requested that CMS address issues related to application of the Medicare blood deductible, differences between donor and nondonor states, hospital markups for blood costs, the appropriate use of HCPCS code P9011 (Split blood unit) in billing, blood processing and preparation costs and autologous blood collection. In addition, the same commenter recommended that CMS share its draft guidance for review with the Outpatient Medicare Technical Advisory Group (MTAG) or the National Uniform Billing Committee (NUBC), or both, to ensure it is correct, comprehensive, and reflective of the billing provider's perspective.

Response: We recognize the need for comprehensive billing guidelines for hospitals and other providers to address a variety of blood-related services under the OPPS. In the near future, we intend to provide further billing guidelines to clarify our original Program Transmittal A–01–50 issued on April 12, 2001 (CR Request 1585) regarding correct billing for blood-related services. We agree with the commenters and intend to gather information from all relevant and available resources.

Comment: One commenter, a hospital association, indicated that the revenue code 390 (Blood Storage and Processing) should not have been included in Table 18 (Proposed Packaged Services by

Revenue Codes) of the August 16, 2004 proposed rule. The commenter expressed concern that by including revenue code 390 in this table, hospitals would not be paid for the services because of a line-item claim rejection.

Response: We are clarifying that a HCPCS code billed with revenue codes listed in Table 18 of the proposed rule could be paid separately as long as the HCPCS code is not assigned a status indicator of ''N.'' When a revenue code charge is billed without a HCPCS code, the charge is reduced to cost using the appropriate CCR for the revenue code. This cost is then added to a line item charge (reduced to cost) for a separately payable HCPCS code. This allows costs associated with uncoded revenue code charges to be captured so we can make a more accurate payment for the claim. If we did not add the costs of the line item revenue code charges without HCPCS codes, the full cost data for all resources necessary to deliver a separately payable service might not be captured, possibly resulting in a lesser payment for the claim.

In summary, after carefully reviewing all public comments received timely, we are adopting as final for CY 2005 OPPS the following proposals:

- To continue to pay separately for blood and blood products, to establish new APCs that would place each blood product in its own separate APC, and to implement proposed APC reassignments for such blood and blood products.
- Effective for services furnished on or after January 1, 2005, in this final rule with comment period, we are providing that the payment rates for blood and blood products, excluding low-volume blood products whose CY 2005 simulated medians decreased from the CY 2004 medians, will be determined according to the methodology we described in the August 16, 2004 proposed rule.
- Effective for services furnished on or after January 1, 2005, in this final rule with comment period, we are providing that the CY 2005 payment rates for low-volume blood products that would have experienced a decrease in median costs from CY 2004 to CY 2005 based on our proposed methodology are adjusted to a 50/50 blend of CY 2004 product-specific median costs and our proposed CY 2005 simulated medians.

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Table 34.—CY 2005 APC Assignment of Blood and Blood Product Codes

HCPCS	Expired HCPCS	Status Indicator	Description	APC
P9010		K	Whole blood for transfusion	0950
P9011		K	Split unit of blood	0967
P9012		K	Cryoprecipitate each unit	0952
P9016		K	RBC leukocytes reduced	0954
P9017		K	Plasma 1 donor frz w/in 8 hr	9508
P9019		K	Platelets, each unit	0957
P9020		K	Plaelet rich plasma unit	0958
P9021		K	Red blood cells unit	0959
P9022		K	Washed red blood cells unit	0960
P9023		K	Frozen plasma, pooled, sd	0949
P9031		K	Platelets leukocytes reduced	1013
P9032		K	Platelets, irradiated	9500
P9033		K	Platelets leukoreduced irradiated	0968
P9034		K	Platelets, pheresis	9507
P9035		K	Platelet pheres leukoreduced	9501
P9036		K	Platelet pheresis irradiated	9502
P9037		K	Plate pheres leukoredu irradiated	1019
P9038		K	RBC irradiated	9505
P9039		K	RBC deglycerolized	9504
P9040		K	RBC leukoreduced irradiated	0969
P9043		K	Plasma protein fract,5%,50ml	0956
P9044		K	Cryoprecipitate reduced plasma	1009
P9048		K	Plasmaprotein fract,5%,250ml	0966
P9050		K	Granulocytes, pheresis unit	9506
P9051	C1010	K	Blood, L/R, CMV-NEG	1010
P9052	C1011	K	Platelets, HLA-m, L/R, unit	1011
P9053	C1015	K	Plt, pher, L/R, CMV, irradiated	1020
P9054	C1016	K	Blood, L/R, Froz/Degly/Washed	1016
P9055	C1017	K	Plt, Aph/Pher, L/R, CMV-Neg	1017
P9056	C1018	K	Blood, L/R, Irradiated	1018
P9057	C1020	K	RBC, frz/deg/wsh, L/R, irradiated	1021
P9058	C1021	K	RBC, L/R, CMV neg, irradiated	1022
P9059	C1022	K	Plasma, frz within 24 hour	0955
P9060	C9503	K	Fresh frozen plasma, ea unit	9503

Table 35.—Low Volume Blood and Blood Product Codes for CY 2005 Payments

HCPCS	Description
P9039	Red blood cells deglycerolized
P9043	Plasma protein fractionated, 5 percent, 50 ml
P9048	Plasmaprotein fractionated, 5 percent, 250 ml
P9050	Granulocytes, pheresis unit
P9053	Platelet, pher, L/R, CMV, irradiated
P9054	Blood, leukocyte reduced, frozen, deglycerolized, washed
P9055	Platelet, APH/PHER, leukocyte reduced, CMV, irradiated
P9057	RBC, frozen/deg/washed, L/R, irradiated
P9058	RBC, L/R CMV-neg, irradiated
P9059	Plasma, frozen within 24 hour
P9060	Fresh frozen plasma, each unit

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VI. Estimated Transitional Pass-Through Spending in CY 2005 for Drugs, Biologicals, and Devices

A. Basis for Pro Rata Reduction

Section 1833(t)(6)(E) of the Act limits the total projected amount of transitional pass-through payments for a given year to an ''applicable percentage'' of projected total Medicare and beneficiary payments under the hospital OPPS. For a year before CY 2004, the applicable percentage is 2.5 percent; for CY 2004 and subsequent years, we specify the applicable percentage up to 2.0 percent.

If we estimate before the beginning of the calendar year that the total amount of pass-through payments in that year would exceed the applicable percentage, section 1833(t)(6)(E)(iii) of the Act requires a prospective uniform reduction in the amount of each of the transitional pass-through payments made in that year to ensure that the limit is not exceeded. We make an estimate of pass-through spending to determine not only whether payments exceed the applicable percentage but also to determine the appropriate reduction to the conversion factor.

For devices, making an estimate of pass-through spending in CY 2005 entails estimating spending for two groups of items. The first group consists of those items for which we have claims data for procedures that we believe used devices that were eligible for pass-through status in CY 2003 and CY 2004 and that would continue to be eligible for pass-through payment in CY 2005. The second group consists of those items for which we have no direct claims data, that is, items that became, or would become, eligible in CY 2004 and would retain pass-through status in CY 2005, as well as items that would be newly eligible for pass-through payment beginning in CY 2005.

B. Estimate of Pass-Through Spending for CY 2005

In the August 16, 2004 proposed rule, we proposed to set the applicable percentage cap at 2.0 percent of the total OPPS projected payments for CY 2005. In this final rule with comment period, we are setting the applicable percentage cap at the same 2.0 percent.

We are using the same methodology described in the proposed rule to estimate the pass-through spending for CY 2005. To estimate CY 2005 pass-through spending for device categories in the first group described above, we used volume information from CY 2003 claims data for procedures associated with a pass-through device and manufacturer's price information from applications for pass-through status. This information was projected forward to CY 2005 levels, using inflation and utilization factors based on total growth in Medicare Part B as projected by the CMS Office of the Actuary (OACT).

To estimate CY 2005 pass-through spending for device categories included in the second group, that is, items for which we have no direct claims data, we used the following approach: For categories with no claims data in CY 2003 that would be active in CY 2005, we followed the methodology described in the November 2, 2001 final rule (66 FR 55857). That is, we used price information from manufacturers and volume estimates based on claims for procedures that would most likely use the devices in question. This information was projected forward to CY 2005 using the inflation and utilization factors supplied by the CMS OACT to estimate CY 2005 pass-through spending for this group of device categories. For categories that become eligible in CY 2005, we will use the same methodology. No new device categories for January 1, 2005, were announced after the publication of the proposed rule. Therefore, the estimate of pass-through spending does not incorporate any pass-through spending for categories made effective January 1, 2005.

With respect to CY 2005 pass-through spending for drugs and biologicals, as we explain in section V.A.3. of this final rule with comment period, the pass-through payment amount for new drugs and biologicals that we determine have pass-through status equals zero. Therefore, our estimate of total pass-through spending for drugs and biologicals with pass-through status in CY 2005 equals zero.

Table 36.--Estimates for CY 2005 Transitional Pass-Through Spending for Current Pass-Through Device Categories Continuing Into CY 2005

New HCPCS	APC	Existing Pass-Through Devices	CY 2005 Estimated Utilization	CY 2005 Anticipated Pass-through Payments
C1814	1814	Retinal tamponade device, silicone oil	33,865	$13,166,712
C1818	1818	Integrated keratoprosthesis device	5	$34,750
C1819	1819	Tissue localization excision device	10,979	$2,031,115

In accordance with the methodology described above, we estimate that total pass-through spending for devices in CY 2005 would equal approximately $23.4 million, which represents 0.10 percent of total OPPS projected payments for CY 2005. This figure includes estimates for the current device categories continuing into CY 2005, in addition to projections for categories that first become eligible during CY 2005. This estimate is significantly lower than previous year's estimates because of the method we discuss in section V.A.3. of this preamble for determining the amount of pass-through payment for drugs and biologicals with pass-through status in CY 2005.

Therefore, we will institute no pro rata reduction for CY 2005.

In section V.G. of this final rule with comment period, we indicate that we are accepting pass-through applications for new radiopharmaceuticals that are assigned a HCPCS code on or after January 1, 2005. The pass-through amount for new radiopharmaceuticals approved for pass-through status in CY 2005 would be the difference between the OPPS payment for the radiopharmaceutical, that is, the payment amount determined for the radiopharmaceutical as a sole source specified covered drug, and the payment amount for the radiopharmaceutical under section 1842(o) of the Act. However, we have no information identifying new radiopharmaceuticals to which a HCPCS code might be assigned after January 1, 2005 for which pass-through status would be sought. We also have no data regarding payment for new radiopharmaceuticals with pass-through status under the methodology that we specify in section V.G. However, we do not believe that pass-through spending for new radiopharmaceuticals in CY 2005 will be significant enough to materially affect our estimate of total pass-through spending in CY 2005. Therefore, we are not including radiopharmaceuticals in our estimate of pass-through spending in CY 2005.

Because we estimate pass-through spending in CY 2005 will amount to 0.10 percent of total projected OPPS CY 2005 spending, we are returning 1.90 percent of the pass-through pool to adjust the conversion factor, as we discuss in section VIII. of this preamble.

We received a few public comments on our estimate of CY 2005 pass-through spending for drugs, biologicals, and devices.

Comment: One commenter, a hospital organization, commended CMS for returning a portion of the pass-through pool that exceeds its estimate for pass-through payments for CY 2005, by increasing the conversion factor.

Response: We appreciate the commenter's support.

Comment: One commenter was concerned that CMS did not provide information on the extent to which amounts that are actually spent on pass-through payments and outlier payments compared to the amounts that are carved out of the total amount allowed OPPS payments for these projected payments. The commenter was concerned that the amounts carved out for these purposes may not actually be spent and thus would be lost to hospitals.

Response: We are required by law to estimate the amounts that we expect to spend on pass-through payments and outliers each year before the start of the calendar year. We share the commenter's interest in making those estimates as accurately as possible to ensure that hospitals receive the amount to which they are entitled. We make our final estimate for each calendar year to the best of our ability based on all of the most recently available data when we prepare our final rule, including comments we receive concerning those issues in response to the proposed rule. With respect to the availability of data, we have established limited data sets that include the set of claims we use for, first, the proposed rule and, ultimately, the final rule estimates. For example, the claims for CY 2003 used for the final rule for CY 2005 will be available to the public in a limited data set format. We will continue to assess the means by which we provide such information to determine if there are alternate ways to ensure that our stakeholders obtain the information that is important to them on a timely basis.

VII. Other Policy Decisions and Policy Changes

A. Statewide Average Default Cost-to-Charge Ratios

CMS uses cost-to-charge ratios (CCRs) to determine outlier payments, payments for pass-through devices, and monthly interim transitional corridor payments under the OPPS. Some hospitals do not have a valid CCR. These hospitals include, but are not limited to, hospitals that are new and have not yet submitted a cost report, hospitals that have a CCR that falls outside predetermined floor and ceiling thresholds for a valid CCR, or hospitals that have recently given up their all-inclusive rate status. When OPPS was first implemented in CY 2000, we used CY 1996 and CY 1997 cost reports to calculate default urban and rural CCRs for each State to use in determining the reasonable cost-based payments for those hospitals without a valid CCR (Program Memorandum A–00–63, CR 1310, issued on September 8, 2000). In the August 16, 2004 OPPS proposed rule, we proposed to update the default ratios for CY 2005.

As we proposed, in this final rule, we calculated the statewide default CCRs using the same CCRs that we use to adjust charges to costs on claims data. Table 31 lists the final CY 2005 default urban and rural CCRs by State. These CCRs are the ratio of total costs to total charges from each provider's most recently submitted cost report, for those cost centers relevant to outpatient services. We also adjusted these ratios to reflect final settled status by applying the differential between settled to submitted costs and charges from the most recent pair of settled to submitted cost reports.

The majority of submitted cost reports, 87 percent, were for CY 2002. We only used valid CCRs to calculate these default ratios. That is, we removed the CCRs for all-inclusive hospitals, CAHs, and hospitals in Guam and the U.S. Virgin Islands because these entities are not paid under the OPPS, or in the case of all-inclusive hospitals, because their CCRs are suspect. We further identified and removed any obvious error CCRs and trimmed any outliers. We limited the hospitals used in the calculation of the default CCRs to those hospitals that billed for services under the OPPS during CY 2003.

Finally, we calculated an overall average CCR, weighted by a measure of volume, for each State except Maryland. This measure of volume is the total lines on claims and is the same one that we use in our impact tables. Calculating a rate for Maryland presented a unique challenge. There are only a few providers in Maryland that are eligible to receive payment under the OPPS. However, we had no usable in-house cost report data for these Maryland hospitals, which is why we remove Maryland providers from our claims data for modeling OPPS. Therefore, we obtained data from the fiscal intermediary for Maryland, which we attempted to use in calculating the CCRs for Maryland, but which we ultimately determined could not be used to calculate representative CCRs. The cost data for three Maryland hospitals with very low volumes of services and cost data were so irregular that we lacked confidence that it would result in a valid statewide CCR. Thus, for Maryland, we used an overall weighted average CCR for all hospitals in the nation to calculate the weighted average CCRs appearing in Table 37. The overall decrease in default statewide CCRs can be attributed to the general decline in the ratio between costs and charges widely observed in the cost report data.

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Table 37.--Statewide Average Cost-to-Charge Ratios

State	Urban/Rural	Previous Default CCR	Default CCR
Alabama	RURAL	0.31552	0.26715
Alabama	URBAN	0.29860	0.24577
Alaska	RURAL	0.59388	0.61859
Alaska	URBAN	0.38555	0.42717
Arizona	RURAL	0.39748	0.32769
Arizona	URBAN	0.30922	0.26980
Arkansas	RURAL	0.35936	0.31754
Arkansas	URBAN	0.38278	0.30471
California	RURAL	0.40335	0.29314
California	URBAN	0.32427	0.24213
Colorado	RURAL	0.51041	0.43069
Colorado	URBAN	0.41863	0.32179
Connecticut	RURAL	0.42702	0.47250
Connecticut	URBAN	0.46592	0.44626
Delaware	RURAL	0.36289	0.36304
Delaware	URBAN	0.45061	0.45948
District of Columbia	URBAN	0.38690	0.37513
Florida	RURAL	0.31782	0.24304
Florida	URBAN	0.28363	0.22401
Georgia	RURAL	0.39829	0.33823
Georgia	URBAN	0.40262	0.32105
Hawaii	RURAL	0.44420	0.41027
Hawaii	URBAN	0.34815	0.34474
Idaho	RURAL	0.49682	0.46454
Idaho	URBAN	0.51942	0.49178
Illinois	RURAL	0.41825	0.34063
Illinois	URBAN	0.36825	0.29964
Indiana	RURAL	0.44596	0.36862
Indiana	URBAN	0.44205	0.37237
Iowa	RURAL	0.50166	0.41996
Iowa	URBAN	0.46963	0.38788
Kansas	RURAL	0.48065	0.38973
Kansas	URBAN	0.34698	0.29271

State	Urban/Rural	Previous Default CCR	Default CCR
Kentucky	RURAL	0.36987	0.31089
Kentucky	URBAN	0.37381	0.32476
Louisiana	RURAL	0.34317	0.29912
Louisiana	URBAN	0.34357	0.27736
Maine	RURAL	0.47857	0.38801
Maine	URBAN	0.54084	0.44897
Massachusetts	URBAN	0.44439	0.38812
Michigan	RURAL	0.44890	0.39418
Michigan	URBAN	0.41143	0.37428
Minnesota	RURAL	0.48514	0.47136
Minnesota	URBAN	0.45259	0.37416
Mississippi	RURAL	0.34264	0.30290
Mississippi	URBAN	0.37097	0.29322
Missouri	RURAL	0.42187	0.34160
Missouri	URBAN	0.38128	0.31081
Montana	RURAL	0.51173	0.47891
Montana	URBAN	0.49396	0.44817
Nebraska	RURAL	0.49386	0.42378
Nebraska	URBAN	0.42043	0.33875
Nevada	RURAL	0.42878	0.50623
Nevada	URBAN	0.22854	0.22333
New Hampshire	RURAL	0.50083	0.43585
New Hampshire	URBAN	0.39954	0.33224
New Jersey	URBAN	0.49024	0.34038
New Mexico	RURAL	0.44932	0.33899
New Mexico	URBAN	0.50857	0.43311
New York	RURAL	0.52062	0.43944
New York	URBAN	0.54625	0.42556
North Carolina	RURAL	0.37776	0.35416
North Carolina	URBAN	0.42726	0.38114
North Dakota	RURAL	0.52829	0.41175
North Dakota	URBAN	0.47341	0.36740
Ohio	RURAL	0.42562	0.41161
Ohio	URBAN	0.42718	0.32814
Oklahoma	RURAL	0.40628	0.32908
Oklahoma	URBAN	0.36264	0.29193
Oregon	RURAL	0.47915	0.42468
Oregon	URBAN	0.49958	0.43762
Pennsylvania	RURAL	0.40582	0.36015
Pennsylvania	URBAN	0.33807	0.28011
Puerto Rico	URBAN	0.42208	0.41376

State	Urban/Rural	Previous Default CCR	Default CCR
Rhode Island	URBAN	0.43930	0.35106
South Carolina	RURAL	0.35996	0.29377
South Carolina	URBAN	0.36961	0.29167
South Dakota	RURAL	0.49599	0.39218
South Dakota	URBAN	0.44259	0.33947
Tennessee	RURAL	0.36663	0.30294
Tennessee	URBAN	0.36464	0.28313
Texas	RURAL	0.41763	0.33642
Texas	URBAN	0.33611	0.30306
Utah	RURAL	0.49748	0.47097
Utah	URBAN	0.46733	0.45230
Vermont	RURAL	0.47278	0.46757
Vermont	URBAN	0.54533	0.44259
Virginia	RURAL	0.39408	0.33502
Virginia	URBAN	0.38604	0.32559
Washington	RURAL	0.54246	0.43429
Washington	URBAN	0.54658	0.41362
West Virginia	RURAL	0.42671	0.35073
West Virginia	URBAN	0.45616	0.40700
Wisconsin	RURAL	0.50126	0.42304
Wisconsin	URBAN	0.46268	0.38487
Wyoming	RURAL	0.54596	0.51581
Wyoming	URBAN	0.41265	0.41087

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Comment: Several commenters recommended that CMS instruct fiscal intermediaries to work with those facilities that have given up their all-inclusive rate status to quickly determine an appropriate CCR that will provide an accurate estimate of costs for each facility.

Response: We have already instructed intermediaries to update CCRs in a timely manner. In Program Memorandum A–03–004 dated January 17, 2003, we instructed fiscal intermediaries to recalculate each provider's CCR on an ongoing basis whenever a more recent full year cost report becomes available, which includes tentatively settled cost reports. Fiscal intermediaries will calculate a hospital-specific CCR for all-inclusive rate hospitals, as with all hospitals relying on default CCRs, when their first tentatively settled cost report becomes available after no longer being considered as all-inclusive rate hospitals.

Comment: A few commenters asserted that the decrease in CCRs between 1996 and 2002 was caused by the fact that charges were increasing faster than costs and that the increase in charges has been much lower since 2003. They requested that CMS take this fact into account in developing default CCRs.

Response: We did not inflate charges when calculating the default CCRs, and therefore, we do not believe that there is a need to adjust for charge inflation since CY 2002.

B. Transitional Corridor Payments: Technical Change

1. Provisions of the August 16, 2004 Proposed Rule

When the OPPS was implemented, every provider was eligible to receive an additional payment adjustment (or transitional corridor payment) if the payments it received under the OPPS were less than the payment it would have received for the same services under the prior reasonable cost-based system (section 1833(t)(7) of the Act). Transitional corridor payments were intended to be temporary payments for most providers but permanent payments for cancer and children's hospitals to ease their transition from the prior reasonable cost-based payment system to the prospective payment system. Section 411 of Pub. L. 108–173 amended section 1833(t)(7)(D)(i) of the Act to extend such payments through December 31, 2005, for rural hospitals with 100 or fewer beds and extended such payments for services furnished during the period that begins with the provider's first cost reporting period beginning on or after January 1, 2004 and ends on December 31, 2005, for sole community hospitals located in rural areas. Accordingly, transitional corridor payments are only available to children's hospitals, cancer hospitals, rural hospitals having 100 or fewer beds, and sole community hospitals located in rural areas.

At the time the OPPS was implemented, section 1833(t)(7)(F)(ii) of the Act defined the payment-to-cost ratio (PCR) used to calculate the ''pre-BBA amount'' [2] for purposes of calculating the transitional corridor

[2] Section 1833(t)(7) of the Act defined the ''pre-BBA'' amount for a period as the amount equal to the product of (1) the payment-to-cost ratio for the hospital based on its *cost reporting period ending in 1996,* and (2) the reasonable cost of the services for the period. (Emphasis added.) In this context, BBA refers to the Balanced Budget Act of 1997, Pub. L. 105–33, enacted on August 5, 1997.

payments to be determined using the payments and reasonable costs of services furnished during the provider's cost reporting period ending in calendar year 1996. The BIPA, Pub. L. 106–554, enacted on December 21, 2000, revised that requirement. Section 403 of BIPA amended section 1833(t)(7)(F)(ii)(I) of the Act to allow transitional corridor payments to hospitals subject to the OPPS that did not have a 1996 cost report by authorizing use of the first available cost reporting period ending after 1996 and before 2001 in calculating a provider's PCR.

Although we discussed the BIPA amendment in the CY 2002 OPPS proposed rule published on August 24, 2001 (66 FR 44674), and implemented the amendment through Program Memorandum No. A–01–51, issued on April 13, 2001, we failed to revise the regulations at § 419.70(f)(2) to reflect the change. In the August 16, 2004 OPPS proposed rule, we proposed a technical correction to § 419.70(f)(2) to conform it to the provision of section 1833(t)(7)(F)(ii)(I) of the Act.

We did not receive any comments on this proposed technical change. Accordingly, in this final rule with comment period, we are adopting as final without modification our proposal and correcting § 419.70(f)(2) to conform it to the provision of section 1833(t)(7)(F)(ii)(I) of the Act.

However, we did receive several comments on the proposed rule related to the transitional corridor payments.

Comment: A few commenters expressed appreciation for the extension of transitional corridor payments for children's hospitals, cancer hospitals, rural hospitals having 100 or fewer beds, and sole community hospitals located in rural areas, but requested that CMS consider extending payment protections to rural hospitals that are not eligible for transitional corridor payments. The commenters noted that rural hospitals that have converted to critical access hospitals are paid at cost and, therefore, have a competitive advantage over rural hospitals that are not eligible for transitional corridor payments and cannot convert to critical access hospital status. One commenter requested protection for rural hospitals that provide emergency services.

A few commenters noted that the transitional corridor payment provision for rural hospitals having 100 or fewer beds and sole community hospitals located in rural areas expires on December 31, 2005, and requested that CMS further extend this payment protection.

Response: We share the concerns of rural hospitals and do not intend to limit access to health care to beneficiaries in rural areas. However, we note that the statute is very specific and does not provide transitional corridor payments for entities other than those listed in the statute, nor extend transitional corridor payments past December 31, 2005, for rural or sole community hospitals.

2. Comments on the Provisions of the January 6, 2004 Interim Final Rule With Comment Period

As discussed in the January 6, 2004 interim final rule with comment period (69 FR 828), section 411(a)(1)(B) of Pub. L. 108–173 provided that hold harmless transitional corridor provisions shall apply to sole community hospitals located in rural areas. Section 411(a)(2) states that the effective date for section 411(a)(1)(B) ''shall apply with respect to cost reporting periods beginning on or after January 1, 2004'' for sole community hospitals located in rural areas. The Conference Agreement for Pub. L. 108–173 states, ''The hold harmless provisions are extended to sole community hospitals located in a rural area starting for services furnished on or after January 1, 2004 * * *''

Comment: Commenters noted that there appears to be a discrepancy between the effective date in section 411 of Pub. L. 108–173 and the Conference Agreement. The commenters noted that, in accordance with section 411, a sole community hospital with a cost reporting period beginning on a date other than January 1 will not receive transitional corridor payments and ''interim'' transitional corridor payments for services furnished after December 31, 2003, and before the beginning of the provider's next cost reporting period.

Response: Section 411(a)(2) of Pub. L. 108–173 provides the effective date with respect to the transitional corridor payments applied to sole community hospitals. Specifically, a sole community hospital with a cost reporting period beginning on or after April 1, 2004, is subject to the hold harmless provisions. We note that if a hospital qualifies as both a rural hospital having 100 or fewer beds and as a sole community hospital located in a rural area, for purposes of receiving transitional corridor payments and interim transitional corridor payments, the hospital will be treated as a rural hospital having 100 or fewer beds. In this case, transitional corridor payments would begin on January 1, 2004, and there would be no gap in transitional corridor payments.

C. Status Indicators and Comment Indicators Assigned in the Outpatient Code Editor (OCE)

1. Payment Status Indicators

The payment status indicators (SIs) that we assign to HCPCS codes and APCs under the OPPS play an important role in determining payment for services under the OPPS because they indicate whether a service represented by a HCPCS code is payable under the OPPS or another payment system and also whether particular OPPS policies apply to the code. As we proposed, for CY 2005, we are providing our status indicator assignments for APCs in Addendum A, for the HCPCS codes in Addendum B, and the definitions of the status indicators in Addendum D1 to this final rule with comment period.

Payment under the OPPS is based on HCPCS codes for medical and other health services. These codes are used for a wide variety of payment systems under Medicare, including, but not limited to, the Medicare fee schedule for physician services, the Medicare fee schedule for durable medical equipment and prosthetic devices, and the Medicare clinical laboratory fee schedule. For purposes of making payment under the OPPS, we must be able to signal the claims processing system through the Outpatient Code Editor (OCE) software, as to HCPCS codes that are paid under the OPPS and those codes to which particular OPPS payment policies apply. We accomplish this identification in the OPPS through the establishment of a system of status indicators with specific meanings. Addendum D1 contains the definitions of each status indicator for purposes of the OPPS for CY 2005.

We assign one and only one status indicator to each APC and to each HCPCS code. Each HCPCS code that is assigned to an APC has the same status indicator as the APC to which it is assigned.

In the August 16, 2004 OPPS proposed rule, for CY 2005, we proposed to use the following status indicators in the specified manner:

- ''A'' to indicate services that are paid under some payment method other than OPPS, such as under the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule or the Medicare Physician Fee Schedule. Some, but not all, of these other payment systems are identified in Addendum D1 to this final rule with comment period.
- ''B'' to indicate the services that are not payable under the OPPS when submitted on an outpatient hospital Part B bill type, but that may be payable by

fiscal intermediaries to other provider types when submitted on an appropriate bill type.

- ''C'' to indicate inpatient services that are not payable under the OPPS.
- ''D'' to indicate a code that is discontinued, effective January 1, 2005.
- ''E'' to indicate items or services that are not covered by Medicare or codes that are not recognized by Medicare.
- ''F'' to indicate acquisition of corneal tissue, which is paid on a reasonable cost basis and certain CRNA services that are paid on a reasonable cost basis.
- ''G'' to indicate drugs, biologicals, and radiopharmaceutical agents that are paid under the OPPS transitional pass-through rules.
- ''H'' to indicate devices that are paid under the OPPS transitional pass-through rules and brachytherapy sources that are paid on a cost basis.
- ''K'' to indicate drugs, biologicals (including blood and blood products), and radiopharmaceutical agents that are paid in separate APCs under the OPPS, but that are not paid under the OPPS transitional pass-through rules.
- ''L'' to indicate flu and pneumococcal immunizations that are paid at reasonable cost but to which no coinsurance or copayment apply.
- ''N'' to indicate services that are paid under the OPPS, but for which payment is packaged into another service or APC group.
- ''P'' to indicate services that are paid under the OPPS, but only in partial hospitalization programs.
- ''S'' to indicate significant procedures that are paid under the OPPS, but to which the multiple procedure reduction does not apply.
- ''T'' to indicate significant services that are paid under the OPPS and to which the multiple procedure payment discount under the OPPS applies.
- ''V'' to indicate medical visits (including emergency department or clinic visits) that are paid under the OPPS.
- ''X'' to indicate ancillary services that are paid under the OPPS.
- ''Y'' to indicate nonimplantable durable medical equipment that must be billed directly to the durable medical equipment regional carrier rather than to the fiscal intermediary.

We proposed the payment status indicators identified above for each HCPCS code and each APC in Addenda A and B and requested comments on the appropriateness of the indicators we have assigned.

We received several public comments on our proposal relating to status indicators.

Comment: Two commenters, representing radionuclide, radiopharmaceutical, and nuclear medicine interests, expressed concern about assignment of status indicator ''N'' in Transmittal 290, issued August 27, 2004, to the new revenue codes for diagnostic and therapeutic radiopharmaceuticals, revenue codes 0343 and 0344, that were effective October 1, 2004. The commenters recommended changing the status indicators for both 0343 and 0344 to ''K'' for nonpass-through drugs, biologicals, and radiopharmaceutical agents, and asked that CMS clarify and notify hospitals to use these revenue codes when billing and reporting costs for radiopharmaceuticals that can be paid separately. The commenters also stated that clarifying that these are nonpass-through and not packaged will assist CMS in tracking and analyzing costs for the radiopharmaceuticals and contribute to more accurate payment determinations. They recommended that CMS require hospitals to use the new revenue codes to report charges for radiopharmaceuticals.

Response: The assignment of status indicator ''N'' to revenue codes 0343 and 0344 in Transmittal 290 relates to OCE treatment of lines on a claim that report a charge with a revenue code but with no HCPCS code. The assignment of certain status indicators to revenue codes reported in the attachment to quarterly OPPS updates entitled ''Summary of Data Modifications'' is an OCE specification only, and should not be confused with how we use the status indicators listed in Addendum D1 that we assign to HCPCS codes and to APCs.

Additional information related to how revenue codes are used can be found in Pub. 100–04, Medicare Claims Processing, Chapter 4, Section 20, Subsection 5.1.1, entitled ''Packaged Revenue Codes.'' As indicated in that section, certain revenue codes when reported on an OPPS bill *without* a HCPCS code, including revenue codes 0343 and 0344, are considered packaged services that are to be factored into the transitional outpatient payment and outlier calculations.

Although we strongly encourage hospitals to report charges and HCPCS codes for diagnostic and therapeutic radiopharmaceuticals using revenue codes 0343 and 0344, respectively, we generally try to not to impose requirements on the assignment of HCPCS codes to revenue codes for OPPS services because the way hospitals assign costs varies so widely. Nevertheless, we agree with the commenters that, to the extent hospitals report charges for radiopharmaceuticals, both packaged and separately payable, using the new revenue codes 0343 and 0344, our cost data related to radiopharmaceuticals should be more precise.

We will review our manual instructions and previous issuances related to the reporting of revenue codes and make any revisions needed to clarify and update those instructions.

Comment: One commenter asked that CMS change the status indicator for code 90780 and 90781 to ''X'' from ''T'' and thereby cease the application of the multiple procedure reduction to these services, which will be billed for administration of infusion therapy in place of Q0081 for CY 2005. The commenter indicated that there is no situation in which the time and resources involved in infusion care should be reduced in the case of an observation patient.

Response: We disagree. The costs of space, utilities and staff attendance are duplicated when the beneficiary is receiving another service at the same time as infusion therapy, in particular when the patient is in observation. Hence, a multiple procedure reduction to infusion therapy is appropriate, particularly when the patient is in observation status. However, we are noting how the multiple procedure discounting logic in the OCE functions. Line items with a service indicator of ''T'' are subject to multiple procedure discounting unless modifiers 76, 77, 78, or 79, or all, are present. The ''T'' line item with the highest payment amount will not be multiple procedure discounted, and all other ''T'' line items will be multiple procedure discounted. All line items that do not have a service indicator of ''T'' will be ignored in determining the discount. Therefore, if the only other services reported with infusion therapy are an emergency department or other visit code, or diagnostic tests and services assigned status indicator ''S,'' the infusion therapy code would not be subject to the multiple procedure discounting.

2. Comment Indicators

In the November 1, 2002 and the November 7, 2003 final rules with comment period, which implemented changes in the OPPS for CYs 2003 and 2004, respectively, we provided code condition indicators in Addendum B. The code condition indicators and their meaning are as follows:

- ''DG''—Deleted code with a grace period; Payment will be made under the deleted code during the 90-day grace period.

• ''DNG''—Deleted code with no grace period; Payment will not be made under the deleted code.

• ''NF''—New code final APC assignment; Comments were accepted on a proposed APC assignment in the Proposed Rule; APC assignment is no longer open to comment.

• ''NI''—New code interim APC assignment; Comments will be accepted on the interim APC assignment for the new code.

Medicare had permitted a 90-day grace period after implementation of an updated medical code set, such as the HCPCS, to give providers time to incorporate new codes in their coding and billing systems and to remove the discontinued codes. HCPCS codes are updated annually every January 1, so the grace period for billing discontinued HCPCS was implemented every January 1 through March 31.

The Health Insurance Portability and Accountability Act (HIPAA) transaction and code set rules require usage of the medical code set that is valid at the time that the service is provided. Therefore, effective January 1, 2005, CMS is eliminating the 90-day grace period for billing discontinued HCPCS codes. Details about elimination of the 90-day grace period for billing discontinued HCPCS codes were issued to our contractors on February 6, 2004, in Transmittal 89, Change Request 3093.

In order to be consistent with the HIPPA rule that results in the elimination of the 90-day grace period for billing discontinued HCPCS codes, in the August 16, 2004 OPPS proposed rule, we proposed, effective January 1, 2005, to delete code condition indicators ''DNG'' and ''DG''. We proposed to designate codes that are discontinued effective January 1, 2005 with status indicator ''D,'' as described in section VII.C.1. of this preamble.

Further, we proposed to rename ''code condition'' indicators as ''comment indicators.'' In Addendum D2 to this final rule with comment period, we list the following two comment indicators that we had proposed to use to identify HCPCS codes assigned to APCs that are or are not subject to comment:

• ''NF''—New code, final APC assignment; Comments were accepted on a proposed APC assignment in the Proposed Rule; APC assignment is no longer open to comment.

• ''NI''—New code, interim APC assignment; Comments will be accepted on the interim APC assignment for the new code.

We did not receive any public comments on our proposal relating to comment indicators. We are implementing the comment indicators and discontinuing the use of code condition indicators as we proposed, without modification.

D. Observation Services

Frequently, beneficiaries are placed in ''observation status'' in order to receive treatment or to be monitored before making a decision concerning their next placement (that is, admit to the hospital or discharge). This status assignment occurs most frequently after surgery or a visit to the emergency department. For a detailed discussion of the clinical and payment history of observation services, see the November 1, 2002 final rule with comment period (67 FR 66794).

Before the implementation of the OPPS in CY 2000, payment for observation care was made on a reasonable cost basis, which gave hospitals a financial incentive to keep beneficiaries in ''observation status'' even though clinically they were being treated as inpatients. With the initiation of the OPPS, observation services were no longer paid separately; that is, they were not assigned to a separate APC. Instead, costs for observation services were packaged into payments for the services with which the observation care was associated.

Beginning in early 2001, the APC Panel began discussing the topic of separate payment for observation services. In its deliberations, the APC Panel asserted that observation services following clinical and emergency room visits should be paid separately, and that observation following surgery should be packaged into the payment for the surgical procedure. For CY 2002, we implemented separate payment for observation services (APC 0339) under the OPPS for three medical conditions: chest pain, congestive heart failure, and asthma. A number of accompanying requirements were established, including the billing of an evaluation and management visit in conjunction with the presence of certain specified diagnosis codes on the claim, hourly billing of observation care for a minimum of 8 hours up to a maximum of 48 hours, timing of observation beginning with the clock time on the nurse's admission note and ending at the clock time on the physician's discharge orders, a medical record documenting that the beneficiary was under the care of a physician who specifically assessed patient risk to determine that the beneficiary would benefit from observation care, and provision of specific diagnostic tests to beneficiaries based on their diagnoses. In developing this policy for separately payable observation services, we balanced issues of access, medical necessity, potential for abuse, and the need to ensure appropriate payment. We selected the three medical conditions, noted previously, and the accompanying diagnosis codes and diagnostic tests to avoid significant morbidity and mortality from inappropriate discharge while, at the same time, avoiding unnecessary inpatient admissions.

Over the past 2 years, we have continued to review observation care claims data for information on utilization and costs, along with additional information provided to us by physicians and hospitals concerning our current policies regarding separately payable observation services. Our primary goal is to ensure that Medicare beneficiaries have access to medically necessary observation care. We also want to ensure that separate payment is made only for beneficiaries actually receiving clinically appropriate observation care.

In January 2003, the APC Panel established an Observation Subcommittee. Over the last year, this subcommittee has held discussions concerning observation care and reviewed data extracted from claims that reported observation services. The subcommittee presented the results of its deliberations to the full APC Panel at the February 2004 meeting. The APC Panel recommendations regarding observation care provided under the OPPS were broad in scope and included elimination of the diagnosis requirement for separate payment for observation services, elimination of the requirement for the concomitant diagnostic tests for patients receiving observation care, unpackaging of observation services beyond the typical expected recovery time from surgical and interventional procedures, and modification of the method for measuring beneficiaries' time in observation to make it more compatible with routine hospital practices and their associated electronic systems.

In response to the APC Panel recommendations, we undertook a number of studies regarding observation services, while acknowledging data limitations from the brief 2-year experience the OPPS has had with separately payable observation services.

To assess the appropriateness of the APC Panel's recommendation not to pay separately for observation services following surgical or interventional procedures, we analyzed the claims for these procedures to determine the extent to which the claims reported packaged observation services codes. This analysis revealed that while

observation services are being reported on some claims for surgical and interventional procedures, the great majority of claims for these procedures reported no observation services. The packaged status of these observation services codes may result in underreporting their frequency, but the proportion of surgical and interventional procedures reported with the packaged observation services codes was so small that any increase would not change our substantive conclusion. This confirmed our belief that, although an occasional surgical case may require a longer recovery period than expected for the procedure, as a rule, surgical outpatients do not require observation care. Given the rapidly changing nature of outpatient surgical and interventional services, it would be difficult to determine an expected typical recovery time for each procedure. We have concerns about overutilization of observation services in the post-procedural setting as partial replacement for recovery room time. However, we noted that, to the extent observation care or extended recovery services are provided to surgical or interventional patients, the cost of that care is packaged into the payment for the procedural APC which may result in higher median costs for those procedures.

We also analyzed the possibility of expanding the list of medical conditions for separately payable visit-related observation services, altering the requirements for diagnostic tests while in observation, and modifying the rules for counting time in observation care.

We looked at CY 2003 OPPS claims data for all packaged visit-related observation care for all medical conditions in order to determine whether or not there were other diagnoses that would be candidates for separately payable observation services. Our analysis confirmed that the three diagnoses that are currently eligible for separate payment for observation services are appropriate, as those diagnoses are frequently reported in our visit-related claims with packaged observation services. In fact, diagnoses related to chest pain were, by far, the diagnosis most frequently reported for observation care, either separately payable or packaged. Other diagnoses that appeared in the claims data with packaged observation services included syncope and collapse, transient cerebral ischemia, and hypovolemia.

The packaged status of those observation stays means that the data are often incomplete and the frequency of services may be underreported. Generally, information about packaged services is not as reliably reported as is that for separately paid services. However, we are not convinced that, for those other conditions (such as hypovolemia, syncope and collapse, among others), there is a well-defined set of hospital services that are distinct from the services provided during a clinic or emergency room visit. Separately payable observation care must include specific, clinically appropriate services, and we are still accumulating data and experience for the three medical conditions for which we are currently making separate payment. Therefore, we believed it was premature to expand the conditions for which we would separately pay for visit-related observation services.

Hospitals have indicated that, even in the cases where the diagnostic tests have been performed, to assure that billing requirements for separately payable observation services under APC 0339 are met, they must manually review the medical records to prepare the claims. If they do not conduct this manual review, they may not be coding appropriately for separately payable observation services.

As noted in our August 16, 2004 proposed rule, we have also received comments from the community and the APC Panel asserting that the requirements for diagnostic testing are overly prescriptive and administratively burdensome, and that hospitals may perform tests to comply with the CMS requirements, rather than based on clinical need. For example, a patient admitted directly to observation care with a diagnosis of chest pain may have had an electrocardiogram in a physician's office just prior to admission to observation and may only need one additional electrocardiogram while receiving observation care. Thus, two more electrocardiograms performed in the hospital as required under the current OPPS observation policy might not be medically necessary.

We continue to believe that the diagnostic testing criteria we established for the three medical conditions are the minimally appropriate tests for patients receiving a well-defined set of hospital observation services for those conditions. The previous example, notwithstanding, we also continue to believe that the majority of these tests would be performed in the hospital outpatient setting. We define observation care as an active treatment to determine if a patient's condition is going to require that he or she be admitted as an inpatient or if the condition resolves itself and the patient is discharged. The currently required diagnostic tests reflect that an active assessment of the patient was being undertaken, and we believe they are generally medically necessary to determine whether a beneficiary will benefit from being admitted to observation care and aid in determining the appropriate disposition of the patient following observation care.

After careful consideration, we agree that specifying which diagnostic tests must be performed as a prerequisite for payment of APC 0339 may be imposing an unreasonable reporting burden on hospitals and may, in some cases, result in unnecessary tests being performed. Therefore, in the August 16, 2004 proposed rule, we proposed, beginning in CY 2005, to remove the current requirements for specific diagnostic testing, and to rely on clinical judgment in combination with internal and external quality review processes to ensure that appropriate diagnostic testing (which we expect would include some of the currently required diagnostic tests) is provided for patients receiving high quality, medically necessary observation care.

Accordingly, we proposed that, beginning in CY 2005, the following tests would no longer be required to receive payment for APC 0339 (Observation):

- For congestive heart failure, a chest x-ray (71010, 71020, 71030), and electrocardiogram (93005) and pulse oximetry (94760, 94761, 94762)
- For asthma, a breathing capacity test (94010) or pulse oximetry (94760, 94761, 94762)
- For chest pain, two sets of cardiac enzyme tests; either two CPK (82550, 82552, 82553) or two troponins (84484, 84512) and two sequential electrocardiograms (93005)

We believe that this proposed policy change would benefit hospitals because it would reduce administrative burden, allow more flexibility in management of beneficiaries in observation care, provide payment for clinically appropriate care, and remove a requirement that may have resulted in duplicative diagnostic testing.

We received numerous public comments supporting our proposed policy. We did not receive any comments that opposed the proposed policy. Therefore, we are adopting, without modification, our proposal to no longer require specified diagnostic tests to receive payment for APC 0339, beginning in CY 2005.

Hospitals and the APC Panel further suggested that we modify the method for accounting for the beneficiary's time in observation care. Currently, hospitals report the time in observation beginning with the admission of the beneficiary to

observation and ending with the physician's order to discharge the patient from observation. There are two problems related to using the time of the physician discharge order to determine the ending time of observation care. First, providers assert that it is not possible to electronically capture the time of the physician's orders for discharge. As a result, manual medical record review is required in order to bill accurately. Second, the hospital may continue to provide specific discharge-related observation care for a short time after the discharge orders are written and, therefore, may not be allowed to account for the full length of the observation care episode. In an effort to reduce hospitals' administrative burden related to accurate billing, in the proposed rule, we proposed to modify our instructions for counting time in observation care to end at the time the outpatient is actually discharged from the hospital or admitted as an inpatient. Our expectation was that specific, medically necessary observation services were being provided to the patient up until the time of discharge. However, we did not expect reported observation time to include the time patients remain in the observation area after treatment is finished for reasons that include waiting for transportation home.

Although beneficiaries may be in observation care up to 48 hours or longer, we believed that, in general, 24 hours was adequate for the clinical staff to determine what further care the patient needs. In CY 2005, we proposed to continue to make separate payment for observation care based on claims meeting the requirement for payment of HCPCS code G0244 (Observation care provided by a facility to a patient with CHF, chest pain, or asthma, minimum 8 hours, maximum 48 hours). However, we proposed not to include claims reporting more than 48 hours of observation care in calculating the final payment rate for APC 0339.

We received several public comments on our proposal.

Comment: A number of commenters urged that CMS include claims for stays greater than 48 hours in the data used to calculate the payment rate for observation because any such claims in our dataset would have withstood local fiscal intermediary scrutiny for reasonableness and medical necessity and should therefore be regarded as legitimate for pricing calculations. One commenter requested that CMS provide clarification to fiscal intermediaries regarding billing for stays that exceed 48 hours because code G0244 (Observation care provided by a facility to a patient with CHF, chest pain or asthma, minimum 8 hours, maximum 48 hours) would seem to preclude billing G0244 for stays that exceed 48 hours but that otherwise meet all the criteria for payment.

Response: In an effort to clarify the apparent confusion cited by commenters with regard to billing for stays that exceed 48 hours, beginning in CY 2005, we are changing the descriptor for HCPCS code G0244 to read as follows:

G0244, Observation care provided by a facility to a patient with CHF, chest pain or asthma, minimum 8 hours.

We expect that hospitals will report one unit of G0244 for each hour of observation care provided to patients for congestive heart failure, chest pain, or asthma, with a minimum 8 units billed to be eligible for separate observation payment.

We carefully considered the comments that urged us to include reporting more than 48 hours to calculate the median cost of G0244. The final payment rate for APC 0339 listed in Addendum A is based on all CY 2003 claims for G0244 taken from the National Claims History file, without regard to units of service. Prior to implementation of the OPPS, when hospital outpatient services were paid on a reasonable cost basis, Medicare did allow payment for observation services that exceeded 48 hours when medical review determined that a more extended period of observation care was reasonable and necessary. Since implementation of the OPPS, Medicare has ceased paying separately for observation care, with the exception of services reported with G0244, because payment for observation services was packaged into payment for services with which observation services were reported. We believe that, in the overwhelming majority of cases, decisions can be and are routinely made in less than 48 hours whether to release a beneficiary from the hospital following resolution of the reason for the outpatient visit or whether to admit the beneficiary as an inpatient. Therefore, we intend to revisit this issue in future updates.

For the reasons stated above, we are not adopting as final for CY 2005, our proposal to exclude claims for G0244 that reported more than 48 hours of observation from calculation of the median cost for APC 0339.

We also proposed the following requirements to receive separate payment for HCPCS code G0244 in APC 0339 for medically necessary observation services involving specific goals and a plan of care that are distinct from the goals and plan of care for an emergency department, physician office, or clinic visit:

- The beneficiary must have one of three medical conditions: congestive heart failure, chest pain, or asthma. The hospital bill must report as the admitting or principal diagnosis an appropriate ICD–9–CM code to reflect the condition. The eligible ICD–9–CM diagnosis codes for CY 2005 are shown in Table 38 below.
- The hospital must provide and report on the bill an emergency department visit (APC 0610, 0611, or 0612), clinic visit (APC 0600, 0601, or 0602), or critical care (APC 0620) on the same day or the day before the separately payable observation care (G0244) is provided. For direct admissions to observation, in lieu of an emergency department visit, clinic visit, or critical care, G0263 (Adm with CHF, CP, asthma) must be billed on the same day as G0244.
- HCPCS code G0244 must be billed for a minimum of 8 hours.
- No procedures with a 'T' status indicator, except the code for infusion therapy of other than a chemotherapy drug (CPT code 90780) can be reported on the same day or day before observation care is provided.
- Observation time must be documented in the medical record and begins with the beneficiary's admission to an observation bed and ends when he or she is discharged from the hospital.
- The beneficiary must be in the care of a physician during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.
- The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.

We received numerous public comments on our proposal.

Comment: Most commenters applauded our proposal to eliminate the requirement that specified diagnostic tests be reported in order to receive payment for HCPCS code G0244. However, many commenters expressed disappointment that CMS did not propose to expand the conditions for which separate payment would be provided for observation care. One commenter, representing cancer centers, requested that CMS study febrile neutropenia, chemotherapy hypersensitivity reaction, hypovolemia, and electrolyte imbalance as conditions that would warrant separate payment for observation. A few commenters

supported the APC Panel recommendation that we eliminate altogether the diagnosis coding requirement for APC 0339. One commenter stated that medical care included in hourly observation charges billed under revenue code 762 for syncope and collapse, transient cerebral ischemia, and hypovolemia is medically necessary and distinct from services rendered in the emergency department or a clinic, is similar to that furnished to patients with congestive heart failure, asthma, and chest pain, and should therefore be paid for separately.

Response: We appreciate the support expressed by numerous commenters for the changes in requirements that we proposed for CY 2005 in order for hospitals to receive separate payment for observation services. As we indicate below, we are making final most of the changes that we proposed, with some modifications based on comments that we received. Although we are not going to implement in the CY 2005 OPPS the recommendations made by commenters and the APC Panel to expand separate payment for observation to include conditions in addition to congestive heart failure, asthma, and chest pain, we will continue to analyze our data and study the impact of such a change for reconsideration in future updates of the OPPS.

Comment: Several commenters supported our proposal to change how we define ending time or ''discharge'' from observation care. However, those commenters also requested further clarification of what we mean by ''discharge.''

Response: We carefully considered the thoughtful comments related to our proposal to modify the current policy regarding the time that should be recorded to designate when observation care ends. Based on suggestions from commenters, we are elaborating upon our proposal to define as the end of observation, the time the outpatient is either discharged from the hospital or admitted as an inpatient. Specifically, we consider the time when a patient is ''discharged'' from observation status to be the clock time when all clinical or medical interventions have been completed, including any necessary followup care furnished by hospital staff and physicians that may take place after a physician has ordered that the patient be released or admitted as an inpatient. However, observation care does not include time spent by the patient in the hospital subsequent to the conclusion of therapeutic, clinical, or medical interventions, such as time spent waiting for transportation to go home.

Comment: A few commenters requested clarification of the starting time for observation. One commenter recommended that CMS make it clear that observation time begins with the patient's placement in the bed and initiation of observation care, regardless of whether the bed is in a holding area or is in an actual observation bed or unit, as long as appropriate observation care is being provided. Another commenter asked if CMS will allow providers to document observation start time on any applicable document in the medical record and not limit the start time documentation to the nurse's observation admission note.

Response: We have stated in past issuances and rules that observation time begins at the clock time appearing on the nurse's observation admission note, which coincides with the initiation of observation care or with the time of the patient's arrival in the observation unit (66 FR 59879, November 30, 2001; Transmittal A–02–026 issued on March 28, 2002; and Transmittal A–02–129 issued on January 3, 2003.) In the August 16, 2004 proposed rule, we stated that observation time must be documented in the medical record and begins with the beneficiary's admission to an observation bed (69 FR 50534). We agree with the commenter on the need for clarification, and we will reiterate in provider education materials developed for the CY 2005 OPPS update that observation time begins at the clock time documented in the patient's medical record, which coincides with the time the patient is placed in a bed for the purpose of initiating observation care in accordance with a physician's order.

Comment: One commenter, a hospital trade association, recommended that CMS reconsider requiring hospitals to report one of the ICD–9–CM diagnosis codes designated for payment of APC 0339 as the admitting or principal diagnosis on the hospital claim. The commenter was concerned that, if we restrict the position of the diagnosis code to the admitting or principal field, many claims that otherwise meet the criteria for separate payment of observation will not be payable because coding rules and the frequency by which Medicare beneficiaries with asthma, congestive heart failure or chest pains have other presenting signs, symptoms, and clinical conditions will result in inappropriate placement of the requisite diagnosis code. Therefore, the commenter recommended that CMS accept the required diagnosis code in any diagnosis code field.

Response: Our proposal to require hospitals to report one of the specified ICD–9–CM codes in the admitting or principal diagnosis field is a modification of policy that we implemented in the November 30, 2001 final rule (66 FR 59880). We disagree with the commenter that this requirement will result in many claims for APC 0339 not being paid. Rather, we believe that requiring hospitals to report the signs, symptoms, and conditions that are the reason for the patient's visit will enhance coding accuracy and ensure that we are paying appropriately for APC 0339 by limiting separate payment to those observation services furnished to monitor asthma, chest pain, or congestive heart failure. If we continued to accept the required ICD–9–CM diagnosis code as a secondary diagnosis, we would remain concerned that we may be making separate payment for observation for conditions other than asthma, congestive heart failure or chest pain because these conditions are reported in the secondary diagnosis field even though they are not the clinical reason that the patient is receiving observation services.

Because we want to give hospitals ample time to incorporate this requirement into their billing systems, we will not implement this requirement before April 1, 2005. However, we are making final in this final rule with comment period the requirement that, beginning April 1, 2005, hospitals must report a qualifying ICD–9 CM diagnosis code in Form Locator (FL) 76, Patient Reason for Visit, and/or FL 67, principal diagnosis, in order for the hospital to receive separate payment for APC 0339. If a qualifying ICD–9 diagnosis code(s) is reported in the secondary diagnosis field but is not reported in either the Patient Reason for Visit field (FL 76) or the principal diagnosis field (FL 67), separate payment for APC 0339 will not be allowed.

Comment: One commenter requested that CMS modify the requirement that there be documentation that the physician has explicitly assessed the beneficiary risk to determine that he would benefit from observation care.

Response: We expect that, prior to issuing an order to place a patient in observation status, it is standard procedure for the physician to assess the patient's condition to determine the clinically appropriate intervention that is most likely to result in maximum benefit for the patient given his or her condition at that time. To expect documentation of that assessment in the medical record of a patient for whom an order to receive observation care has been issued is not new, excessive, or

unduly burdensome, but rather is an essential part of the patient's medical record to support the medically reasonable and necessary nature of the services ordered and furnished.

Comment: One commenter requested that CMS allow observation care following surgery if recovery time is longer than expected.

Response: As stated in the proposed rule, this situation is precisely contrary to the purpose of the observation care benefit. We again note that recovery time has been factored into the payment for the surgery. Although there is variation among patients' recovery times, that variation is part of the averaging that is inherent in a prospective payment system. Those costs are not considered as part of the payment for observation care, which serves an entirely different purpose for beneficiaries in the outpatient setting.

Comment: One commenter recommended adding ICD–9–CM diagnosis code 427.31 (Atrial fibrillation) to the list of specified diagnosis codes that could be included on claims for separately payable observation services furnished to patients with congestive heart failure or chest pain, or both.

Response: While many patients may have chronic atrial fibrillation that is asymptomatic, we agree that some patients may present chest pain as a significant symptom associated with atrial fibrillation. Atrial fibrillation may also complicate acute myocardial infarction. Patients who are being evaluated and managed with observation care for chest pain in a hospital may be found to have symptomatic atrial fibrillation as the likely etiology of their chest discomfort following comprehensive assessment. However, we would generally expect that patients with chest pain and atrial fibrillation receiving observation services in the hospital would be receiving these services specifically for their chest pain and that one of the chest pain diagnoses already on our list of diagnosis codes would be present on the claim as the reason for the visit or the principal diagnosis. Similarly, with respect to atrial fibrillation and congestive heart failure, congestive heart failure is an independent predictor of atrial fibrillation. However, as with chest pain and atrial fibrillation, we would generally expect that patients with congestive heart failure and atrial fibrillation receiving observation services in the hospital to be receiving these services specifically for their congestive heart failure and that one of the congestive heart failure diagnoses already on our list of diagnosis codes would be present on the claim as the reason for the visit or the principal diagnosis.

Therefore, while we agree with the commenter's suggestion that code 427.31 could be viewed as a reasonable diagnosis code for chest pain for which separate payment for observation services might be made under the OPPS, we believe it is unnecessary and redundant to add it to the list for chest pain because any of the existing ICD–9–CM diagnosis codes listed in Table 32 for chest pain suffices for purposes of the OPPS observation payment policy. Likewise, we are not adding code 427.31 to the list of acceptable congestive heart failure diagnoses for which separate payment for observation services is made by the OPPS.

Comment: One commenter recommended that diagnostic heart catheterization procedures, CPT codes 93510 through 92529, performed within 24 hours of an observation stay not disqualify separate payment for the observation even though these codes are assigned status indicator ''T,'' because it is not uncommon for patients admitted through the emergency department to observation for chest pain to be followed up with a diagnostic heart catheterization within 24 hours.

Response: This scenario was discussed during the February 2004 APC Panel meeting, although it was not advanced as a formal recommendation. While we are not adopting the commenter's recommendation at this time, we are making final in this final rule with comment period several changes in the requirements for separate payment for observation care, for implementation in CY 2005. We believe further analysis of any impact of such a change, in addition to analysis of the other changes being implemented in CY 2005, is necessary. We note that by the APC Panel may wish to consider this in future meetings.

Comment: One commenter, representing a health system, suggested extensive billing and coding changes to further simplify claims submission for observation services. These suggestions included revision of the definition of HCPCS code G0263 and elimination of HCPCS code G0264 for direct admissions; replacing use of HCPCS code G0244 with a revenue code and CPT codes and letting the OCE determine if the criteria for payment of APC 0339 are met; clarification of billing for postanesthesia care unit (PACU) services; and use of revenue codes to distinguish between observation in a clinic and observation in an emergency department.

Response: We welcome the commenter's suggestions and will endeavor during the next year to evaluate their feasibility and impact of any such changes. However, we recognize that extensive systems changes would be required to implement many of these suggestions, but will consider them for possible implementation in future updates of the OPPS.

After carefully considering the public comments received related to our proposed requirements to receive separate payment for observation services in CY 2005, we are adopting our proposal as final without modification.

BILLING CODE 4120–01–P

Table 38.--CY 2005 Eligible Diagnosis Codes for Billing Observation Services

Required Diagnosis For:	Eligible ICD-9-CM Code	Code Descriptor
Chest Pain	411.0	Postmyocardial infarction syndrome
	411.1	Intermediate coronary syndrome
	411.81	Coronary occlusion without myocardial infarction
	411.89	Other acute ischemic heart disease
	413.0	Angina decubitus
	413.1	Prinzmetal angina
	413.9	Other and unspecified angina pectoris
	786.05	Shortness of breath
	786.50	Chest pain, unspecified
	786.51	Precordial pain
	786.52	Painful respiration
	786.59	Other chest pain
Asthma	493.01	Extrinsic asthma with status asthmaticus
	493.02	Extrinsic asthma with acute exacerbation
	493.11	Intrinsic asthma with status asthmaticus
	493.12	Intrinsic asthma with acute exacerbation
	493.21	Chronic obstructive asthma with status asthmaticus
	493.22	Chronic obstructive asthma with acute exacerbation
	493.91	Asthma, unspecified with status asthmaticus
	493.92	Asthma, unspecified with acute exacerbation
Heart Failure	391.8	Other acute rheumatic heart disease
	398.91	Rheumatic heart failure (congestive)
	402.01	Malignant hypertensive heart disease with congestive heart failure
	402.11	Benign hypertensive heart disease with congestive heart failure
	402.91	Unspecified hypertensive heart disease with congestive heart failure

Required Diagnosis For:	Eligible ICD-9-CM Code	Code Descriptor
	404.01	Malignant hypertensive heart and renal disease with congestive heart failure
	404.03	Malignant hypertensive heart and renal disease with congestive heart and renal failure
	404.11	Benign hypertensive heart and renal disease with congestive heart failure
	404.13	Benign hypertensive heart and renal disease with congestive heart and renal failure
	404.91	Unspecified hypertensive heart and renal disease with congestive heart failure
	404.93	Unspecified hypertensive heart and renal disease with congestive heart and renal failure
	428.0	Congestive heart failure
	428.1	Left heart failure
	428.20	Unspecified systolic heart failure
	428.21	Acute systolic heart failure
	428.22	Chronic systolic heart failure
	428.23	Acute on chronic systolic heart failure
	428.30	Unspecified diastolic heart failure
	428.31	Acute diastolic heart failure
	428.32	Chronic diastolic heart failure
	428.33	Acute on chronic diastolic heart failure
	428.40	Unspecified combined systolic and diastolic heart failure
	428.41	Acute combined systolic and diastolic heart failure
	428.42	Chronic combined systolic and diastolic heart failure
	428.43	Acute on chronic combined systolic and diastolic heart failure
	428.9	Heart failure, unspecified

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E. Procedures That Will Be Paid Only as Inpatient Procedures

Before implementation of the OPPS, Medicare paid reasonable costs for services provided in the outpatient department. The claims submitted were subject to medical review by the fiscal intermediaries to determine the appropriateness of providing certain services in the outpatient setting. We did not specify in regulations those services that were appropriate to provide only in the inpatient setting and that, therefore, should be payable only when provided in that setting.

Section 1833(t)(1)(B)(i) of the Act gives the Secretary broad authority to determine the services to be covered and paid for under the OPPS. In the April 7, 2000 final rule with comment period, we identified procedures that are typically provided only in an inpatient setting and, therefore, would not be paid by Medicare under the OPPS (65 FR 18455). These procedures comprise what is referred to as the ''inpatient list.'' The inpatient list specifies those services that are only paid when provided in an inpatient setting. These are services that require inpatient care because of the nature of the procedure, the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged, or the underlying physical condition of the patient. As we discussed in the April 7, 2000 final rule with comment period (65 FR 18455) and the November 30, 2001 final rule (66 FR 59856), we use the following criteria when reviewing procedures to determine whether or not they should be moved from the inpatient list and assigned to an APC group for payment under the OPPS:

- Most outpatient departments are equipped to provide the services to the Medicare population.
- The simplest procedure described by the code may be performed in most outpatient departments.
- The procedure is related to codes that we have already removed from the inpatient list.

In the November 1, 2002 final rule (67 FR 66792), we added the following criteria for use in reviewing procedures to determine whether they should be removed from the inpatient list and assigned to an APC group for payment under the OPPS:

- We have determined that the procedure is being performed in multiple hospitals on an outpatient basis; or

• We have determined that the procedure can be appropriately and safely performed in an ASC and is on the list of approved ASC procedures or proposed by us for addition to the ASC list.

In the November 7, 2003 final rule with comment period, we did not implement any changes in our payment policies for the OPPS inpatient list. However, we addressed issues and concerns raised by commenters in response to the August 12, 2003 proposed rule and further clarified payment policies related to the OPPS inpatient list.

At the February 2004 meeting, the APC Panel made the recommendation to remove the following four abscess drainage CPT codes from the inpatient list: 44901, 49021, 49041, and 49061. As discussed in the proposed rule, we agreed with the APC Panel's recommendation and we proposed to remove these four abscess codes from the inpatient list and to assign them to APC 0037 for OPPS payment in CY 2005.

The APC Panel also made a recommendation to either eliminate the inpatient list from the OPPS or to evaluate the current list of procedures for any other appropriate changes. As recommended by the APC Panel, we sought to identify additional procedure codes to propose for removal from the inpatient list, consistent with the criteria listed above. To assist us in identifying procedures that were being widely performed on an outpatient basis for clinical review, we looked for services on the inpatient list that were performed on Medicare beneficiaries in all sites of service other than the hospital inpatient setting approximately 60 percent or more of the time. We relied on CY2003 Medicare Part B Extract and Summary System (BESS) data for this information. We chose 60 percent as a threshold because, in general, we believe that a procedure should be specifically considered for removal from the inpatient list if there is evidence that it is being performed less than one half of the time in the hospital inpatient setting. For procedures where data demonstrate that they are being delivered to Medicare beneficiaries in a safe and appropriate manner on an outpatient basis in a variety of different hospitals, we believe that it is reasonable to consider the removal of these procedures from the inpatient list. After further clinical evaluation of codes that met our 60-percent threshold to ensure that these procedures met our other criteria for removal from the inpatient list and were truly appropriate for consideration, we proposed to place 20 procedures that are on the inpatient list for the CY 2004 OPPS into clinical APCs for payment under the OPPS for CY 2005. We proposed to assign all of these codes the status indicator ''T.'' Two additional services, CPT codes 00174 and 00928, were proposed to be removed and assigned a status indicator ''N'' because, under the OPPS, anesthesia codes are packaged into the procedures with which they are billed.

We proposed not to accept the APC Panel's recommendation to completely eliminate the inpatient list for CY 2005. We solicited comments, especially from professional societies and hospitals, on whether any procedures on the CY 2005 proposed inpatient list were appropriate for removal and whether any other such procedures should be separately paid under the OPPS. We also asked commenters who recommend that a procedure that is currently on the inpatient list be reclassified to an APC to include evidence (preferably from peer-reviewed medical literature) that the procedure is being performed on an outpatient basis in a safe and effective manner. We requested that commenters suggest an appropriate APC assignment for the procedure and furnish supporting data to assist us in determining, based on comments, if the procedure could be payable under the OPPS in CY 2005.

We received a number of public comments on our proposal to retain the inpatient list and to delete 22 procedure codes from the inpatient list and our solicitation of additional procedures currently on the inpatient list that should be reclassified to an APC, with supporting evidence.

Comment: One commenter recommended that CMS remove the following CPT codes for spinal procedures currently on the inpatient list: CPT codes 22554, 22585, 22840, 22842, 22845, 22846, 22855, 63043, 63044, 63075, and 63076. The commenter submitted several published articles related to the performance of these procedures in the hospital outpatient setting.

Response: After careful review of the list of procedures and the accompanying articles submitted by the commenter, we believe these procedures should remain on the inpatient list for CY 2005. All of the procedures recommended by the commenter for removal were performed more than 90 percent of the time in the hospital inpatient setting on Medicare beneficiaries according to our BESS data. There was no evidence submitted to demonstrate that the procedures were being provided safely and effectively to patients demographically similar to Medicare beneficiaries in multiple hospitals in the outpatient hospital setting. We are concerned that none of the published studies, with the exception of one, included patients in the general Medicare-eligible age range of 65 years or older. We do not believe that experience in providing these major spinal procedures to young and middle-aged adults in the outpatient setting can necessarily be generalized as safe and appropriate for typical Medicare beneficiaries.

Comment: One commenter requested that CPT code 58260 (Vaginal hysterectomy) be removed from the inpatient list. The commenter stated that surgeons at the hospital believed that performing this procedure in an outpatient setting has been a standard of practice for a long time.

Response: According to our BESS data, the procedure described by CPT 58260 was performed more than 90 percent of the time in the hospital inpatient setting on Medicare beneficiaries. There was no evidence submitted by the commenter to demonstrate that this procedure was being provided safely and effectively to patients demographically similar to Medicare beneficiaries in multiple hospitals in the outpatient hospital setting. Thus, we believe this procedure should remain on the inpatient list.

Comment: Several commenters, including a hospital association, recommended the elimination of the inpatient list, echoing the APC Panel's recommendation from February 2004. The commenters stated that, while it is appropriate to leave the decision of site of service to the physicians, hospitals are unable to receive payment for services on this list that are performed in the hospital outpatient setting. One commenter argued that the current policy penalizes beneficiaries because they must be admitted as inpatients to receive these procedures, rather than receiving these services in an outpatient setting and being allowed to return home.

Response: In the November 7, 2003 final rule (67 FR 66797), we specified the inpatient list to include services that are payable by Medicare only when provided in an inpatient setting. These are services that generally require inpatient care because of the nature of the procedure, the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged, or the underlying physical condition of the Medicare beneficiary. We also listed in the November 7, 2003 final rule (68 FR 63466) the criteria that we use to evaluate whether a procedure should be

removed from the inpatient list. We do not believe that all services can be safely and effectively delivered to Medicare beneficiaries in the outpatient setting. We are concerned that elimination of the inpatient list could result in unsafe or uncomfortable care for Medicare beneficiaries. Among the potential results are long observation stays after some procedures and imposition of OPPS copayments, which could differ significantly from a patient's inpatient cost-sharing responsibilities.

We believe that it is important for hospitals to educate physicians on Medicare services provided under the OPPS to avoid inadvertently providing services in an outpatient setting that are more appropriate to an inpatient setting.

Comment: A few commenters recommended that CMS consider developing an appeals process to address circumstances in which payment for a procedure provided on an outpatient basis is denied because it is on the inpatient list.

Response: We would like to emphasize that procedures on the inpatient list that are performed on a patient whose status is that of an outpatient are not payable under Medicare. CPT codes assigned a status indicator of ''C,'' such as those listed in Addendum E, are not payable under the OPPS, except under conditions described in the November 1, 2002 final rule (67 FR 66799).

Comment: A few commenters requested that CMS clarify the criteria and the sources of data used to determine whether a procedure is appropriate for removal from the list. Other commenters expressed concern with the 60-percent threshold criterion used to evaluate codes for removal from the inpatient list. One commenter recommended that CMS revise its criteria because major teaching hospital outpatient departments often are the first places to perform services that had previously been performed only in the inpatient setting. This commenter argued that there would most likely be a time gap between when these services could be performed safely in teaching hospital outpatient departments and their dissemination to most hospitals' outpatient departments. The commenter recommended that the determining factor regarding whether a procedure should be removed from the inpatient list should be whether the procedure can be performed safely in an outpatient department and not the number of outpatient departments in which the procedure is performed.

Response: We recognize that teaching hospitals may have more technologically advanced equipment, more experienced staff, and greater resources than nonteaching hospitals. These characteristics may lead teaching hospitals to be the first places to perform on an outpatient basis some procedures on the inpatient list. On the other hand, community, nonteaching hospitals have pioneered the movement of some procedures to the outpatient setting, in part because of their responsiveness to identified local needs or their development of specific pathways for care. We cannot expect that all hospitals will have the necessary staff experience, resources, equipment, and interest to move many procedures to the outpatient setting. For these reasons, we do not believe that procedures that have been demonstrated to be performed safely and effectively on an outpatient basis in any single hospital or small group of hospitals alone are routinely appropriate for removal from the inpatient list.

In addition, we want to clarify that the 60-percent threshold discussed in our proposed rule is not an established criterion that we use to determine whether a procedure is appropriate for removal from the inpatient list. The 60-percent threshold was used as an operational tool to identify from the entire inpatient list those procedures that we believe are currently already being performed in the outpatient setting a majority of the time based on our CY 2003 BESS data, so that these services could then undergo clinical review against the criteria for removal from the inpatient list. The BESS database aggregates all physician billing throughout the year for each service provided to Medicare beneficiaries and billed under the Medicare Physician Fee Schedule. Summary data include information regarding the site of service (hospital inpatient, hospital outpatient, physician's office, among others) and specialty of the physician performing the service. We emphasize that our review of the codes recommended by the commenters for removal from the list was not based on this threshold. Rather, our determination was based on the set of criteria described in the November 7, 2003 final rule (68 FR 63466).

We encourage hospitals and physicians to submit recommendations regarding procedures they believe meet our criteria for removal from the inpatient list at any time. We ask that evidence be submitted to demonstrate that the procedure is being performed on an outpatient basis in a safe and appropriate manner in a variety of different types of hospitals.

Comment: Numerous commenters supported the proposed removal of the 22 CPT codes from the inpatient list. In addition, a few commenters expressed support for retaining the list of inpatient procedures. One commenter stated that eliminating the list could create an increase in inappropriate observation stays by assigning observation status to patients whose status should have been inpatient.

Response: We appreciate the commenters' support.

In this final rule, we are finalizing our proposed retention of the inpatient list for the OPPS. We also are finalizing our proposal to remove 22 procedures from the CY 2004 list. Table 39 below lists the procedure codes that are being removed from the inpatient list and their APC assignments, effective January 1, 2005.

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Table 39.--Procedure Codes Removed From Inpatient List and APC Assignment, Effective January 1, 2005

HCPCS	Description	APC Assignment	SI
00174	Anesth, pharyngeal surgery	n/a	N
00928	Anesth, removal of testis	n/a	N
21356	Treat cheek bone fracture	0254	T
21557	Remove tumor, neck/chest	0022	T
22222	Revision of thorax spine	0208	T
24149	Radical resection of elbow	0050	T
31292	Nasal/sinus endoscopy, surg	0075	T
43510	Surgical opening of stomach	0141	T
45541	Correct rectal prolapse	0150	T
50020	Renal abscess, open drain	0162	T
50570	Kidney endoscopy	0160	T
50572	Kidney endoscopy	0160	T
50574	Kidney endoscopy & biopsy	0160	T
50575	Kidney endoscopy	0163	T
50576	Kidney endoscopy & treatment	0161	T
53085	Drainage of urinary leakage	0166	T
58770	Create new tubal opening	0195	T
50578	Renal endoscopy/radiotracer	0161	T
44901	Drain app abscess, precut	0037	T
49021	Drain abdominal abscess	0037	T
49041	Drain, percut, abdom abscess	0037	T
49061	Drain, percut, retroper absc	0037	T

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F. Hospital Coding for Evaluation and Management Services

1. Background

Currently, for claims processing purposes, we direct hospitals to use the CPT codes used by physicians to report clinic and emergency department visits on claims paid under the OPPS. However, as discussed in the proposed rule, we have received comments suggesting that the CPT codes are insufficient to describe the range and mix of services provided to patients in the clinic and emergency department setting because they are defined to reflect only the activities of physicians (for example, ongoing nursing care, and patient preparation for diagnostic tests). For both clinic and emergency department visits, there are currently five levels of care. To facilitate proper coding, we require each hospital to create an internal set of guidelines to determine what level of visit to report for each patient (April 7, 2000, final rule with comment period (65 FR 18434)).

We have continued our efforts to address the situation of proper coding of clinic and emergency department visits to ensure proper Medicare payments to hospitals. Commenters who responded to the August 24, 2001 OPPS proposed rule (66 FR 44672) recommended that we retain the existing evaluation and management coding system until facility-specific evaluation and management codes for emergency department and clinic visits, along with national coding guidelines, were established. Commenters also recommended that we convene a panel of experts to develop codes and guidelines that are simple to understand and to implement, and that are compliant with the HIPAA requirements. We agreed with these commenters, and in our November 1, 2002 OPPS final rule (67 FR 66792), we stated that we believed the most appropriate forum for development of new code definitions and guidelines would be an independent expert panel that could provide information and data to us. We believed that, in light of the expertise of organizations such as the AHA and the AHIMA, these organizations were particularly well equipped to do so and to provide ongoing education to providers.

The AHA and the AHIMA, on their own initiative, convened an independent expert panel comprised of members of the AHA and AHIMA, as well as representatives of the American College of Emergency Physicians, the Emergency Nurses Association, and the American Organization of Nurse Executives, to develop code descriptions and guidelines for hospital emergency department and clinic visits and to provide us with the information and data. In June 2003, we received the panel's input concerning a set of national coding guidelines for emergency and clinic visits.

As we noted in the proposed rule, we are still considering the panel's set of coding guidelines. Although we did not propose the panel's set of coding guidelines, we received several comments on the Panel's coding guidelines and are continuing to review these public comments. In the November 7, 2003 OPPS final rule with comment period (68 FR 63463), we also indicated that we would implement new evaluation and management codes only when we are also ready to implement guidelines for their use. As we have not yet proposed new evaluation and management codes, we again note that we will allow ample opportunity for public comment, systems changes, and provider education before implementing such new coding requirements.

2. Proposal for Evaluation and Management Guidelines

In the November 7, 2003 OPPS final rule with comment period (68 FR 63463), we discussed our primary concerns and direction for developing the proposed coding guidelines for emergency department and clinic visits and indicated our plans to make available for public comment the proposed coding guidelines that we are considering through the CMS OPPS Web site as soon as we have completed them.

We received a number of comments on our proposal.

Comment: Many commenters supported the development of evaluation and management codes and guidelines in the hospital outpatient setting and urged CMS to move forward as quickly as possible with reviewing the guidelines presented by the AHA and AHIMA Evaluation and Management Panel. Several commenters expressed concern that the current lack of uniformity impairs CMS' ability to gather consistent, meaningful data on services provided in the emergency department and hospital clinics. Commenters reminded CMS of its commitment to make the evaluation and management codes and guidelines available for public comment and to provide at least 6 to 12 months notice prior to implementation of the new evaluation and management codes and guidelines.

Response: As stated in the August 16, 2004 OPPS proposed rule, we intend to make available for public comment the proposed coding guidelines that we are considering through the CMS OPPS Web site as soon as we have completed them. As stated in the August 16, 2004 OPPS proposed rule, we will notify the public through our ''listserve'' when the proposed guidelines will become available. To subscribe to this listserve, individuals should access the following Web site: *http://www.cms.hhs.gov/medlearn/listserv.asp* and follow the directions to the OPPS listserve. When we post the proposed guidelines on the Web site, we will provide ample opportunity for the public to comment.

In addition, we will provide ample time to train clinicians and coders on the use of new codes and guidelines and for hospitals to modify their systems. We anticipate providing at least 6 to 12 months notice prior to implementation of the new evaluation and management codes and guidelines. We will continue working to develop and test the new codes even though we have not yet made plans for their implementation.

G. Brachytherapy Payment Issues Related to Pub. L. 108–173

1. Payment for Brachytherapy Sources (Section 621(b) of Pub. L. 108–173)

Sections 621(b)(1) and (b)(2) of Pub. L. 108–173 amended the Act by adding section 1833(t)(16)(C) and section 1833(t)(2)(H), respectively, to establish separate payment for devices of brachytherapy consisting of a seed or seeds (or radioactive source) based on a hospital's charges for the service, adjusted to cost. Charges for the brachytherapy devices may not be used in determining any outlier payments under the OPPS. In addition, consistent with our practice under the OPPS to exclude items paid at cost from budget neutrality consideration, these items must be excluded from budget neutrality as well. The period of payment under this provision is for brachytherapy sources furnished from January 1, 2004 through December 31, 2006.

In the OPPS interim final rule with comment period published on January 6, 2004 (69 FR 827), we implemented sections 621(b)(1) and 621(b)(2)(C) of Pub. L. 108–173. We stated that we will pay for the brachytherapy sources listed in Table 4 of the interim final rule with comment period (69 FR 828) on a cost basis, as required by the statute. The status indicator for brachytherapy sources was changed to ''H.'' The definition of status indicator ''H'' was for pass-through payment only for devices, but the brachytherapy sources affected by new sections 1833(t)(16)(C) and 1833(t)(2)(H) of the Act are not pass-through device categories. Therefore, we also changed, for CY 2004, the definition of payment status indicator ''H'' to include nonpass-through brachytherapy sources paid on a cost basis. This use of status indicator ''H'' was a pragmatic decision that allowed us to pay for brachytherapy sources in accordance with new section 1833(t)(16)(C) of the Act, effective January 1, 2004, without having to modify our claims processing systems. We stated in the January 6, 2004 interim final rule with comment period that we would revisit the use and definition of status indicator ''H'' for this purpose in the OPPS update for CY 2005. Therefore, in the August 16, 2004 proposed rule, we solicited further comments on this policy.

We received several public comments on our August 16, 2004 proposal and on the January 6, 2004 interim final rule with comment period.

Comment: One commenter, a hospital association, recommended that CMS establish a new status indicator for brachytherapy sources paid on a cost basis other than the status indicator ''H'', which is also used for device categories paid on a transitional pass-through basis. The commenter noted that, because brachytherapy sources are subject to coinsurance and devices paid on a pass-through basis are not, a separate status indicator is needed for consistency in the classification of status indicators.

Response: The commenter is correct that beneficiaries are not subject to copayment for the cost of device categories with pass-through payment, while beneficiaries are subject to copayment for other separately paid brachytherapy sources. However, our systems' logic incorporates this difference in copayment for pass-through device categories versus nonpass-through brachytherapy sources, even though the status indicator for each is ''H''. Therefore, we are not establishing a separate status indicator at this time. However, we will consider making a change if the need arises.

Comment: A number of commenters on the January 6, 2004 interim final rule with comment period urged us to continue to use, for CY 2005, the C-codes and descriptors that we published in that interim final rule with comment period (69 FR 828) for both prostate and nonprostate brachytherapy that we implemented for CY 2004. Several commenters also suggested that we add the phrase ''per source'' to each of the brachytherapy source descriptors to reinforce that each source equals one unit of payment.

Response: We agree and are retaining the current brachytherapy source C-codes and descriptors with which hospitals are familiar. We have been using these codes and descriptors since we unpackaged brachytherapy sources when the pass-through payment for

these sources ended on December 31, 2002, in addition to other C-codes that we established either for pass-through payment (for example, C2632) or nonpass-through payment (for example, C2633). We also note that, in the August 16, 2004 proposed rule, we proposed adding ''per source'' to each of the applicable brachytherapy descriptors, similar to the APC Panel's recommendation (and the commenter's suggestion) to do so for two new high-activity source categories, discussed below. We are adopting this clarification as final policy in this final rule with comment period and adding ''per source'' to the brachytherapy source descriptors that are paid on a per unit basis for each source.

2. HCPCS Codes and APC Assignments for Brachytherapy Sources

As we indicated in the January 6, 2004 interim final rule with comment period, we began payment for the brachytherapy source in HCPCS code C1717 (Brachytx source, HCR lr-192) based on the hospital's charge adjusted to cost beginning January 1, 2004. Prior to enactment of Pub. L. 108–173, these sources were paid as packaged services in APC 0313. As a result of the requirement under Pub. L. 108–173 to pay for C1717 separately, we adjusted the payment rate for APC 0313, Brachytherapy, to reflect the unpackaging of the brachytherapy source. We received no public comments on this methodology, and we are finalizing the payment methodology in this final rule with comment period.

Section 1833(t)(2)(H) of the Act, as added by section 621(b)(2)(C) of Pub. L. 108–173, mandated the creation of separate groups of covered OPD services that classify brachytherapy devices separately from other services or groups of services. The additional groups must be created in a manner that reflects the number, isotope, and radioactive intensity of the devices of brachytherapy furnished, including separate groups for Palladium-103 and Iodine-125 devices.

We invited the public to submit recommendations for new codes to describe brachytherapy sources in a manner that reflects the number, radioisotope, and radioactive intensity of the sources. We requested commenting parties to provide a detailed rationale to support recommended new codes. We stated that we would propose appropriate changes in codes for brachytherapy sources in the CY 2005 OPPS update.

At its meetings of February 18 through 20, 2004, the APC Panel heard from parties that recommended the addition of two new brachytherapy codes and HCPCS codes for high activity Iodine-125 and high activity Paladium-103. The APC Panel, in turn, recommended that CMS establish new HCPCS codes and new APCs, on a per source basis, for these two brachytherapy sources.

We considered this recommendation and agreed with the APC Panel. Therefore, in the August 16, 2004 proposed rule, we proposed to establish the following two new brachytherapy source codes for CY 2005:

- Cxxx1 Brachytherapy source, high activity, Iodine-125, per source.
- Cxxx2 Brachytherapy source, high activity, Paladium-103, per source.

In addition, we believe the APC Panel's recommendation to establish new HCPCS codes that would distinguish high activity Iodine-125 from high activity Paladium-103 on a per source basis should be implemented for other brachytherapy code descriptors, as well. Therefore, as stated previously, we proposed to include ''per source'' in the HCPCS code descriptors for all those brachytherapy source descriptors for which units of payment are not already delineated.

Further, a new linear source Paladium-103 came to our attention in CY 2003 by means of an application for a new device category for pass-through payment. While we declined to create a new category for pass-through payment, we believe that this source falls under the provisions of Pub. L. 108–173 for separate cost-based payment as a brachytherapy source. Accordingly, we proposed to add, for separate payment, the following code of linear source Paladium-103: Cxxx3 Brachytherapy linear source, Paladium-103, per 1 mm.

We received a number of public comments on our August 16, 2004 proposed rule and on the January 6, 2004 interim final rule with comment period, which deal with these issues.

Comment: In response to the January 6, 2004 interim final rule with comment period, several commenters recommended adding two new brachytherapy source codes and descriptors, to reflect the ranges in radioactive intensities that are frequently required in clinical practice for Iodine-125 and Palladium-103. The recommendations are for high activity payment codes for these two isotopes. The commenters recommended the following specific descriptors:

Cxxx1 Brachytherapy source, Low Dose Rate, High Activity Iodine-125, greater than 1.01 mCi (NIST), per source.

Cxxx2 Brachytherapy source, Low Dose Rate, High Activity Palladium-103, greater than 2.2 mCi (NIST), per source.

The commenters suggested that CMS include in the two proposed APCs and HCPCS codes an appropriate measurement of minimum radioactivity in mCi, based on calibrations establish by the National Institute of Standards and Technology (NIST).

In response to the August 16, 2004 OPPS proposed rule, one commenter agreed with our proposal to create two new brachytherapy codes for high activity Iodine-125 and Palladium-103 sources, but recommended that we change the proposed descriptors. The commenter again recommended that we add the mCi (NIST) descriptions for the high activity ranges to these new high activity Iodine-125 and Palladium-103 sources we proposed.

Response: During its meetings of February 18 through 20, 2004, the APC Panel recommended that CMS establish two new HCPCS codes and APCs for High Activity Iodine-125 and High Activity Palladium-103 on a per source basis, but did not recommend adoption of other specific language regarding mCi in the descriptions above. As previously mentioned, in the August 16, 2004 proposed rule, we noted the APC Panel's recommendation to establish two new HCPCS codes and APCs for these high activity sources, as noted above.

We agree that, with the establishment of these new codes, which are the first to specify high activity, we should provide an appropriate quantitative measurement of minimum source activity to specifically differentiate the high activity sources from other sources with differences in radioactive intensity for the two isotopes.

Accordingly, we are accepting the commenter's suggestion to utilize the calibrations established by the NIST to specify the high activity ranges.

The final code descriptors are:

C2634 Brachytherapy source, High Activity Iodine-125, greater than 1.01 mCi (NIST), per source.

C2635 Brachytherapy source, High Activity Palladium-103, greater than 2.2 mCi (NIST), per source.

Comment: One commenter objected to our proposal to create the two high activity brachytherapy codes based on radioactive intensity and claimed that there is uncertainty regarding availability of radioactive substance and that providers will need to distinguish between low and high activity without a definition of high activity.

Response: We have now defined high activity level in our code descriptors for C2634 and C2635, using calibrations

established by the NIST. We will implement these codes with the definitions described herein.

Comment: One commenter on the January 6, 2004 interim final rule with comment period suggested that we include ''low dose rate'' into the descriptors for each of the existing APCS for which the low dose rate may be applicable, to clarify that those descriptors refer to ''low dose rate'' brachytherapy.

Response: We do not believe that changes in the descriptors of all APCs and HCPCS codes are warranted without evidence that there are alternative low and high dose rate sources requiring a high or low dose rate indicator in the C-code descriptor to distinguish among the sources. In this manner, if there are both low and high dose rate forms, they may be paid on a cost basis for brachytherapy sources described by the same C-code until a new code is indicated for a high dose rate source. If we receive evidence that high dose rate sources are used in clinical practice, we will determine at that time whether to establish new codes and APCs and whether the existing codes need to be modified in some way.

Comment: One commenter on the January 6, 2004 interim final rule with comment period recommended that we establish a new source category for Brachytherapy linear source, Palladium-103, per 10 millimeter length. The commenter claimed that this linear source is provided in 10-millimeter lengths from 10 to 60 millimeters, and not on a ''per seed'' basis. Although the commenter indicated there were dosimetry studies comparing the Palladium-103 linear source to the per seed form, the commenter recommended against using the same Palladium-103 code for both sources, claiming it would cause confusion in billing and cost reporting.

Response: We agree that a separate code for Palladium-103 linear source should be established for payment under Pub. L. 108–173. In our proposed rule, we indicated that we were aware of a new linear source Palladium-103, which came to our attention by means of an application for a new device category for pass-through payment. We stated that, while we decided not to create a new category for pass-through payment, we believed that the new linear source falls under the provisions of Pub. L. 108–173 for separate cost-based payment as a brachytherapy source. Therefore, we proposed to add the following code for linear source Palladium-103: Cxxx3 Brachytherapy linear source, Palladium-103, per 1 mm. We believe that the 1 millimeter increments of payment affords greater flexibility for describing other linear source Palladium-103 sources that may enter the market and be sold in other than 10 mm increments.

We received several public comments in support of our proposed addition and descriptor of Brachytherapy linear source, Palladium-103, per 1 mm. Therefore, in this final rule with comment period, we are establishing the new code and descriptor for this new brachytherapy source, to be paid at cost:

C2636 Brachytherapy linear source, Palladium-103, per 1 mm.

Comment: One commenter on the January 6, 2004 interim final rule with comment period stated that CMS should pay for codes C1715 (Brachytherapy needle) and C1728 (Catheter, brachytherapy seed administration) on a cost basis as well as brachytherapy sources, asserting that these are brachytherapy devices.

Response: Brachytherapy needles and catheters for administration of sources are not brachytherapy devices under section 621(b) of Pub. L. 108–173. Section 1833(t)(16)(C) of the Act specifies that, to qualify for payment at charges reduced to cost, a device of brachytherapy must consist of ''a seed or seeds (or radioactive sources).'' The special payment provision does not include needles or catheters in the definition of devices of brachytherapy. Therefore, in this final rule with comment period, we are not establishing new payment categories for these devices that were formerly paid as transitional pass-through devices.

Comment: One commenter, a developer of a brachytherapy radiation system, recommended that CMS create a C-code and APC for miscellaneous brachytherapy sources for payment of new brachytherapy sources at cost in accordance with Pub. L. 108–173. This commenter contended that such a miscellaneous source code would allow CMS to pay hospitals for new brachytherapy sources in the interval between FDA approval of the source and the development of specific coding for new sources.

Response: Section 621(b) of Pub. L. 108–173 requires us to establish new codes and separate payment for specific seed or seeds or other radioactive sources of brachytherapy. We do not believe that the statute contemplates a separate payment for an over-inclusive (''catch-all'') category such as a miscellaneous brachytherapy source code. Such a category would inappropriately include all new brachytherapy sources until separate payment is established. Moreover, we note that hospitals and brachytherapy source manufacturers might be able to use a miscellaneous category to bill Medicare for brachytherapy systems that do not meet our standard of a separately payable radioactive source of brachytherapy. In addition, new brachytherapy sources may be added more frequently than annually, when we are able to add new codes and payment instructions to our electronic claims processing systems. Therefore, in this final rule with comment period, we are not creating a new code of miscellaneous brachytherapy sources.

Table 40 provides a complete listing of the HCPCS codes, long descriptors, APC assignments and status indicators that we will use for brachytherapy sources paid under the OPPS in CY 2005.

TABLE 40.—SEPARATELY PAYABLE BRACHYTHERAPY SOURCES

HCPCS	Long descriptor	APC	APC title	New status indicator
C1716	Brachytherapy source, Gold 198, per source	1716	Brachytx source, Gold 198	H
C1717	Brachytherapy source, High Dose Rate Iridium 192, per source.	1717	Brachytx source, HDR Ir-192	H
C1718	Brachytherapy source, Iodine 125, per source	1718	Brachytx source, Iodine 125	H
C1719	Brachytherapy source, Non-High Dose Rate Iridium 192, per source.	1719	Brachytx source, Non-HDR Ir-192	H
C1720	Brachytherapy source, Palladium 103, per source	1720	Brachytx source, Palladium 103	H
C2616	Brachytherapy source, Yttrium-90, per source	2616	Brachytx source, Yttrium-90	H
C2632*	Brachytherapy solution, Iodine125, per mCi	2632	Brachytx sol, I–125, per mCi	H
C2633	Brachytherapy source, Cesium-131, per source	2633	Brachytx source, Cesium-131	H

TABLE 40.—SEPARATELY PAYABLE BRACHYTHERAPY SOURCES—Continued

HCPCS	Long descriptor	APC	APC title	New status indicator
C2634**	Brachytherapy source, High Activity, Iodine-125, greater than 1.01 mCi (NIST), per source.	2634	Brachytx source, HA, I–125	H
C2635**	Brachytherapy source, High Activity, Palladium-103, greater than 2.2 mCi (NIST), per source.	2635	Brachytx source, HA, P–103	H
C2636**	Brachytherapy linear source, Palladium-103, per 1MM	2636	Brachytx linear source, P–103	H

* Currently paid as a pass-through device category, scheduled to expire from pass-through payment as of January 1, 2005.
** Newly created brachytherapy payment codes beginning January 1, 2005.

Comment: A few commenters requested that CMS discuss in the OPPS final rule the process for adding other new brachytherapy devices for qualification under the separate cost-based payment methodology under Pub. L. 108–173. The commenters urged CMS to add new brachytherapy devices for separate cost-based payment on a quarterly basis, rather than annually.

Response: In the OPPS interim final rule published on January 6, 2004 that implemented the brachytherapy provisions of Pub. L. 108–173 for CY 2004, we invited the public to submit recommendations for new codes to describe brachytherapy sources in a manner reflecting the number, radioisotope, and radioactivity intensity of the sources (69 FR 828). We requested that commenters provide a detailed rationale to support recommended new codes. The public may send such recommendations to the Division of Outpatient Care, Mailstop C4–05–17, Centers for Medicare and Medicaid Services, 7500 Security Blvd., 21244. We will endeavor to add new brachytherapy source codes and descriptors to our systems for payment on a quarterly rather than an annual basis.

H. Payment for APC 0375, Ancillary Outpatient Services When Patient Expires

In CY 2003, we implemented a new modifier –CA, Procedure payable only in the inpatient setting when performed emergently on an outpatient who dies before admission. The purpose of this modifier is to allow payment, under certain conditions, for outpatient services on a claim that have the same date of service as a HCPCS code with status indicator ''C'' that is billed with modifier –CA. When a procedure with status indicator ''C'' (inpatient services not payable under the OPPS) was billed with modifier –CA, we made payment of a fixed amount, under New Technology APC 0977.

In the November 7, 2003 final rule with comment period, we implemented APC 0375 to pay for services furnished in CY 2004 on the same date billed for a procedure code with modifier –CA (68 FR 63467). We were concerned that our policy of paying a fixed amount under a new technology APC for otherwise payable outpatient services furnished on the same date of service that a procedure with status indicator ''C'' is performed emergently on an outpatient would not result in appropriate payment for these services. That is, continuing to make payment under a new technology APC would not allow us to establish a relative payment weight for the services, subject to recalibration based on actual hospital costs.

We implemented a payment rate of $1,150 for APC 0375, which is the payment amount for the restructured New Technology—Level XIII, APC 1513, that replaced APC 0977, in CY 2004. We also stated that for the CY 2005 update of the OPPS, we would calculate a median cost and relative payment weight for APC 0375 using charge data from CY 2003 claims for line items with a HCPC code and status indicator ''V,'' ''S,'' ''T,'' ''X,'' ''N,'' ''K,'' ''G,'' and ''H,'' in addition to charges for revenue codes without a HCPCS code, that have the same date of service reported for a procedure billed with modifier –CA. We would then determine whether to set payment for APC 0375 based on our claims data or continue a fixed payment rate for these special services.

In accordance with this methodology, for CY 2005 we reviewed the services on the 18 claims that reported modifier –CA in CY 2003. We calculated a median cost for the aggregated payable services on the 18 claims reporting modifier –CA in the amount of $2,804.18. The mix of outpatient services that were reported appeared reasonable for a patient with an emergent condition requiring immediate medical intervention, and revealed a wide range of costs, which would also be expected. As we indicated in the August 16, 2004 proposed rule, we proposed to set the payment rate for APC 0375 in accordance with the same methodology we have followed to set payment rates for the other procedural APCS in CY 2005, based on the relative payment weight calculated for APC 0375.

Comment: A few commenters were concerned whether the proposed rate of $2,757.68 for CY 2005 appropriately reflects the costs incurred by hospitals in cases where the –CA modifier is reported and requested that CMS review the rate and adjust it accordingly for CY 2006.

Response: We appreciate the commenters' concerns. Services with a –CA modifier appended are paid under APC 0375. As we explained in our August 16, 2004 proposed rule, the proposed rate of $2,757.68 for CY 2005 was calculated using actual claims billed in CY 2003. The final payment rate for CY 2005, using the updated data file, is calculated as $3,214.22. As we stated previously, review of the claims data revealed a reasonable mix of outpatient services that a hospital could be expected to furnish during an encounter with a patient with an emergent condition requiring immediate medical intervention, as well as cases with a wide range of costs. We will continue to monitor the appropriateness of this payment rate as we develop future rules.

VIII. Conversion Factor Update for CY 2005

Section 1833(t)(3)(C)(ii) of the Act requires us to update the conversion factor used to determine payment rates under the OPPS on an annual basis. Section 1833(t)(3)(C)(iv) of the Act provides that, for CY 2005, the update is equal to the hospital inpatient market basket percentage increase applicable to hospital discharges under section 1886(b)(3)(B)(iii) of the Act.

The forecast of the hospital market basket increase for FY 2005 published in the IPPS final rule on August 11, 2004 is 3.3 percent (69 FR 49272), the same as the forecast published in the IPPS proposed rule on May 18, 2004 (69 FR 28374) and referenced in the CY 2005 OPPS August 16, 2004 proposed rule. To set the OPPS conversion factor

for CY 2005, we increased the CY 2004 conversion factor of $54.561, as specified in the November 7, 2003 final rule with comment period (68 FR 63459), by 3.3 percent.

In accordance with section 1833(t)(9)(B) of the Act, we further adjusted the conversion factor for CY 2004 to ensure that the revisions we are making to our updates by means of the wage index are made on a budget-neutral basis. For the OPPS proposed rule, we calculated a budget neutrality factor of 1.001 for wage index changes by comparing total payments from our simulation model using the FY 2005 IPPS wage index values to those payments using the FY 2004 IPPS wage index values. For this final rule with comment period, we calculated a budget neutrality factor of 0.9986 for wage index changes by comparing total payments from our simulation model using the revised final FY 2005 IPPS wage index values to those payments using the current (FY 2004) IPPS wage index values. In addition, for CY 2005, allowed pass-through payments have decreased to 0.10 percent of total OPPS payments, down from 1.3 percent in CY 2004. The conversion factor is also adjusted by the difference in estimated pass-through payments of 1.20 percent.

The market basket increase update factor of 3.3 percent for CY 2005, the required wage index budget neutrality adjustment of approximately 0.9986, and the 1.20 percent adjustment to the pass-through estimate result in a conversion factor for CY 2005 of $56.983.

We did not receive any public comments on the proposed conversion factor update for CY 2005.

IX. Wage Index Changes for CY 2005

Section 1833(t)(2)(D) of the Act requires the Secretary to determine a wage adjustment factor to adjust, for geographic wage differences, the portion of the OPPS payment rate and the copayment standardized amount attributable to labor and labor-related cost. This adjustment must be made in a budget neutral manner. As we have done in prior years, we proposed to adopt the IPPS wage indices and extend these wage indices to TEFRA hospitals that participate in the OPPS but not the IPPS.

As discussed in the proposed rule and finalized in section III.B. of this preamble, we standardize 60 percent of estimated costs (labor-related costs) for geographic area wage variation using the IPPS wage indices that are calculated prior to adjustments for reclassification to remove the effects of differences in area wage levels in determining the OPPS payment rate and the copayment standardized amount.

As published in the original OPPS April 7, 2000 final rule (65 FR 18545), OPPS has consistently adopted the final IPPS wage indices as the wage indices for adjusting the OPPS standard payment amounts for labor market differences. As initially explained in the September 8, 1998 OPPS proposed rule, we believed and continue to believe that using the IPPS wage index as a source of an adjustment factor for OPPS is reasonable and logical, given the inseparable, subordinate status of the hospital outpatient within the hospital overall. We also continue to believe that individual hospitals do not distinguish in hiring practices between their inpatient and outpatient departments and that hospitals face one labor market for both inpatient and outpatient services. Further, because hospital staff frequently provide services in both the inpatient and outpatient departments, labor costs associated with the hospital outpatient services are generally reflected in the hospital wage and salary data that are the basis of the IPPS wage index. In accordance with section 1886(d)(3)(E) of the Act, the IPPS wage index is updated annually. In the August 16, 2004 proposed rule, we proposed to use the corrected proposed FY 2005 hospital IPPS wage index for urban areas published in the **Federal Register** on June 25, 2004 (69 FR 35919) and the proposed FY 2005 hospital IPPS wage index for rural areas published in the **Federal Register** on May 18, 2004 (69 FR 28580) to determine the wage adjustments for the OPPS payment rate and the copayment standardized amount for CY 2005.

We customarily publish the wage index tables in the final rule for the OPPS update. We are not including the tables in this final rule with comment period as CMS is in the process of reviewing the wage indices for IPPS. This review may impact the wage index values. We emphasize that our methodology for calculating the wage index for the OPPS has not changed. As noted above, our policy has consistently been to adopt the IPPS wage index for purposes of payment under the OPPS. We will publish finalized tables in a later **Federal Register** document.

We note that the FY 2005 IPPS wage indices reflect a number of changes as a result of the new OMB standards for defining geographic statistical areas, the implementation of an occupational mix adjustment as part of the wage index, and new wage adjustments provided for under Pub. L. 108–173. The following is a brief summary of the changes in the FY 2005 IPPS wage indices and any adjustments that we are applying to the OPPS for CY 2005. (We refer the reader to the August 11, 2004 IPPS final rule (69 FR 49026–49070) and the October 7, 2004 IPPS correction notice (69 FR 60242) for a fuller discussion of the changes to the wage indices.)

A. The use of the new Core Based Statistical Areas (CBSAs) issued by the Office of Management and Budget (OMB) as revised standards for designating geographical statistical areas based on the 2000 Census data, to define labor market areas for hospitals for purposes of the IPPS wage index. The OMB revised standards were published in the **Federal Register** on December 27, 2000 (65 FR 82235), and OMB announced the new CBSAs on June 6, 2003, through an OMB bulletin. In the FY 2005 hospital IPPS final rule, CMS adopted the new OMB definitions for wage index purposes. We treated, as urban, hospitals located in MSAs and treated, as rural, hospitals that are located in Micropolitan Areas or Outside CBSAs. To help alleviate the decreased payments for previously urban hospitals that became rural under the new MSA definitions, we allowed these hospitals to maintain their assignment to the MSA where they previously had been located for the 3-year period from FY 2005 through FY 2007. To be consistent, we are applying the same criterion to TEFRA hospitals paid under the OPPS but not under the IPPS and to maintain that MSA designation for determining a wage index for the next 3 years. This policy will impact four TEFRA providers for purposes of OPPS payment. In addition to this ''hold harmless'' provision, the IPPS final rule implemented a one-year transition for hospitals that experienced a decrease in their FY 2005 wage index compared to their FY 2004 wage index due solely to the changes in labor market definitions. These hospitals received 50 percent of their wage indices based on the new MSA configurations and 50 percent based on the FY 2004 labor market areas. For purposes of the OPPS, we also are applying this 50-percent transition blend to TEFRA hospitals.

B. The incorporation of a blend of an occupational mix adjusted wage index into the unadjusted wage index to reflect the effect of hospitals' employment choices of occupational categories to provide specific patient care. Specifically, OPPS will adopt the 10-percent blend of an average hourly wage, adjusted for occupational mix, and 90 percent of an average hourly wage, unadjusted for occupational mix, as finalized in the IPPS final rule. As discussed in the IPPS final rule, this

blend is appropriate because this was the first time that the occupational mix survey was administered and optimum data could not be collected in the limited timeframe available. In addition, CMS had no baseline data to use in developing a desk review program that could ensure the accuracy of the occupational mix survey data. Moving slowly to implement the occupational mix adjustment is also appropriate because of changing trends in the hiring nurses due changes in State law governing staffing levels and physician shortages. Finally, the blend minimizes the impact of the occupational mix adjustment on hospitals' wage index values without nullifying the value and intent of the adjustment.

C. The reclassifications of hospitals to geographic areas for purposes of the wage index. For purposes of the OPPS wage index, we are adopting all of the IPPS reclassifications in effect for FY 2005, including reclassifications that the Medicare Geographic Classification Review Board (MGCRB) approved under the one-time appeal process for hospitals under section 508 of Pub. L. 108–173.

D. The implementation of an adjustment to the wage index to reflect the ''out-migration'' of hospital employees who reside in one county but commute to work in a different county with a higher wage index, in accordance with section 505 of Pub. L. 108–173 (August 11, 2004 IPPS final rule (69 FR 49061 through 49067), as revised and corrected on October 7, 2004 (69 FR 60242)). Hospitals paid under the IPPS located in the qualifying section 505 ''out-migration'' counties received a wage index increase. We are applying the same criterion to TEFRA hospitals paid under the OPPS but not paid under the IPPS. Therefore, TEFRA hospitals located in a qualifying section 505 county will also receive an increase to their wage index under OPPS.

We will use final revised IPPS indices to adjust the payment rates and coinsurance amounts that we are publishing in this OPPS final rule with comment period for CY 2005.

In general, geographic labor market area reclassifications must be done in a budget neutral manner. Accordingly, in calculating the OPPS budget neutrality estimates for CY 2005, we have included the wage index changes that result from MGCRB reclassifications, implementation of section 505 of Pub. L. 108–173, and other refinements made in the IPPS final rule, such as the 50-percent transition blend for hospitals with FY 2005 wage indices that decreased solely as a result of the new MSA definitions. However, we did not take into account the reclassifications that resulted from implementation of the one-time appeal process under section 508 of Pub. L. 108–173. Section 508 set aside $900 million to implement the section 508 reclassifications. We considered the increased Medicare payments that the section 508 reclassifications would create in both the IPPS and OPPS when we determined the impact of the one-time appeal process. Because the increased OPPS payments already counted against the $900 million limit, we did not consider these reclassifications when we calculated the OPPS budget neutrality adjustment.

We received a number of public comments on the application of the FY 2005 IPPS wage indices under the OPPS.

Comment: In general, commenters approved of CMS' adoption of the FY 2005 final rule wage indices for IPPS. Several commenters requested clarification that CMS would adopt the temporary, 1-year relief for hospitals with wage areas changing due to the revised labor market definitions provided in the FY 2005 IPPS final rule.

Response: We are adopting the IPPS temporary, 1-year relief provision of a 50/50 blend of old and new wage indices in this OPPS final rule with comment period. Hospitals billing Medicare under IPPS in FY 2005 will receive the same wage index for OPPS.

Comment: One commenter requested clarification that CMS would adopt the technical correction to the IPPS wage index to include counties incorrectly excluded from the out-migration adjustment under section 505 of Pub. L. 108–173.

Response: In this OPPS final rule with comment period, we are adopting all technical corrections to the FY 2005 IPPS final rule wage indices, including the referenced correction to the out-migration counties.

Comment: Several commenters requested clarification that CMS would adopt the wage index provisions for ''Special Circumstances of Hospitals in All-Urban States.''

Response: We are adopting all of the changes to the IPPS wage indices discussed in the FY 2005 IPPS final rule and any subsequent corrections to that final rule, including calculation of a wage index floor for hospitals in all-urban States.

Comment: One commenter noted that the wage index listed in the impact file that we made available on the CMS Web site for the August 16, 2004 proposed rule listed a different wage index from the wage index adopted in the FY 2005 IPPS final rule and requested clarification that the hospital would receive the IPPS final rule wage index.

Response: We note that the proposed wage indices have to be assembled before the IPPS wage indices are finalized in order to model impact tables for the OPPS proposed rule. The final wage indices used for payment in CY 2005 for OPPS will reflect the wage indices in the FY 2005 IPPS final rule and any subsequent corrections to that final rule.

Comment: Several commenters, specifically individual hospitals adversely impacted by the final FY 2005 IPPS wage index, requested that CMS address several issues beyond the scope of the OPPS proposed rule, such as exempting hospitals from the new wage indices and employing former wage indices, calculating new wage indices or recalculating the current wage indices with additional provider or providers removed, calculating new ''in-migration'' adjustments, and, where permanent wage indices changes are not possible, providing a transition period beyond the 1-year 50/50 blend discussed above or extending ''hold harmless'' provisions. One commenter also requested that adversely impacted hospitals be able to bill under the provider numbers of affiliated institutions.

Response: As noted earlier in this section of the preamble, we believe, and other commenters concurred, that hospitals face the same labor costs for their inpatient and outpatient departments and that separate wage indices are not appropriate for different integrated components of the same institution. It is for this reason that we have always adopted the same wage index for both the IPPS and the OPPS payment systems. Moreover, our policy has consistently been to use the IPPS wage indices and, to the extent these wage indices are used, the IPPS process provides an opportunity for hospitals to comment specifically on the construction of the IPPS wage indices.

Comment: Several commenters requested that CMS reduce the labor-related share from the current 60 percent to some smaller percentage, frequently 52 percent or less, for outpatient payment purposes for hospitals in areas with a Medicare wage index of 1.0 or lower to maintain consistency with the inpatient hospital policy.

Response: Section 403 of Pub. L. 108–173 mandated that the IPPS make a change to the labor-related share of the wage index, reducing the percentage from 71 to 62 for hospitals in areas with a wage index of 1.0 or lower. However, as discussed in the IPPS final rule (69

FR 49069, August 11, 2004), prior to this mandate, we had determined that the labor-related share was increasing for inpatient services, not declining. Unlike IPPS, OPPS has no mandate to reduce the labor-related share, and we believe the current 60 percent labor-related share remains appropriate for OPPS payment purposes. We recognize that the IPPS final rule discusses CMS' current analyses of the labor-related share, and we will carefully consider any research findings in light of their appropriateness for OPPS.

Comment: Several commenters expressed concern that CMS proposed to adopt the IPPS proposed wage index rather than the IPPS final wage index.

Response: As we have stated previously in this section of the preamble, we note that we are adopting the final IPPS wage indices and any subsequent corrections for the OPPS.

X. Determination of Payment Rates and Outlier Payments for CY 2005

A. Calculation of the National Unadjusted Medicare Payment

The basic methodology for determining prospective payment rates for OPD services under the OPPS is set forth in existing regulations at §§ 419.31 and 419.32. The payment rate for services and procedures for which payment is made under the OPPS is the product of the conversion factor calculated in accordance with section VIII. of this final rule with comment period, and the relative weight determined under section III. of this final rule with comment period. Therefore, the national unadjusted payment rate for APCs contained in Addendum A to this final rule with comment period and for payable HCPCS codes in Addendum B to this final rule with comment period (Addendum B is provided as a convenience for readers) was calculated by multiplying the CY 2005 scaled weight for the APC by the CY 2005 conversion factor.

To determine the payment that will be made in a calendar year under the OPPS to a specific hospital for an APC for a service other than a drug, in a circumstance in which the multiple procedure discount does not apply, we take the following steps:

Step 1. Calculate 60 percent (the labor-related portion) of the national unadjusted payment rate. Since initial implementation of the OPPS, we have used 60 percent to represent our estimate of that portion of costs attributable, on average, to labor. (See the April 7, 2000 final rule with comment period (65 FR 18496 through 18497), for a detailed discussion of how we derived this percentage.)

Step 2. Determine the wage index area in which the hospital is located and identify the wage index level that applies to the specific hospital. The wage index values assigned to each area reflect the new geographic statistical areas as a result of revised OMB standards (urban and rural) to which hospitals would be assigned for FY 2005 under the IPPS, reclassifications through the Medicare Classification Geographic Review Board, LUGAR, and section 401 of Pub. L. 108–173, and the reclassifications of hospitals under the one-time appeals process under section 508 of Pub. L. 108–173. Assess whether the previous MSA-based wage index is higher than the CBSA-based wage index, and, if higher, apply a 50/50 blend. The wage index values include the occupational mix adjustment described in section IX. of this final rule with comment period that was developed for the IPPS.

Step 3. Adjust the wage index of hospitals located in certain qualifying counties that have a relatively high percentage of hospital employees who reside in the county but who work in a different county with a higher wage index, in accordance with section 505 of Pub. L. 108–173. This step is to be followed only if the hospital has chosen not to accept reclassification under step 2 above.

Step 4. Multiply the applicable wage index determined under Steps 2 and 3 by the amount determined under Step 1 that represents the labor-related portion of the national unadjusted payment rate.

Step 5. Calculate 40 percent (the nonlabor-related portion) of the national unadjusted payment rate and add that amount to the resulting product of Step 4. The result is the wage index adjusted payment rate for the relevant wage index area.

B. Hospital Outpatient Outlier Payments

For OPPS services furnished between August 1, 2000, and April 1, 2002, we calculated outlier payments in the aggregate for all OPPS services that appear on a bill in accordance with section 1833(t)(5)(D) of the Act. In the November 30, 2001 final rule (66 FR 59856 through 59888), we specified that, beginning with CY 2002, we calculate outlier payments based on each individual OPPS service. We revised the aggregate method that we had used to calculate outlier payments and began to determine outlier payments on a service-by-service basis.

As explained in the April 7, 2000 final rule with comment period (65 FR 18498), we set a projected target for outlier payments at 2.0 percent of total payments. For purposes of simulating payments to calculate outlier thresholds, we set the projected target for outlier payments at 2.0 percent for CYs 2001, 2002, 2003, and 2004. For reasons discussed in the November 7, 2003 final rule with comment period (68 FR 63469), for CY 2004, we established a separate outlier threshold for CMHCs. For CY 2004, the outlier threshold is met when costs of furnishing a service or procedure by a hospital exceed 2.6 times the APC payment amount or when the cost of furnishing services by a CMHC exceeds 3.65 times the APC payment amount. The current outlier payment is calculated to equal 50 percent of the amount of costs in excess of the threshold.

As we proposed, for CY 2005, we are continuing to set the projected target for outlier payments at 2.0 percent of total OPPS payments (a portion of that 2.0 percent, 0.6 percent, will be allocated to CMHCs for partial hospitalization program (PHP) services).

Outlier payments are intended to ensure beneficiary access to services by having the Medicare program share in the financial loss incurred by a provider associated with individual, extraordinarily expensive cases. They are not intended to pay hospitals additional amounts for specific services on a routine basis. In its March 2004 Report, MedPAC found that 50 percent of OPPS outlier payments in CY 2004 were for 21 fairly common services that had relatively low APC payment rates, such as plain film x-rays and pathology services. We remain concerned by the MedPAC findings which indicate that a significant portion of outlier payments are being made for high volume, lower cost services rather than for unusually high cost services, contrary to the intent of an outlier policy. (A full discussion of the 2004 MedPAC recommendations related to the OPPS and the CMS response to those recommendations can be found in section XII. of this preamble.)

In light of the MedPAC findings, in the August 16, 2004 proposed rule, we proposed to change the standard we have used to qualify a service for outlier payments since the OPPS was originally implemented. That is, in addition to the outlier threshold we have applied since the beginning of the OPPS, which requires that a hospital's cost for a service exceed the APC payment rate for that service by a specified multiple of the APC payment rate, we proposed to add a fixed dollar threshold that would have to be met in order for a service to qualify for an outlier payment. Section 1833(t)(5)(A) of the Act gives the

Secretary the authority to impose a fixed dollar threshold in addition to an APC multiplier threshold. By imposing a dollar threshold, we expect to redirect outlier payments from lower cost, relatively simple procedures to more complex, expensive procedures for which the costs associated with individual cases could be exceptionally high and for which hospitals would be at greater risk financially.

In the proposed rule, we proposed to require that, in order to qualify for an outlier payment, the cost of a service must exceed 1.5 times the APC payment rate and the cost must also exceed the sum of the APC rate plus a $625 fixed dollar threshold. Based upon our review of the data, a proposed threshold of $625 best met our 2.0 percent projected target. When the cost of a hospital outpatient service exceeds these thresholds, we proposed to pay 50 percent of the amount by which the cost of furnishing the service exceeds 1.5 times the APC payment rate (the APC multiple) as an outlier payment.

However, in this final rule, we are increasing the proposed APC multiplier of 1.5 to 1.75 and the fixed-dollar threshold from $625 to $1,175. This revision to the proposed rule estimates results from the inclusion of a charge inflation factor of 18.76 percent to account for charge inflation between the CY 2003 claims data that we used to model the outlier thresholds and their application in CY 2005. As we note below, many hospital associations expressed concern that the proposed $625 threshold for outlier payments was too high and suggested that OPPS consider the decision in the IPPS final rule to lower the charge inflation assumption from 31.1 percent to 18.76 percent. These same commenters suggested that we provide the details of the assumptions used to set outlier thresholds and asked that we ensure that the charges used to set outlier thresholds were not inappropriately inflated.

Previously, OPPS has not used a charge inflation factor to adjust charges on the claims used to model the payment system to reflect current dollars. We have historically set the projected target for outlier payments at 2 percent of the estimated spending under the proposed payment system, but have modeled that projected target without inflating charges on the claims, which usually lag behind the proposed system by 2 years. This year, we used CY 2003 claims to model the CY 2005 payment system. When we modeled the thresholds discussed in the August 16, 2004 proposed rule, we did not include a charge inflation factor. By not adjusting for charge inflation between CY 2003 and CY 2005, the estimated service costs will be lower than those that will be billed under OPPS next year. Underestimated service costs also led us to underestimate our outlier thresholds. As reflected in the comments, we should have included a charge inflation factor similar to that used in the IPPS outlier calculation when we developed the proposed outlier payments. In this final rule with comment period, we have done so as explained below, which results in an APC multiplier of 1.75 and a fixed-dollar threshold of $1,175.

To calculate the 1.75 multiple and $1,175 fixed-dollar thresholds, we first estimated the 2-percent projected target for outlier payments by estimating 2 percent of total spending in CY 2005 using the CY 2005 APC payment rates in this final rule with comment period and services in the CY 2003 claims. We then inflated the charges on these claims by 18.76 percent, which is the estimated increase in charges between CY 2003 and CY 2005 used in the outlier policy for the IPPS final rule. We believe the use of this estimate is appropriate for OPPS because, with the exception of the routine service cost centers, hospitals use the same cost centers to capture costs and charges across inpatient and outpatient services. As also noted in the IPPS final rule, we believe that this inflation factor is more appropriate than an adjustment to costs because charges increase at a faster rate than costs. We then used the same CCRs that we used to adjust charges to costs in our ratesetting process to estimate a cost for each service from the inflated charges on the CY 2003 claims. Although these CCRs are based largely on CY 2002 cost report data, we did not adjust them for probable increases in charges relative to costs between CY 2002 and CY 2005. Finally, we estimated a multiple threshold and fixed-dollar threshold that would produce outlier payments that met our 2-percent projected target amount.

The large increase in the fixed-dollar threshold is largely a function of the additive impact of increasing all estimated outlier payments by 18.76 percent and restricting increased estimates of outlier payments to a fixed, projected target of 2 percent, as well as the addition of a fixed-dollar threshold to determine outlier eligibility instead of using only a multiple threshold to determine outlier payment. As charges are inflated, each estimated outlier payment is higher by some proportional amount, but the total dollar increase varies with the magnitude of the difference in the cost of the service and APC payment rate. The addition of the fixed-dollar threshold policy ensures that outlier payments are made for high-cost services, thereby increasing the dollar amount of outlier payments and the total dollar impact of 18.76 percent that must be contained within the projected outlier target. Further, the actual based on outlier payment for a service is not affected by the fixed-dollar threshold but, rather, is the difference between the hospital's cost and the product of the multiple threshold and the APC payment rate. Changing the fixed-dollar threshold does not impact the amount of outlier payment. Adding the inflation adjustment to charges also increases the number of services eligible for an outlier payment under the proposed 1.5 multiple and $625 fixed-dollar thresholds. The combined impact of more services and higher payments greatly increases estimated outlier payments. Therefore, in order to reduce the number of services eligible for higher payments and the payments themselves to stay within our projected target of 2 percent of total OPPS payments, we had to raise both the fixed-dollar and multiple thresholds.

We are setting the dollar threshold at a level that will, for all intents and purposes, exclude outliers for a number of lower cost services. For example, under the CY 2004 methodology, a service mapped to an APC with a payment rate of $20 would only have to exceed $52 (2.6 × APC payment amount) in order to qualify for an outlier payment. Our final policy for CY 2005 with the additional fixed dollar threshold will require that the service in this example exceed $1,195 in order to qualify for an outlier payment. That is, the cost of the service will have to exceed both 1.75 times the APC payment rate, or $35, and $1,195 ($20 + $1,175).

The dollar threshold will also enable us to lower the APC multiplier portion of the total outlier threshold from 2.6 to 1.75. We have chosen a multiple of 1.75 because this continues to recognize some variability relative to APC payment implicit in the current statute, but limits its impact in determining outlier payments. Under the changes to the outlier methodology, it will also be easier for the higher cost cases of a complex, expensive procedure or service to qualify for outlier payments because the $1,175 threshold is a small portion of the total payment rate for high cost services. For example, under the CY 2004 methodology, a service mapped to an APC with a payment rate of $20,000 would have to exceed $52,000 in order to qualify for an outlier

payment but, as proposed for CY 2005, will have to exceed only $35,000. That is, the cost of the service will have to exceed both 1.75 times the APC payment rate, or $35,000, and $21,175 ($20,000 + $1,175). Further, outlier payments for unusually expensive cases would be higher because the APC multiplier for outlier payment would decrease from 2.6 to 1.75 times the APC payment rate.

Comment: Many commenters, including MedPAC, favored our proposed outlier policy that redirects outlier payments to expensive procedures for which hospitals' financial risk is potentially greater. (Under the proposed rule, outlier payments would be made when the cost of a separately payable service exceeds both 1.5 times the APC payment and a fixed dollar amount.) Several commenters agreed with this revision in policy, but requested that CMS monitor the impact of the new policy on hospitals with a relatively high volume of low cost cases and find some way to ensure that providers of less-intensive services be afforded outlier ''protection.''

Response: As noted above, outlier payments are intended to ensure beneficiary access to services by having the Medicare program share in the financial loss incurred by a provider associated with individual, extraordinarily expensive cases. They are not intended to pay hospitals additional amounts for specific services on a routine basis, and we demonstrated in Table 39 of the proposed rule that this policy moderately redistributes outlier dollars to providers of high-cost, complex services, such as teaching hospitals. We will continue to model the distribution of outlier payments among hospitals. However, the purpose of the new policy is to limit financial risk attributable to patients whose costs are extraordinarily high. Therefore, our goal is to redirect outlier payments to those services that better meet our goal of providing outlier payments to those costly services with high financial risk. The intent is not to continue to provide a significant portion of outlier payments to high volume, low cost services.

Using the final rule data and updated charge inflation estimates, we have modeled a fixed-dollar threshold of $1,175 for CY 2005.

Comment: Several commenters requested data that support the presumption that the revised outlier methodology will definitely result in payment of 2 percent of total OPPS payments. The commenters also urged CMS to release data on actual outlier payments made in CY 2004 and in prior years, and to continue to report this data in the future.

Response: The outlier thresholds and payment percentages are determined each year based on our best estimate of the thresholds and payment percentages needed to achieve the projected target of outlier payment. As discussed above, in order to estimate the outlier multiple and fixed-dollar thresholds, we first estimated 2 percent of the total spending using the APC payment rates in this final rule with comment period and the services in the CY 2003 claims. Using this estimate, we inflated the charges on the CY 2003 claims to reflect CY 2005 dollars using the 1.1876 inflation adjustment used in the IPPS final rule. We then applied the overall CCR for each hospital based on their most recently submitted cost report, whether tentatively settled or final, and if tentatively settled, adjusted by a submitted-to-settled ratio taken from the previous year's cost report. These are the same CCRs that we use in our ratesetting process. We then estimated outlier payments for various combinations of multiple and fixed-dollar thresholds until we reached the targeted outlier expenditures.

Interested parties may calculate the amount of outlier spending from previous years. Such information is available in the claims data, not the limited data set, available from CMS for this final rule with comment period.

Comment: Several commenters were concerned that the proposed fixed-dollar threshold of $625 was too high. Specifically, the commenters were concerned that CMS had overstated its charge inflation estimates in calculating the fixed dollar threshold, as had been done in the FY 2005 IPPS proposed rule. The commenters requested that CMS review its estimates and make comparable adjustments to these in the FY 2005 IPPS final rule.

Response: As noted previously, the OPPS had not used a charge inflation factor. In this final rule with comment period, we realized that we should have adopted a charge inflation estimate. We used the charge inflation estimate used in the IPPS final rule of 18.76 percent to update charges on the CY 2003 claims that we used to model the fixed-dollar threshold in order to reflect CY 2005 dollars. Comparable to IPPS, we did not update the CCRs that we employed to estimate costs from these inflated charges. The CCRs are based on hospitals' most recently submitted cost report, frequently CY 2002, adjusted by the most recent settled-to-submitted ratio, and were not updated for changes in relative costs and charges since the cost report year.

Comment: One commenter supported the proposed change, but urged CMS to adopt MedPAC's recommendation to fully eliminate outpatient outlier payments and to increase the base APC rates by a commensurate amount. The commenter asserted that the separate payment of services under OPPS eliminates the need for an outlier policy.

Response: We believe that an outlier policy is necessary and appropriate under the OPPS. Outlier payments dampen the financial risk of and improve beneficiary access to expensive, complex outpatient services. The range of services provided in the outpatient setting continues to expand, continually including more services previously performed in the inpatient setting. Many of these procedures are high-cost, extensive, and as complex as inpatient procedures. The device-dependent APCs provide a good example. We agree that separate payment for many individual services under OPPS reduces the need for an extensive outlier policy, but do not believe it eliminates the need entirely. We believe that the lower outlier payment percentage under the OPPS of 50 percent relative to 80 percent under the IPPS and the smaller OPPS projected outlier target of 2 percent relative to the IPPS projected target of between 5 and 6 percent reflect the more limited outlier liability associated with the outpatient payment system.

Comment: One commenter disagreed with our proposed policy and noted that it will substantially restrict outlier payments for a lot of outpatient services and recommended that CMS remove the fixed-dollar threshold and apply outlier payments only when the cost of a service exceeds 1.5 times the APC payment.

Response: We disagree with the commenter as removing the fixed-dollar threshold and relying only on a multiple of 1.5 or 1.75 would result in outlier payments well in excess of the proposed 2-percent projected target. To meet the projected target, we would have to raise the multiple threshold to 2.95 if we eliminated the fixed dollar threshold.

Comment: Several commenters requested that CMS release limited data set data files in a more timely manner.

Response: We have always attempted to, and will continue to, provide data necessary for evaluation of the OPPS in a timely manner. For example, this year, several data files were available through CMS' Web site before the publication of the proposed rule.

Comment: Several commenters recommended that CMS consider reinstating outlier payments at the claim

level, rather than at the individual service level, resulting in easier administration of outliers and payments that are more equitable for high cost patients.

Response: We believe that calculating outliers on a service-by-service basis is the most appropriate way to calculate outliers for outpatient services. Outliers on a claim or bill basis requires both the aggregation of costs and the aggregation of OPPS payments thereby introducing some degree of offset among services; that is, the aggregation of low cost services and high cost services on a bill may result in the claim or bill not meeting the outlier criterion. While the implementation of service-based outliers is somewhat more complex because it involves allocating the costs of packaged services across multiple payable codes, we believe that under this approach, outlier payments are more appropriately directed to those specific services for which a hospital incurs significantly increased costs. We also believe that the introduction of the fixed dollar threshold improves payment for expensive patients by targeting outlier payments to the more high-cost, complex services.

Comment: One commenter requested that CMS demonstrate the accuracy of its assumption that providers are receiving inappropriate outlier payments and suggest that the distribution of packaged costs on a claim could be affecting the outlier determination and payment. The commenter specifically requested that CMS exempt all drug administration APCs from the new fixed-dollar threshold methodology.

Response: We agree that the allocation of packaged costs could modestly under or overestimate the cost of a single procedure for purposes of determining outlier payments. However, this observation cannot explain the huge concentration of services in low-cost, simple procedures receiving outlier payments observed by MedPAC in its March 2004 report referenced above. This concentration is clearly a function of the multiple threshold policy.

In accordance with section 1833(t)(5) of the Act, we have set a uniform fixed-dollar outlier threshold that applies to all OPPS services in a given calendar year. We cannot exempt specific services from the outlier methodology because the statute does not provide for different thresholds for different types of OPPS services. Further, the magnitude of the multiple and fixed dollar thresholds is determined prospectively before the beginning of each year based on all OPPS services qualifying for outlier payments in that year.

Comment: One commenter was concerned that CMS does not provide information to determine how the amounts that are actually spent on pass-through and outlier payments compare to the amount that is carved out of the total amount allowed OPPS payment for these projected payments. The commenter was concerned that the amounts carved out for these purposes may not actually be spent and thus, would be lost to hospitals.

Response: We are required by law to estimate the amounts that we expect to spend on pass-through and outlier payments each year before the start of the calendar year. We share the commenter's interest in assuring that those estimates are made as accurately as possible to ensure that hospitals receive the amount to which they are entitled by law. We make our final estimate for each calendar year to the best of our ability based on all of the best data available at the time we prepare our final rule, including comments we receive in response to our proposed rule. With respect to the availability of data for modeling our outlier estimates, we have established limited data sets which include the set of claims we used first for the proposed rule estimates and, ultimately, for those for our final rule with comment period. For example, the CY 2003 claims used in ratesetting and modeling for this final rule with comment period for CY 2005 OPPS will be available to the public in a limited data set format. However, estimates of total outlier payments made in previous years are not available in the limited data set, in no small part because outlier payments on these claims would underestimate total outlier payments. Interested parties can estimate total outlier expenditures from a full year of OPPS claims data. We will continue to assess the means by which we provide data.

Comment: One commenter who did not support the proposed outlier policy suggested that the payment for outliers in low-cost services could be an indication that the APC payment rate is too low for these services. The commenter also wondered if the concentration of outlier payments in low-cost services was the result of high packaged costs appearing with these separately payable services, and indicated that one example might include packaged observation services. Ultimately, this commenter suggested that a better understanding of why outlier payments are directed to common services is necessary before a change in policy can be supported.

Response: As MedPAC discussed in its March 2004 report, the main reason to include outlier policies with prospective payment systems is to limit providers' financial risk attributable to patients whose costs are extraordinarily high relative to the median cost of providing the service. We believe that such risk is more substantial in high cost procedures. When the financial risk of providing a service becomes too high, providers may choose not to provide the service, an outcome that can harm beneficiary access.

The CY 2004 outlier policy does not distinguish between high cost services and low cost services. In fact, MedPAC found that 50 percent of OPPS outlier payments in CY 2004 were for services in low-paying APCs. These observations suggested the need to modify the outlier policy to provide better protection against financial risk. The fixed-dollar threshold limits financial risk to providers who provide high-cost services.

Although it is possible that extensive packaged costs have created the current concentration of outliers in low cost services, it is unlikely in most circumstances. Separately payable services consistently billed with extensive packaged costs would ultimately increase payment rates as packaged costs were incorporated in the cost of the payable service. Although packaged observation services can be extensive, the review of OPPS claims data indicates that there are too many outlier payments to be associated with the limited number of claims with packaged observation services. We believe the current policy creates an easy threshold for low-cost services to qualify for outlier payments and does little to protect hospitals against the financial risk associated with complex and high-cost services.

C. Payment for Partial Hospitalization

1. Background

Partial hospitalization is an intensive outpatient program of psychiatric services provided to patients as an alternative to inpatient psychiatric care for beneficiaries who have an acute mental illness. A partial hospitalization program (PHP) may be provided by a hospital to its outpatients or by a Medicare-certified CMHC. Section 1833(t)(1)(B)(i) of the Act provides the Secretary with the authority to designate the hospital outpatient services to be covered under the OPPS. Section 419.21(c) of the Medicare regulations that implement this provision specifies that payments under the OPPS will be made for partial hospitalization services

furnished by CMHCs. Section 1883(t)(2)(C) of the Act requires that we establish relative payment weights based on median (or mean, at the election of the Secretary) hospital costs determined by 1996 claims data and data from the most recent available cost reports. Payment to providers under the OPPS for PHPs represents the provider's overhead costs associated with the program. Because a day of care is the unit that defines the structure and scheduling of partial hospitalization services, we established a per diem payment methodology for the PHP APC, effective for services furnished on or after August 1, 2000. For a detailed discussion, see the April 7, 2000 OPPS final rule (65 FR 18452).

2. PHP APC Update for CY 2005

As proposed, for calculation of the CY 2005 per diem payment in this final rule, we used the same methodology that was used to compute the CY 2004 per diem payment. For CY 2004, the per diem amount was based on three quarters of hospital and CMHC PHP claims data (for services furnished from April 1, 2002, through December 31, 2002). We used data from all hospital bills reporting condition code 41, which identifies the claim as partial hospitalization, and all bills from CMHCs because CMHCs are Medicare providers only for the purpose of providing partial hospitalization services. We used CCRs from the most recently available hospital and CMHC cost reports to convert each provider's line item charges as reported on bills, to estimate the provider's cost for a day of PHP services. Per diem costs are then computed by summing the line item costs on each bill and dividing by the number of days on the bill.

Unlike hospitals, CMHCs do not file cost reports electronically and the cost report information is not included in the Healthcare Cost Report Information System (HCRIS). The CMHC cost reports are held by the Medicare fiscal intermediaries. In a Program Memorandum issued on January 17, 2003 (Transmittal A–03–004), we directed fiscal intermediaries to recalculate hospital and CMHC CCRs using the most recently settled cost reports by April 30, 2003. Following the initial update of CCRs, fiscal intermediaries were further instructed to continue to update a provider's CCR and enter revised CCRs into the outpatient provider specific file. Therefore, for CMHCs, we use CCRs from the outpatient provider specific file. For CY 2005, we analyzed 12 months of data for hospital and CMHC PHP claims for services furnished between January 1, 2003, and December 31, 2003. Updated CCRs reduced the median cost per day for CMHCs. The revised medians are $310 for CMHCs and $215 for hospitals. Combining these files results in a median per diem PHP cost of $289. As with all APCs in the OPPS, the median cost for each APC is scaled to be relative to a mid-level office visit and the conversion factor is applied. The resulting APC amount for PHP is $281.33 for CY 2005, of which $56.33 is the beneficiary's coinsurance.

Comment: One commenter summed payments for three Group Therapy Sessions (APC 0325) and one Extended Individual Therapy Session (APC 0323) and requested that amount as the minimum for a day of PHP.

Response: We do not believe this is an appropriate comparison. It is important to note that the APC services cited by the commenter (APC 0325 and APC 0323) are not PHP services, but rather single outpatient therapeutic sessions. As stated earlier, we used data from PHP programs (both hospitals and CMHCs) to determine the median cost of a day of PHP. PHP is a program of services where savings can be realized by hospitals and CMHCs over delivering individual psychotherapy services. In addition, a minimal day of PHP treatment does encompass three services.

Comment: One commenter requested that the same provisions given to rural hospital outpatient departments also be given to rural CMHCs.

Response: We believe the commenter may be referring to the statutory hold harmless provisions. Section 1833(t)(7)(D) of the Act authorizes such payments, on a permanent basis, for children's hospitals and cancer hospitals and, through CY 2005, for rural hospitals having 100 or fewer beds and sole community hospitals in rural areas. Section 1866(t)(7)(D) of the Act does not authorize hold harmless payments to CMHC providers.

3. Separate Threshold for Outlier Payments to CMHCs

In the November 7, 2003 final rule with comment period (68 FR 63469), we indicated that, given the difference in PHP charges between hospitals and CMHCs, we did not believe it was appropriate to make outlier payments to CMHCs using the outlier percentage target amount and threshold established for hospitals. There was a significant difference in the amount of outlier payments made to hospitals and CMHCs for PHP. Further analysis indicated the use of outlier payments was contrary to the intent of the outlier policy as discussed previously in section X.B. above. Therefore, for CY 2004, we established a separate outlier threshold for CMHCs. We designated a portion of the estimated 2.0 percent outlier target amount specifically for CMHCs, consistent with the percentage of projected payments to CMHCs under the OPPS in CY 2004, excluding outlier payments.

As stated in the November 7, 2003 final rule with comment period, CMHCs were projected to receive 0.5 percent of the estimated total OPPS payments in CY 2004. The CY 2004 outlier threshold is met when the cost of furnishing services by a CMHC exceeds 3.65 times the APC payment amount. The current outlier payment percentage is 50 percent of the amount of costs in excess of the threshold.

CMS and the Office of the Inspector General are continuing to monitor the excessive outlier payments to CMHCs. However, we do not yet have CY 2004 claims data that will show the effect of the separate outlier threshold for CMHCs that was effective January 1, 2004. Therefore, for CY 2005, as discussed in section X.B. of this preamble, we are continuing to set the target for hospital outpatient outlier payments at 2.0 percent of total OPPS payments. We are also allocating a portion of that 2.0 percent, 0.6 percent, to CMHCs for PHP services. We are adopting as final 0.6 percent for CMHCs because the percentage of CMHC's payment to total OPPS payment rose slightly in the CY 2003 claims data. In the absence of CY 2004 claims data, we developed simulations for CY 2005. As discussed in section X.B. of this final rule, we are establishing a dollar threshold in addition to an APC multiplier threshold for hospital OPPS outlier payments. However, because PHP is the only APC for which CMHCs may receive payment under the OPPS, we would not expect to redirect outlier payments by imposing a dollar threshold. Therefore, we are not establishing a dollar threshold for CMHC outliers. In this final rule, we are setting the outlier threshold for CMHCs for CY 2005 at 3.5 percent times the APC payment amount and the CY 2005 outlier payment percentage applicable to costs in excess of the threshold at 50 percent.

Comment: One commenter expressed concern about a separate outlier threshold for partial hospitalization services because many partial hospitalization programs are hospital based. The commenter recommended that CMS use the same threshold for all hospital services.

Response: We agree that the same outlier policy should apply to all

hospital services. Under OPPS, we establish two sets of outlier thresholds, one for hospitals and one for CMHCs. The higher multiple threshold of 3.5 is reserved for services provided by CMHCs only. Hospitals billing for partial hospitalization will be subject to the outlier thresholds and payment percentages identified for all hospital services.

XI. Beneficiary Copayments for CY 2005

A. Background

Section 1833(t)(3)(B) of the Act requires the Secretary to set rules for determining copayment amounts to be paid by beneficiaries for covered OPD services. Section 1833(t)(8)(C)(ii) of the Act specifies that the Secretary must reduce the national unadjusted copayment amount for a covered OPD service (or group of such services) furnished in a year in a manner so that the effective copayment rate (determined on a national unadjusted basis) for that service in the year does not exceed specified percentages. For all services paid under the OPPS in CY 2005, the specified percentage is 45 percent of the APC payment rate. The statute provides a further reduction in CY 2006 so that the national unadjusted coinsurance for an APC cannot exceed 40 percent in CY 2006 and in calendar years thereafter. Section 1833(t)(3)(B)(ii) of the Act provides that, for a covered OPD service (or group of such services) furnished in a year, the national unadjusted coinsurance amount cannot be less than 20 percent of the OPD fee schedule amount.

Comment: One commenter expressed concern that the law does not further reduce the maximum coinsurance rate for CY 2007. The commenter believed that this may cause coinsurance rates to stagnate at 40 percent for a few years. The commenter indicated that its organization will continue to advocate for a legislative change that would accelerate the copayment buy-down.

Response: We understand the concerns of this organization. In CY 2004, we determined that 63 percent of APCs had a national unadjusted coinsurance rate of 20 percent. Therefore, we will continue to apply our current methodology for calculating national unadjusted coinsurance rates, as explained in earlier **Federal Register** notices, which ensures that the copayments of the remaining 37 percent of APCs will continue to decrease relative to increases in payment rates.

B. Copayment for CY 2005

For CY 2005, we determined copayment amounts for new and revised APCs using the same methodology that we implemented for CY 2004 (see the November 7, 2003 OPPS final rule with comment period, 68 FR 63458). The unadjusted copayment amounts for services payable under the OPPS effective January 1, 2005 are shown in Addendum A and Addendum B of this final rule with comment period.

XII. Addendum Files Available to the Public Via Internet

The data referenced for Addendum C to this final rule with comment period are available on the following CMS Web site via Internet only: *http://www.cms.hhs.gov/providers/hopps/*. We are not republishing the data represented in this Addendum to this final rule with comment period because of its volume. For additional assistance, contact Chris Smith Ritter at (410) 786–0378. Addendum C—Healthcare Common Procedure Coding System (HCPCS) Codes by Ambulatory Payment Classification (APC).

This file contains the HCPCS codes sorted by the APCs into which they are assigned for payment under the OPPS. The file also includes the APC status indicators, relative weights, and OPPS payment amounts.

XIII. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

XIV. Regulatory Impact Analysis

A. OPPS: General

We have examined the impacts of this final rule with comment period as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

1. Executive Order 12866

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

We estimate the effects of the provisions that will be implemented by this final rule with comment period will result in expenditures exceeding $100 million in any 1 year. We estimate the total increase (from changes in this final rule with comment period as well as enrollment, utilization, and case-mix changes) in expenditures under the OPPS for CY 2005 compared to CY 2004 to be approximately $1.5 billion. Therefore, this final rule with comment period is an economically significant rule under Executive Order 12866, and a major rule under 5 U.S.C. 804(2).

2. Regulatory Flexibility Act (RFA)

The RFA requires agencies to determine whether a rule would have a significant economic impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any 1 year (65 FR 69432).

For purposes of the RFA, we have determined that approximately 37 percent of hospitals would be considered small entities according to the Small Business Administration (SBA) size standards. We do not have data available to calculate the percentages of entities in the pharmaceutical preparation manufacturing, biological products, or medical instrument industries that would be considered to be small entities according to the SBA size standards. For the pharmaceutical preparation manufacturing industry (NAICS 325412), the size standard is 750 or fewer employees and $67.6 billion in annual sales (1997 business census). For biological products (except diagnostic) (NAICS 325414), with $5.7 billion in annual sales, and medical instruments (NAICS 339112), with $18.5 billion in annual sales, the standard is 50 or fewer employees (see the standards Web site at *http://www.sba.gov/regulations/siccodes/*). Individuals and States are not included in the definition of a small entity.

3. Small Rural Hospitals

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a

significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we previously defined a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) (or New England County Metropolitan Area (NECMA)). However, under the new labor market definitions that we are adopting in this final rule with comment period (consistent with the FY 2005 IPPS final rule), we no longer employ NECMAs to define urban areas in New England. Therefore, we now define a small rural hospital as a hospital with fewer than 100 beds that is located outside of an MSA. Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the OPPS, we classify these hospitals as urban hospitals. We believe that the changes in this final rule with comment period will affect both a substantial number of rural hospitals as well as other classes of hospitals and that the effects on some may be significant. Therefore, we conclude that this final rule with comment period will have a significant impact on a substantial number of small entities.

4. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in an expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This final rule with comment period does not mandate any requirements for State, local, or tribal governments. This final rule with comment period also does not impose unfunded mandates on the private sector of more than $110 million dollars.

5. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it publishes any rule (proposed or final rule) that imposes substantial direct costs on State and local governments, preempts State law, or otherwise has Federalism implications.

We have examined this final rule with comment period in accordance with Executive Order 13132, Federalism, and have determined that it would not have an impact on the rights, roles, and responsibilities of State, local or tribal governments. The impact analysis (see Table 41) shows that payments to governmental hospitals (including State, local, and tribal governmental hospitals) will increase by 3.7 percent under this final rule with comment period.

Comment: One commenter expressed concern that CMS had removed the eye and ear specialty hospital category from our regulatory impact analysis and requested that we reinstate this line-item. They further requested information on why specific analyses were retained for cancer and children's hospitals.

Response: We removed the specific regulatory impact analysis of eye and ear hospitals because, unlike cancer and children's hospitals, they are not specifically protected by statute. Section 1833(t)(7)(D) of the Act holds harmless cancer hospitals, children's hospitals, small rural hospitals with less than 100 beds, and sole community hospitals in rural areas. These hospitals cannot receive less payment in CY 2005 than they did in the CY 2004. However, because hold harmless provisions for cancer and children's hospitals are permanent, we will not specifically identify these hospital classes in future impact analyses.

Comment: One commenter expressed concern about the observed impact on teaching hospitals, specifically the observed increase of 2.9 percent under the proposed system, which is less than the overall increase modeled for all hospitals of 4.6 percent in the proposed rule. This commenter requested that CMS conduct analyses assessing the need for an adjustment for specific classes of hospitals, which is within CMS' regulatory authority. The commenter further suggested that these analyses assess whether teaching hospitals rely more on pass-through, outlier, transitional corridor, and device-dependent APC payments, and suggested that an adjustment is necessary if this is the outcome.

Response: We agree that it is important to monitor ongoing trends for specific classes of hospitals, and we are especially concerned when hospitals experience a negative increase. In this specific instance, major teaching hospitals are experiencing a positive increase in payments. We also agree that major teaching hospitals may be more dependent on costs estimated outside of the primary impact tables provided in the regulation. However, we are not convinced that a reliance on pass-through, outlier, or transitional corridor payments is a reason to propose an adjustment. This is especially true in light of the outlier policy as proposed, which redirects money to complex and costly procedures that are more likely to be performed at academic medical institutions.

B. Impact of Changes in This Final Rule With Comment Period

We are adopting as final the proposed changes to the OPPS that are required by the statute. We are required under section 1833(t)(3)(C)(ii) of the Act to update annually the conversion factor used to determine the APC payment rates. We are also required under section 1833(t)(9)(A) of the Act to revise, not less often than annually, the wage index and other adjustments. In addition, we must review the clinical integrity of payment groups and weights at least annually. Accordingly, in this final rule with comment period, we are updating the conversion factor and the wage index adjustment for hospital outpatient services furnished beginning January 1, 2005, as we discuss in sections VIII. and IX., respectively, of this final rule with comment period. We also have revised the relative APC payment weights using claims data from January 1, 2003, through December 31, 2003. Finally, we are removing 6 device categories and 13 drugs and biological agents from pass-through payment status. In particular, see section V.A.2 with regard to the expiration of pass-through status for devices and see section IV.A.2 with regard to the expiration of pass-through status for drugs and biological agents.

Under this final rule with comment period, the update change to the conversion factor as provided by statute as well as the additional money for the OPPS payments in CY 2005 as authorized by Pub. L. 108–173, including money for drugs and increases in the wage indices, will increase total OPPS payments by 4.0 percent in CY 2005. The changes to the wage index and to the APC weights (which incorporate the cessation of pass-through payments for several drugs and devices) would not increase OPPS payments because the OPPS is budget neutral. However, the wage index and APC weight changes would change the distribution of payments within the budget neutral system as shown in Table 41 and described in more detail in this section.

C. Alternatives Considered

Alternatives to the changes we are making and the reasons that we have chosen the options we have are discussed throughout this final rule with comment period. Some of the

major issues discussed in this final rule with comment period and the options considered are discussed below.

1. Payment for Device-Dependent APCs

We package payment for an implantable device into the APC payment for the procedure performed to insert the device. Because almost all devices lost pass-through status at the end of CY 2002, we discontinued use of separate codes to report devices in CY 2003. We have found that claims that we use to set payment rates for device-dependent APCs frequently have packaged costs that are much lower than the cost of the device. This is attributed, in part, to variations in hospital billing practices. In response, we reestablished device codes for reporting on a voluntary basis in CY 2004.

The APC Panel recommended that we use CY 2004 device-dependent APC rates updated for inflation as the CY 2005 payments. We considered this option but did not adopt it because it would not recognize changes in relative cost for these APCs and would not advance us towards our goal of using unadjusted claims data as the basis for payment weights for all OPPS services.

In addition to consideration of the APC Panel's recommendation, we considered using CY 2002 claims to calculate a ratio between the median calculated using all single bills and the median calculated using only claims with HCPCS codes for devices on them, and applying that ratio to the median calculated using CY 2003 claims data. We rejected this option because it assumes that the relationship between the costs of the claims with and without codes for devices is a valid relationship not only for CY 2002 but CY 2003 as well. It also assumes no changes in billing behavior. We have no reason to believe either of these assumptions is true and, therefore, we did not choose this option. We also considered using external data provided by manufacturers and other stakeholders as the estimated device cost. We did not choose this alternative because we believe that, in a relative weight system, there should be a single stable and objective source of data for setting relative weights for all items and services for which payment is made in the system.

We do not believe that any of the above options would help us progress toward reliance on our data. Rather than adopt any of those approaches, we developed an option to adjust the payment for only those device-dependent APCs that have the most dramatic decreases for CY 2005. We believe that the better payment approach for determining median costs for device-dependent APCs in CY 2005 is to base these medians on the greater of: (1) Median costs calculated using CY 2003 claims data; or (2) 95 percent of the APC payment median used in CY 2004 for these services. We believe that this adjustment methodology provides an appropriate transition to eventual use of all single bill claims data without adjustment.

We are also requiring hospitals to report C-codes for device categories used in conjunction with procedures billed and paid for under the OPPS. We have decided to implement edits, starting April 1, to enforce the reporting of C-codes to bill for most of the device-dependent procedures for which we adjusted the medians for CY 2005, as well as for a few APCs that require devices that are coming off pass-through payment in CY 2005 (a continuation of current billing practice). We believe that adoption of our proposal will mitigate barriers to beneficiary access to care while encouraging hospitals to bill correctly for the services they furnish. For a more detailed discussion of this issue, see section III.C. of this final rule with comment period.

2. Hospital Outpatient Outlier Payments

In its March 2004 Report, MedPAC made a recommendation to the Congress to eliminate the outlier provision under the OPPS. MedPAC made its recommendation after studying outlier payments on claims for services furnished during CY 2002 and concluding that in 2002, 50 percent of outlier payments were paid for 21 fairly common services that had relatively low APC payment rates, while high cost services accounted for only a small share of outlier payments. However, outlier payments are required under the statute. Therefore, we cannot discontinue outlier payments absent a legislative change by the Congress.

In light of the MedPAC findings, we are adopting a fixed-dollar threshold in addition to the threshold based on a multiple of the APC amount that we have applied since the beginning of the OPPS. A fixed-dollar threshold will redirect OPPS outlier payments toward the complex and expensive services that can create high financial risk for a hospital. In its comments on the proposed rule, MedPAC recognized that elimination of the outlier policy for OPPS requires a legislative change and approved of the proposed policy to adopt a fixed-dollar threshold. For a more detailed discussion of this issue, see section X. of this final rule with comment period.

D. Limitations of Our Analysis

The distributional impacts presented here are the projected effects of the policy changes, as well as the statutory changes that would be effective for CY 2005, on various hospital groups. We estimate the effects of individual policy changes by estimating payments per service while holding all other payment policies constant. We use the best data available but do not attempt to predict behavioral responses to our policy changes. We also do not make adjustments for future changes in variables such as service volume, service mix, or number of encounters.

E. Estimated Impacts of This Final Rule With Comment Period on Hospitals

The estimated increase in the total payments made under OPPS is limited by the increase to the conversion factor set under the methodology in the statute. The distributional impacts presented do not include assumptions about changes in volume and service-mix. However, total payments actually made under the system also may be influenced by changes in volume and service-mix, which CMS cannot forecast. The enactment of Pub. L. 108–173 on December 8, 2003, provided for the payment of additional dollars in 2004 and 2005 to providers of OPPS services outside of the budget neutrality requirements for both specified covered outpatient drugs (see section V.A.3.a. of this final rule with comment period) and the wage indexes for specific hospitals through reclassification reform in section 508 of Pub. L. 108–173 (see section IX. of this final rule with comment period). Table 41 shows the estimated redistribution of hospital payments among providers as a result of a new APC structure and wage indices, which are budget neutral; the estimated distribution of increased payments in CY 2005 resulting from the combined impact of APC recalibration and wage effects, and market basket update to the conversion factor; and estimated payments considering all payments for CY 2005 relative to all payments for CY 2004. In some cases, specific hospitals may receive more total payment in CY 2005 than in CY 2004, while, in other cases, they may receive less total payment than they received in CY 2004. However, our impact analysis suggests that no class of hospitals would receive less total payments in CY 2005 than in CY 2004. Because updates to the conversion factor, including the market basket and any reintroduction of pass-through dollars, are applied uniformly, observed redistributions of payments in the impact table largely depends on the

mix of services furnished by a hospital (for example, how the APCs for the hospital's most frequently furnished services would change) and the impact of the wage index changes on the hospital. However, the extent to which this final rule redistributes money during implementation will also depend on changes in volume, practice patterns, and case-mix of services billed between CY 2003 and CY 2005.

Overall, the final OPPS rates for CY 2005 will have a positive effect for all hospitals paid under OPPS. Adopted changes will result in a 4.0 percent increase in Medicare payments to all hospitals, exclusive of outlier and transitional pass-through payments. As described in the preamble, budget neutrality adjustments are made to the conversion factor and the relative weights to ensure that the revisions in the wage indices, APC groups, and relative weights do not affect aggregate payments. The impact of the wage and APC recalibration changes are fairly moderate across most classes of hospitals.

To illustrate the impact of the CY 2005 changes adopted in this final rule with comment period, our analysis begins with a baseline simulation model that uses the final CY 2004 weights, the FY 2004 final post-reclassification IPPS wage indices, as subsequently corrected, without changes in wage indices resulting from section 508 reclassifications, and the final CY 2004 conversion factor. Columns 2 and 3 in Table 41 reflect the independent effects of the changes in the APC reclassification and recalibration changes and the wage indices, respectively. These effects are budget neutral, which is apparent in the overall zero impact in payment for all hospitals in the top row. Column 2 shows the independent effect of changes resulting from the reclassification of HCPCS codes among APC groups and the recalibration of APC weights based on a complete year of CY 2003 hospital OPPS claims data. We modeled the independent effect of APC recalibration by varying only the weights, the final CY 2004 weights versus the final CY 2005 weights, in our baseline model, and calculating the percent difference in payments. Column 3 shows the impact of updating the wage indices used to calculate payment by applying the final FY 2005 IPPS wage indices, as subsequently corrected. In addition to new wage data, the new IPPS wage indices use the CBSA system as the basis for geographic adjustment for wages, rather than the MSA designations used previously. The FY 2005 IPPS wage indices also include the new adjustment for occupational mix, the reclassifications of hospitals to geographic areas by the MGCRB, the increased payment authorized by section 505 of Pub. L. 108–173 for out-migration, hold-harmless provisions for hospitals redesignated from urban to rural by the new labor market definitions, and the one-year transition, 50/50 blend for hospitals that experienced a decrease in their FY 2005 wage index compared to their FY 2004 wage index due solely to the changes in labor market definitions. The OPPS wage indices used in Column 3 do not include wage increases due to reclassification of hospitals through section 508 of Pub. L. 108–173. We modeled the independent effect of introducing the new wage indices by varying only the wage index between years, using CY 2004 weights, and a CY 2004 conversion factor that included a budget neutrality adjustment for changes in wage effects between 2004 and 2005.

Column 4 demonstrates the combined ''budget neutral'' impact of APC recalibration and wage index updates on various classes of hospitals, as well as the impact of updating the conversion factor with the market basket. We modeled the independent effect of budget neutrality adjustments and the market basket update by using the weights and wage indices for each year, and using a CY 2004 conversion factor that included a budget neutrality adjustment for differences in wages and the market basket increase. Finally, column 5 depicts the full impact of final CY 2005 policy on each hospital group by including the effect of all the changes for CY 2005 and comparing them to the full effect of all payments in CY 2004, including those authorized by Pub. L. 108–173. Column 5 shows not only the combined budget neutral effects of APC and wage updates, and the market basket update, but it also shows the effects of additional monies added to the OPPS as a result of Pub. L. 108–173 and pass-through money returned to the conversion factor from CY 2004. We modeled the independent effect of all changes using the final weights for CY 2004 and CY 2005 with additional money for drugs authorized by section 621 of Pub. L. 108–173, final wage indices including wage index increases for hospitals eligible for reclassification under section 508 of Pub. L. 108–173, and the CY 2005 conversion factor of $56.983.

Column 1: Total Number of Hospitals

Column 1 in Table 41 shows the total number of hospital providers (4,296) for which we were able to use CY 2003 hospital outpatient claims to model CY 2004 and CY 2005 payments by classes of hospitals. We excluded all hospitals for which we could not accurately estimate CY 2004 or CY 2005 payment and entities that are not paid under the OPPS. The latter include critical access hospitals, all-inclusive hospitals, and hospitals located in Guam, the U.S. Virgin Islands, and the State of Maryland. This process is discussed in greater detail in section III.B of this final rule with comment period. In prior years, we displayed non-TEFRA hospitals paid under PPS separately from TEFRA hospitals in our impact and outlier tables. The distinction between TEFRA and non-TEFRA holds little value for OPPS as all hospitals are treated equally under the OPPS payment system. For this reason, we did not include TEFRA hospitals as a distinct hospital category in Table 41. The impact on this specific class of hospitals is captured in the rows addressing disproportionate share (DSH) as we only calculate a DSH variable for hospitals participating in the IPPS. Finally, of the hospitals displayed in Table 41 and Table 42, it is important to note that section 1833(t)(7)(D) of the Act holds harmless cancer hospitals, children's hospitals, small rural hospitals with less than 100 beds, and sole community hospitals in rural areas. The hold harmless provisions for cancer and children's hospitals are permanent; these hospitals cannot receive less payment in CY 2005 than they did in the CY 2004. For this reason, we will not specifically identify these classes of hospitals in future impact analyses.

Column 2: APC Recalibration

The APC reclassification and recalibration changes tend to favor rural hospitals especially those characterized as small, although the overall redistribution impact is modest. Rural hospitals show a 0.6 percent increase, which is somewhat less than that observed in the proposed rule of 0.9. Specifically, rural hospitals with 50 to 100 beds show a 0.8 percent increase and rural hospitals with 101 to 149 beds show a 0.7 percent increase attributable to the APC recalibration. Mid-volume hospitals performing between 11,000 and 20,999 services experience an increase of 1.0 percent. Rural hospitals also show overall increases by region, with the East North Central and East South Central regions benefiting by at least 0.9 percent and the South Atlantic and West North Central regions benefiting by 0.7 percent.

Urban hospitals show, on an average, a 0.2 percent decrease, which is comparable to that observed in the

proposed rule. This decrease is spread among all urban hospitals. Large urban hospitals experience a decline of 0.1 percent and ''other'' urban hospitals experience a decline of 0.2 percent. Urban hospitals with greater than 200 beds show decreases, and the largest urban hospitals with bed size greater than 500 report a decrease of 0.9 percent. The smallest urban hospitals report a positive percent increases. Urban hospitals providing the lowest volume of services and those providing the highest also demonstrate negative impacts from APC recalibration. Decreases for urban hospitals are also concentrated in some regions, specifically, the South Atlantic, West South Central, Mountain, and Pacific experience decreases of at least 0.1 percent. West South Central loses the most, 0.9 percent.

The largest observed impacts among other hospital classes resulting from APC recalibration include declines of 1 percent for major teaching hospitals and 2.3 percent for hospitals without a valid DSH variable, most of which are TEFRA hospitals. Hospitals treating more low-income patients (high DSH percentage) also demonstrate declines of 0.8 percent. However, hospitals treating fewer low-income patients experience positive impacts from APC recalibration. Government hospitals demonstrate a decline of 0.8 percent. The specialty hospitals, cancer and children's hospitals, also would experience declines of 2.4 and 1.5 percent due to APC recalibration, respectively, if they were not held harmless under section 1833(t)(7)(D) of the Act.

In general, APC changes effect the distribution of hospital payments by increasing payments to small rural hospitals while decreasing payments made to large urban hospitals, including major teaching hospitals and those serving a high percentage of low-income patients.

Column 3: Wage Effect

Changes introduced by the new IPPS wage indices had a modest impact, but the distributions have changed since the proposed rule with the changes and additional provisions included in the final IPPS wage indices. Decreases in OPPS payment due to the new wage indices are generally located in rural hospitals, although specific classes of other hospitals also experience declines. Overall, urban hospitals experience no change in payments as a result of the new wage indices. However, large urban hospitals experience an increase of 0.1 percent. We estimate that rural hospitals will experience a decrease in payments of 0.2 percent. This pattern of urban gain and rural loss is evident in all of the urban and rural comparisons. Low-volume urban hospitals with fewer than 5,000 services and urban hospitals in the West South Central region show the largest percentage increase of 0.5.

Rural hospitals show modest decreases for most bed sizes but show the largest losses for hospitals with more than 200 beds. The new wage indices result in a 0.5 percent decrease for the largest rural hospitals. Similarly, high volume rural hospitals demonstrate an anticipated decline of 0.4 percent. Hospitals located in the New England and Middle Atlantic regions show a negative impact due to wage index changes regardless of urban or rural designation. However, rural hospitals in New England and the Middle Atlantic experience the largest decreases among regions of 0.7 and 0.6 percent, respectively. Rural hospitals in the South Atlantic, East North Central, East South Central, and Mountain regions also experience decreased payments. Rural sole community hospitals show the same impact as other rural hospitals; they experience a decline of 0.2 percent.

Looking across other categories of hospitals, major teaching hospitals are estimated to lose 0.3 percent. Almost all hospitals serving low-income patients lose 0.1 percent. Hospitals for which DSH is not available, mostly TEFRA hospitals, lose 0.3 percent.

Column 4: Budget Neutrality and Market Basket Update

In general, the market basket update alleviates any negative impacts on payments created by the budget neutrality adjustments made in columns 2 and 3. As column 4 demonstrates, with the addition of the market basket update, we do not expect any class of hospital providers to experience an overall negative impact as a result of the proposed changes to OPPS for CY 2005. Further, the redistributions created by APC recalibration tend to offset those created by the new wage indices. For example, rural hospitals gain 0.6 percent from the APC changes but lose 0.2 percent as a result of changes to the wage indices, leading to an overall adjustment of 3.7 percent with the addition of the market basket. Urban hospitals show a decrease of 0.2 percent resulting from APC recalibration and no change as a result of the new wage index, leading to an update in column 4 of 3.2 percent.

For several classes of hospitals, positive or neutral wage effects do not offset the larger impacts of APC recalibration leading to lower update amounts. For example, low volume urban hospitals experience a negative APC recalibration effect of 1.1, but a positive wage effect of 0.5. The result is an overall update of 2.6, which is less than the market basket. A few hospital providers may experience much lower and much higher update amounts than the market basket because the combined impact of the budget neutrality adjustments for the APC recalibration and the new wage index are reinforcing. Urban hospitals with more than 500 beds show a gain of 2.2 percent because the impact of APC recalibration was −0.9 percent and the new wage indices added −0.1 percent. Major teaching hospitals experience a decline in payment due to APC recalibration of −1.0 and a decline due to wage indices of −0.3 resulting in an overall, budget neutral update of 2.0. Hospitals for which we have no DSH variable, mostly TEFRA hospitals, will experience a decrease in payments due to both APC recalibration and the new wage indices, leading to a budget neutral increase of 0.7 percent. Hospitals serving a high number of low-income patients experience an overall update of 2.4 percent. Finally, cancer hospitals show an update of only 0.2 percent, and children's hospitals, of only 2.0 percent, but statutory provisions ensure that each of these hospitals is ''held harmless'' relative to last year's payments.

A few hospitals may also gain from the combined positive effect of the APC recalibration and the wage effect. Overall, mid-volume urban hospitals and urban hospitals with a small number of beds, rural hospitals in the East South and North Central, West North and South Central, and nonteaching hospitals experience positive impacts from both APC recalibration and the new wage indices.

Column 5: All Changes for CY 2005

Column 5 compares all changes for CY 2005 to a final simulated payment for CY 2004 and includes all additional dollars resulting from provisions in Pub. L. 108–173 in both years and the difference in pass-through estimates. Overall, we estimate that hospitals will gain 4.0 percent under this final rule with comment period relative to total spending with Pub. L. 108–173 dollars for drugs and wage indices in CY 2004. Hospitals do receive a 4.5-percent increase in dollars (3.3 percent for the market basket and 1.2 percent for pass-through dollars returned to the conversion factor), which is reflected in the conversion factor. However, hospitals received more additional money from provisions in Pub. L. 108–173 for spending on drugs and wage

indices in CY 2004 than in CY 2005. This is largely a result of the decline in the statutory minimum payment for sole source specified covered outpatient drugs from 88 percent to 83 percent of AWP. The observed 4.0 percent reflects this difference in spending.

Some hospitals experience large increases in addition to those already garnered under budget neutrality. In rural areas, hospitals providing between 11,000 and 20,999 services are projected to experience an increase of 5.1 percent. Rural hospitals in the East South Central, West North Central, and West South Central are all projected to experience an increase of at least 5 percent. Very small urban hospitals, less than 99 beds, will experience an increase of 4.9 percent. On the other hand, a handful of types of hospitals will experience much smaller updates. Large urban hospitals will receive an update of 3.9 percent. Urban hospitals in the Middle Atlantic and Mountain regions will experience updates less than or equal to 3.5 percent. Rural hospitals in New England and the Middle Atlantic also have updates less than or equal to 3.5 percent.

Major teaching hospitals are projected to experience a smaller increase in payments, 2.6 percent, than the 4.0 percent aggregate for all hospitals due to negative impacts from both the APC recalibration, the new wage indices, and most probably the decline in spending for drugs under Pub. L. 108–73. Hospitals serving a disproportionate share of low-income patients also experience a lower increase, 3.4 percent. Hospitals for which there is no DSH information, mostly TEFRA hospitals, are estimated to receive an update of 0.3 percent. This low-observed increase appears to be largely due to APC recalibration issues and declines in the payment for drugs. The impact of final payment on the specialty hospitals, cancer and children's hospitals, is not shown. If these hospitals were paid under OPPS, the cancer hospitals would experience a negative impact. However, these hospitals are held harmless and, therefore, will not experience any decline in payment. As noted above, we do not intend to specifically identify these hospitals in our future impact analyses.

F. Projected Distribution of Outlier Payments

As stated in section X.B. of this preamble, we have a projected target of 2 percent of the estimated CY 2005 expenditures to outlier payments. For CY 2005, we are adopting a fixed-dollar threshold. As discussed in section X.B. of the preamble, we are changing our current policy, which sets the outlier threshold using only a multiple of the APC payment rate, to a policy that includes both a multiple of the APC payment rate and a new fixed dollar threshold. This policy will better target outlier payments to higher cost, complex cases that create greater financial risk for hospitals.

For CY 2005, we are specifically proposing to require that, in order to qualify for an outlier payment, the cost of a service must exceed 1.75 times the APC payment rate and the cost must also exceed the sum of the APC rate plus a $1,175 fixed-dollar threshold. The outlier payment under this policy remains at 50 percent of the cost minus the multiple of the APC payment rate.

Table 42 below compares the percentage of outlier payments relative to total projected payments for the simulated CY 2004 and CY 2005 outlier policies. As discussed in section X.B. of this preamble, we included a charge inflation factor in our modeling for this final rule with comment period that was not included in our modeling for the proposed rule. This resulted in increased thresholds for both the simulated CY 2004 and final CY 2005 outlier policies. To provide an accurate comparison for the new policy, we estimated the CY 2004, multiple-only policy, using the CY 2003 claims with inflated charges to pay total outlier payments that are 2 percent of total estimated spending. This resulted in a multiple threshold of 2.95.

Overall, Table 42 demonstrates that the outlier policy accomplishes the goal of redistributing outlier payments to hospitals performing more expensive procedures and incurring greater financial risk. Notwithstanding the inclusion of a charge inflation factor, the observed distributions for both policies differ very little from those provided in the proposed rule. First, based on the mix of services for the hospitals that would be paid under the OPPS in CY 2005, fewer hospitals would receive outlier payments. This is appropriate as more outlier money is targeted to specific services. We estimate that approximately 85 percent of all hospitals will receive outlier payments under the new policy, whereas 95 percent of all hospitals were estimated to get outlier payments under the CY 2004 policy.

We estimate that the redistribution of outlier payments is modest, rarely shifting total payments by more than 1 percent. In light of this, many hospitals receiving outlier payments under the previous policy will continue to receive outlier payments but for a different set of services. Nonetheless, this final outlier policy appears to accomplish the goal of redirecting payments to high-cost, expensive services. The adopted outlier policy tends to benefit large urban hospitals, teaching hospitals, proprietary hospitals, and hospitals serving a moderate share of low-income patients. The distribution observed here may offset the less than average increases in payment observed for these same classes of hospitals in the overall impact Table 41. Selected hospitals are predicted to lose outlier payments. Rural hospitals, specifically those that show a small number of beds and provide a low volume of services, are eligible for fewer outlier payments when compared to other types of hospital categories, but, in general, these hospitals experience greater OPPS payment increases. Government hospitals experience a decrease in outlier payments of 0.3 percent, and TEFRA hospitals are projected to lose 1.2 percent in outlier payments.

G. Estimated Impacts of This Final Rule With Comment Period on Beneficiaries

For services for which the beneficiary pays a coinsurance of 20 percent of the payment rate, the beneficiary share of payment will increase for services for which OPPS payments will rise and will decrease for services for which OPPS payments will fall. For example, for a mid-level office visit (APC 0601), the minimum unadjusted copayment in CY 2004 was $10.71. In this final rule with comment period, the minimum unadjusted copayment for APC 601 is $11.22 because the OPPS payment for the service will increase under this final rule with comment period. In another example, for a Level III Pathology Procedure (APC 0344), the minimum unadjusted copayment in CY 2004 was $17.16. In this final rule with comment period, the minimum unadjusted copayment for APC 0344 is $15.66 because the minimum unadjusted copayment is limited to 45 percent of the APC payment rate for CY 2005, as discussed in section XI. of this final rule with comment period.

However, in all cases, the statute limits beneficiary liability for co-payment for a service to the inpatient hospital deductible for the applicable year. This amount is $912 for CY 2005.

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Table 41.—Impact Changes for CY 2005 Hospital Outpatient Prospective Payment System

	(1) Number of Hospitals	(2) APC Changes	(3) New Wage Index	(4) Market Basket and Budget Neutrality	(5) All CY 2005 Effects to All CY 2004 Effects: includes additional PT and MMA $
ALL HOSPITALS	4,296	0.0	0.0	3.3	4.0
Urban Hospitals	2,981	-0.2	0.0	3.2	3.9
Large Urban (greater than 1 million)	1,613	-0.1	0.1	3.3	3.9
Other Urban (less than or equal to 1 million)	1,368	-0.2	0.0	3.1	3.9
Rural Hospitals	1,315	0.6	-0.2	3.7	4.5
BEDS (URBAN)					
0 - 99 Beds	929	0.6	0.3	4.3	4.9
100-199 Beds	990	0.3	0.0	3.6	4.3
200-299 Beds	508	-0.1	0.2	3.4	4.2
300-499 Beds	397	-0.2	0.0	3.0	3.7
500 + Beds	157	-0.9	-0.1	2.2	3.2
BEDS (RURAL)					
0 - 49 Beds[2]	584	0.4	0.1	3.9	4.6
50- 100 Beds[2]	437	0.8	-0.1	4.1	4.7
101- 149 Beds	183	0.7	-0.2	3.8	4.4
150- 199 Beds	62	0.1	-0.2	3.1	4.3
200 + Beds	49	0.4	-0.5	3.1	4.4
VOLUME (URBAN)					

	(1) Number of Hospitals	(2) APC Changes	(3) New Wage Index	(4) Market Basket and Budget Neutrality	(5) All CY 2005 Effects to All CY 2004 Effects: includes additional PT and MMA $
Less than 5,000 Lines	636	-1.1	0.5	2.6	3.8
5,000 - 10,999 Lines	291	0.0	0.4	3.7	4.8
11,000 - 20,999 Lines	410	0.6	0.3	4.3	5.2
21,000 - 42,999 Lines	665	0.2	0.1	3.5	4.5
Greater than 42,999 Lines	979	-0.3	0.0	3.0	3.7
VOLUME (RURAL)					
Less than 5,000 Lines	186	0.0	0.0	3.3	4.9
5,000 - 10,999 Lines	312	-0.2	-0.1	2.9	3.8
11,000 - 20,999 Lines	387	1.0	0.1	4.4	5.1
21,000 - 42,999 Lines	301	0.7	-0.1	4.0	4.7
Greater than 42,999 Lines	129	0.3	-0.4	3.2	4.1
REGION (URBAN)					
New England	169	0.1	-0.2	3.2	3.7
Middle Atlantic	396	0.0	-0.2	3.1	3.5
South Atlantic	458	-0.5	0.1	2.9	4.1
East North Central	478	0.2	0.0	3.5	4.2
East South Central	196	0.0	-0.3	3.0	3.9
West North Central	192	0.0	0.0	3.4	4.3
West South Central	432	-0.9	0.5	2.9	3.9
Mountain	168	-0.4	-0.2	2.7	3.3
Pacific	440	-0.1	0.1	3.4	4.2
Puerto Rico	52	0.8	-0.1	4.0	5.0
REGION (RURAL)					
New England	38	0.2	-0.7	2.7	3.0
Middle Atlantic	79	0.1	-0.6	2.7	3.5
South Atlantic	191	0.7	-0.1	3.9	4.6
East North Central	189	1.0	-0.3	4.0	4.9
East South Central	205	0.9	-0.2	4.0	5.0

	(1) Number of Hospitals	(2) APC Changes	(3) New Wage Index	(4) Market Basket and Budget Neutrality	(5) All CY 2005 Effects to All CY 2004 Effects: includes additional PT and MMA $
West North Central	205	0.7	0.1	4.2	5.1
West South Central	247	0.3	0.3	4.0	5.0
Mountain	99	-0.1	-0.3	2.9	3.7
Pacific	62	-0.8	0.3	2.8	3.6
TEACHING STATUS					
Nonteaching	3,171	0.4	0.1	3.8	4.6
Minor	807	-0.1	0.0	3.3	4.1
Major	318	-1.0	-0.3	2.0	2.6
DSH PATIENT PERCENTAGE					
0	5	2.3	0.6	6.3	7.6
Greater than 0 - 0.10	502	0.3	-0.1	3.5	4.4
0.10 - 0.16	633	0.2	-0.1	3.4	4.2
0.16 - 0.23	856	0.3	-0.1	3.5	4.3
0.23 - 0.35	910	-0.1	0.2	3.5	4.2
Greater than or equal to 0.35	770	-0.8	-0.1	2.4	3.4
DSH Not Available[1]	620	-2.3	-0.3	0.7	0.3
URBAN TEACHING/DSH					
Teaching & DSH	962	-0.4	-0.1	2.8	3.6
No Teaching/DSH	1466	0.3	0.2	3.8	4.7
No Teaching/No DSH	4	1.8	0.7	5.9	7.3
DSH Not Available[1]	549	-2.6	-0.1	0.6	0.2
RURAL HOSPITAL TYPES					
No Special Status	815	0.7	-0.1	3.9	4.6
SCH[2]	500	0.3	-0.2	3.4	4.5
TYPE OF OWNERSHIP					

	(1) Number of Hospitals	(2) APC Changes	(3) New Wage Index	(4) Market Basket and Budget Neutrality	(5) All CY 2005 Effects to All CY 2004 Effects: includes additional PT and MMA $
Voluntary	2,498	0.1	0.0	3.4	4.1
Proprietary	1,031	-0.1	0.0	3.3	4.3
Government	767	-0.8	0.1	2.6	3.6
SPECIALTY HOSPITALS[2]					
Cancer	11	-2.4	-0.6	0.2	
Children's	46	-1.5	0.3	2.0	

(1) Total hospitals in CY 2005.

(2) This column shows the impact of changes resulting from the reclassification of HCPCS codes among APC groups and the recalibration of APC weights based on CY 2003 hospital claims data.

(3) This column shows the impact of updating the wage index used to calculate payment by applying the final FY 2005 IPPS wage indices, as corrected including the impact of new wage data, occupational mix, CBSA system, geographic reclassification by the MGCRB, and any technical corrections or updates made in the IPPS final rule and subsequent correction notices.

(4) This column shows the combined impact of budget neutrality (columns 2 and 3) with the market basket update.

(5) This column shows changes in total payment from CY 2004 to CY 2005, excluding outlier and pass-through payments. It incorporates all of the changes reflected in columns 2, 3, and 4. In addition, it shows the impact of payment for drugs under MMA, 508 additions to the wage index, and any additional pass through money included in the conversion factor.

1 Complete DSH numbers are not available for some hospitals, including TEFRA hospitals.

2 Section 1833(t)(7)(D) of the Act holds harmless cancer hospitals, children's hospitals, small rural hospitals with 100 or fewer beds beds, and sole community hospitals located in rural areas.

Table 42.--Distribution of Outlier Payments for 2005 Hospital Outpatient Prospective Payment System

	(1) 2004 Policy Adjusted to 2005 Total Outlier Target: 2.95 Multiple Threshold and No Fixed Dollar Threshold			(2) 2005 Policy 1.75 Multiple Threshold and Separate $1,175 Threshold		
	Number of Hospitals	Number of Hospitals with Outliers	Outlier Payments as a Percent of Total Payments	Number of Hospitals with Outliers	Outlier Payments as a Percent of Total Payments	Percent Change in Total Payments Attributable to Differences in Outlier Policies [2]
ALL HOSPITALS	4,296	4,075	2.0	3,671	2.0	0.0
Urban Hospitals	2,981	2,774	2.0	2,496	2.1	0.1
Large Urban (greater than 1 million)	1,613	1,499	2.3	1,364	2.2	0.0
Other Urban (less than or equal to I million	1,368	1,275	1.8	1,132	2.0	0.2
Rural Hospitals	1,315	1,301	1.6	1,175	1.2	-0.4
BEDS (URBAN)						
0 – 99 Beds	929	770	2.0	564	1.7	-0.3
100-199 Beds	990	948	1.8	887	1.7	-0.1
200-299 Beds	508	503	1.8	493	1.9	0.1
300-499 Beds	397	396	2.0	395	2.1	0.1
500 + Beds	157	157	2.7	157	2.9	0.3
BEDS (RURAL)						
0 – 49 Beds	584	576	2.2	472	1.2	-1.0
50- 100 Beds	437	431	1.5	410	1.1	-0.4
101- 149 Beds	183	183	1.4	182	1.1	-0.3
150- 199 Beds	62	62	1.4	62	1.2	-0.2
200 + Beds	49	49	1.3	49	1.3	0.0
VOLUME (URBAN)						
Less than 5,000 Lines	636	435	3.3	207	2.5	-0.8
5,000 - 10,999 Lines	291	287	2.1	249	1.9	-0.2
11,000 – 20,999 Lines	410	408	2.0	397	2.1	0.0

	(1) 2004 Policy Adjusted to 2005 Total Outlier Target: 2.95 Multiple Threshold and No Fixed Dollar Threshold			(2) 2005 Policy 1.75 Multiple Threshold and Separate $1,175 Threshold		
	Number of Hospitals	Number of Hospitals with Outliers	Outlier Payments as a Percent of Total Payments	Number of Hospitals with Outliers	Outlier Payments as a Percent of Total Payments	Percent Change in Total Payments Attributable to Differences in Outlier Policies [2]
21,000 – 42,999 Lines	665	665	1.9	664	1.9	0.0
Greater than 42,999 Lines	979	979	2.1	979	2.2	0.1
VOLUME (RURAL)						
Less than 5,000 Lines	186	172	3.2	98	1.7	-1.5
5,000 - 10,999 Lines	312	312	2.3	268	1.3	-1.1
11,000 - 20,999 Lines	387	387	1.9	380	1.2	-0.7
21,000 - 42,999 Lines	301	301	1.4	300	1.1	-0.3
Greater than 42,999 Lines	129	129	1.3	129	1.1	-0.2
REGION (URBAN)						
New England	169	156	2.0	139	1.6	-0.4
Middle Atlantic	396	378	2.5	349	2.3	-0.2
South Atlantic	458	425	1.9	393	2.2	0.3
East North Central	478	446	1.9	412	2.0	0.1
East South Central	196	182	1.6	161	1.8	0.2
West North Central	192	186	1.5	167	1.6	0.1
West South Central	432	381	2.5	319	2.4	-0.2
Mountain	168	155	2.1	134	2.3	0.1
Pacific	440	417	2.1	387	2.5	0.4
Puerto Rico	52	48	1.2	35	1.8	0.6
REGION (RURAL)						
New England	38	36	1.7	37	1.4	-0.2
Middle Atlantic	79	79	1.4	76	0.7	-0.8
South Atlantic	191	189	1.4	185	1.1	-0.3
East North Central	189	188	1.4	186	1.2	-0.2

	(1) 2004 Policy Adjusted to 2005 Total Outlier Target: 2.95 Multiple Threshold and No Fixed Dollar Threshold			(2) 2005 Policy 1.75 Multiple Threshold and Separate $1,175 Threshold		
	Number of Hospitals	Number of Hospitals with Outliers	Outlier Payments as a Percent of Total Payments	Number of Hospitals with Outliers	Outlier Payments as a Percent of Total Payments	Percent Change in Total Payments Attributable to Differences in Outlier Policies [2]
East South Central	205	203	1.2	163	0.8	-0.4
West North Central	205	203	1.6	184	1.3	-0.3
West South Central	247	243	1.7	192	1.1	-0.6
Mountain	99	99	2.6	92	2.1	-0.6
Pacific	62	61	2.2	60	1.6	-0.6
TEACHING STATUS						
Nonteaching	3,171	2,964	1.6	2,581	1.5	-0.1
Minor	807	793	1.7	776	1.8	0.1
Major	318	318	3.1	314	3.2	0.1
DSH PATIENT PERCENTAGE						
0	5	5	2.5	3	4.2	1.8
Greater than 0 - 0.10	502	502	1.8	477	1.8	0.0
0.10 - 0.16	633	633	1.6	614	1.5	-0.1
0.16 - 0.23	856	855	1.7	818	1.7	0.1
0.23 - 0.35	910	906	1.8	872	1.9	0.1
Greater than or equal to 0.35	770	769	3.0	721	2.9	-0.1
DSH Not Aavilable[1]	620	405	3.0	166	1.8	-1.2
URBAN TEACHING/DSH						
Teaching & DSH	962	962	2.3	959	2.4	0.2
No Teaching/DSH	1,466	1,462	1.7	1,408	1.7	0.0
No Teaching/NO DSH	4	4	3.4	3	5.7	2.4
DSH Not Available[1]	549	346	3.1	126	1.8	-1.2
RURAL HOSPITAL TYPES						

	(1) 2004 Policy Adjusted to 2005 Total Outlier Target: 2.95 Multiple Threshold and No Fixed Dollar Threshold			(2) 2005 Policy 1.75 Multiple Threshold and Separate $1,175 Threshold		
	Number of Hospitals	Number of Hospitals with Outliers	Outlier Payments as a Percent of Total Payments	Number of Hospitals with Outliers	Outlier Payments as a Percent of Total Payments	Percent Change in Total Payments Attributable to Differences in Outlier Policies [2]
No special Status	815	801	1.5	716	1.1	-0.4
SCH[3]	500	500	1.7	459	1.2	-0.4
TYPE OF OWNERSHIP						
Voluntary	2,498	2,442	1.9	2,305	1.9	0.0
Proprietary	1,031	877	1.6	715	1.8	0.2
Government	767	756	2.7	651	2.4	-0.3
SPECIALTY HOSPITALS						
Cancer[3]	11	11	3.5	11	2.2	
Children's[3]	46	44	9.2	38	9.0	

(1) The column shows the impact of the CY 2004 policy, after adjusting the multiple to pay the 2 percent of estimated CY 2005 total payments.
FY 2005 costs were estimated from 2003 claims using a charge inflation factor of 1.1876.
The outlier threshold is 2.95 times the APC payment, and the outlier payment is 50 percent of the observed cost less 2.95 times APC payment

(2) This column shows the impact of the CY 2005 policy.
CY 2005 costs were estimated from CY 2003 claims using a charge inflation factor of 1.1876.
The outlier thesholds are 1.75 times the APC payment and $1,175 plus the APC payment.
The outlier payment is 50 percent of the observed cost less 1.75 times the APC payment

1 DSH is not available for some hospitals, including TEFRA.

2 Calculated differences may not be exact due to rounding.

3 Section 1833(t)(7)(D) of the Act holds harmless cancer hospitals, children's hospitals, small rural hospitals with 100 or fewer beds and sole community hospitals located in rural areas.

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Conclusion

The changes in this final rule with comment period affect all classes of hospitals. Some hospitals experience significant gains and others less significant gains, but all hospitals will experience positive updates in OPPS payments in CY 2005. Table 41 demonstrates the estimated distributional impact of the OPPS budget neutrality requirements and an additional 4.0 percent increase in payments for CY 2005, exclusive of outlier and transitional pass-through payments, across various classes of hospitals. Table 42 demonstrates the distributional impact of outlier payments under the new policy of a multiple and fixed-dollar threshold. These two tables and the accompanying discussion, in combination with the rest of this final rule with comment period, constitute a regulatory impact analysis.

In accordance with the provisions of Executive Order 12866, this final rule with comment period was reviewed by the Office of Management and Budget.

XV. Regulation Text

List of Subjects in 42 CFR Part 419

Hospitals, Medicare, Reporting and recordkeeping requirements.

■ For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR Chapter IV, Part 419, as set forth below:

PART 419—PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

■ 1. The authority citation for Part 419 continues to read as follows:

Authority: Secs. 1102, 1833(t), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395l(t), and 1395hh).

■ 2. Section 419.21 is amended by adding a new paragraph (e) to read as follows:

§ 419.21 Hospital outpatient services subject to the outpatient prospective payment system.

* * * * *

(e) Effective January 1, 2005, an initial preventive physical examination, as defined in § 410.16 of this chapter, if the examination is performed no later than 6 months after the individual's initial Part B coverage date that begins on or after January 1, 2005.

■ 3. Section 419.22 is amended by adding a new paragraph (s) to read as follows:

§ 419.22 Hospital outpatient services excluded from payment under the hospital outpatient prospective payment system.

* * * * *

(s) Effective December 8, 2003, screening mammography services and effective January 1, 2005, diagnostic mammography services.

■ 4. Section 419.64 is amended by revising paragraph (d) to read as follows:

§ 419.64 Transitional pass-through payments: Drugs and biologicals.

* * * * *

(d) *Amount of pass-through payment.* Subject to any reduction determined under § 419.62(b), the pass-through payment for a drug or biological equals the amount determined under section 1842(o) of the Social Security Act, minus the portion of the APC payment amount that CMS determines is associated with the drug or biological.

■ 5. Section 419.70 is amended by revising the section heading and paragraphs (f)(2)(i) and (f)(2)(ii) to read as follows:

§ 419.70 Transitional adjustment to limit decline in payments.

* * * * *

(f) *Pre-BBA amount defined.* * * *

(2) *Base payment-to-cost ratio defined.* * * *

(i) The provider's payment under this part for covered outpatient services furnished during one of the following periods, including any payment for these services through cost-sharing described in paragraph (e) of this section:

(A) The cost reporting period ending in 1996; or

(B) If the provider does not have a cost reporting period ending in 1996, the first cost reporting period ending on or after January 1, 1997, and before January 1, 2001; and

(ii) The reasonable costs of these services for the same cost reporting period.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: October 28, 2004.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Dated: October 28, 2004.

Tommy G. Thompson,

Secretary.

Addendum A.--List of Ambulatory Payment Classifications (APCs) With Status Indicators, Relative Weights, Payment Rates, and Copayment Amounts Calendar Year 2005

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0001	Level I Photochemotherapy	S	0.4007	22.83	7.00	4.57
0002	Level I Fine Needle Biopsy/Aspiration	T	0.9553	54.44		10.89
0003	Bone Marrow Biopsy/Aspiration	T	2.4779	141.20		28.24
0004	Level I Needle Biopsy/ Aspiration Except Bone Marrow	T	1.7081	97.33	22.36	19.47
0005	Level II Needle Biopsy/Aspiration Except Bone Marrow	T	3.7391	213.07	71.59	42.61
0006	Level I Incision & Drainage	T	1.6854	96.04	23.26	19.21
0007	Level II Incision & Drainage	T	12.4496	709.42		141.88
0008	Level III Incision and Drainage	T	19.3572	1103.03		220.61
0009	Nail Procedures	T	0.6817	38.85	8.34	7.77
0010	Level I Destruction of Lesion	T	0.5940	33.85	9.65	6.77
0011	Level II Destruction of Lesion	T	2.4040	136.99	27.88	27.40
0012	Level I Debridement & Destruction	T	0.7477	42.61	11.18	8.52
0013	Level II Debridement & Destruction	T	1.1380	64.85	14.20	12.97
0015	Level III Debridement & Destruction	T	1.7248	98.28	20.35	19.66
0016	Level IV Debridement & Destruction	T	2.8321	161.38	57.31	32.28
0017	Level VI Debridement & Destruction	T	17.3894	990.90	227.84	198.18
0018	Biopsy of Skin/Puncture of Lesion	T	0.9669	55.10	16.04	11.02
0019	Level I Excision/ Biopsy	T	4.1677	237.49	71.87	47.50
0020	Level II Excision/ Biopsy	T	7.6248	434.48	113.25	86.90
0021	Level III Excision/ Biopsy	T	14.8872	848.32	219.48	169.66
0022	Level IV Excision/ Biopsy	T	19.3700	1103.76	354.45	220.75
0023	Exploration Penetrating Wound	T	3.2236	183.69	40.37	36.74
0024	Level I Skin Repair	T	1.7742	101.10	33.10	20.22
0025	Level II Skin Repair	T	4.7315	269.62	101.85	53.92
0027	Level IV Skin Repair	T	16.8355	959.34	329.72	191.87
0028	Level I Breast Surgery	T	18.7869	1070.53	303.74	214.11
0029	Level II Breast Surgery	T	31.3655	1787.30	632.64	357.46
0030	Level III Breast Surgery	T	39.2810	2238.35	763.55	447.67
0032	Insertion of Central Venous/Arterial Catheter	T	10.7448	612.27		122.45
0033	Partial Hospitalization	P	4.9370	281.33		56.27
0035	Placement of Arterial or Central Venous Catheter	T	0.2889	16.46		3.29
0036	Level II Fine Needle Biopsy/Aspiration	T	2.2377	127.51		25.50
0037	Level III Needle Biopsy/Aspiration Except Bone Marrow	T	9.3421	532.34	234.20	106.47
0039	Level I Implantation of Neurostimulator	S	219.9203	12531.72		2506.34

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0040	Level II Implantation of Neurostimulator Electrodes	S	49.2740	2807.78		561.56
0041	Level I Arthroscopy	T	28.0254	1596.97		319.39
0042	Level II Arthroscopy	T	43.5802	2483.33	804.74	496.67
0043	Closed Treatment Fracture Finger/Toe/Trunk	T	1.8527	105.57		21.11
0045	Bone/Joint Manipulation Under Anesthesia	T	14.2091	809.68	268.47	161.94
0046	Open/Percutaneous Treatment Fracture or Dislocation	T	35.1105	2000.70	535.76	400.14
0047	Arthroplasty without Prosthesis	T	31.0492	1769.28	537.03	353.86
0048	Level I Arthroplasty with Prosthesis	T	40.3978	2301.99	570.30	460.40
0049	Level I Musculoskeletal Procedures Except Hand and Foot	T	20.2046	1151.32		230.26
0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	24.6002	1401.79		280.36
0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	35.8607	2043.45		408.69
0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	43.5754	2483.06		496.61
0053	Level I Hand Musculoskeletal Procedures	T	15.5097	883.79	253.49	176.76
0054	Level II Hand Musculoskeletal Procedures	T	24.8731	1417.34		283.47
0055	Level I Foot Musculoskeletal Procedures	T	19.3444	1102.30	355.34	220.46
0056	Level II Foot Musculoskeletal Procedures	T	26.5813	1514.68	405.81	302.94
0057	Bunion Procedures	T	27.0029	1538.71	475.91	307.74
0058	Level I Strapping and Cast Application	S	1.1091	63.20		12.64
0060	Manipulation Therapy	S	0.4737	26.99		5.40
0068	CPAP Initiation	S	1.1546	65.79	29.48	13.16
0069	Thoracoscopy	T	29.9158	1704.69	591.64	340.94
0070	Thoracentesis/Lavage Procedures	T	3.3166	188.99		37.80
0071	Level I Endoscopy Upper Airway	T	0.7396	42.14	11.31	8.43
0072	Level II Endoscopy Upper Airway	T	1.3903	79.22	21.27	15.84
0073	Level III Endoscopy Upper Airway	T	4.1373	235.76	73.38	47.15
0074	Level IV Endoscopy Upper Airway	T	16.1205	918.59	295.70	183.72
0075	Level V Endoscopy Upper Airway	T	20.9362	1193.01	445.92	238.60
0076	Level I Endoscopy Lower Airway	T	9.4372	537.76	189.82	107.55
0077	Level I Pulmonary Treatment	S	0.3228	18.39	7.74	3.68
0078	Level II Pulmonary Treatment	S	0.8315	47.38	14.55	9.48
0079	Ventilation Initiation and Management	S	2.4268	138.29		27.66
0080	Diagnostic Cardiac Catheterization	T	36.2660	2066.55	838.92	413.31
0081	Non-Coronary Angioplasty or Atherectomy	T	32.7548	1866.47		373.29
0082	Coronary Atherectomy	T	103.0652	5872.96	1263.32	1174.59

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0083	Coronary Angioplasty and Percutaneous Valvuloplasty	T	55.3618	3154.68		630.94
0084	Level I Electrophysiologic Evaluation	S	10.6370	606.13		121.23
0085	Level II Electrophysiologic Evaluation	T	34.7491	1980.11	426.25	396.02
0086	Ablate Heart Dysrhythm Focus	T	45.0490	2567.03	833.33	513.41
0087	Cardiac Electrophysiologic Recording/Mapping	T	37.2315	2121.56		424.31
0088	Thrombectomy	T	36.0282	2052.99	655.22	410.60
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	T	109.5827	6244.35	1682.28	1248.87
0090	Insertion/Replacement of Pacemaker Pulse Generator	T	90.5432	5159.42	1612.80	1031.88
0091	Level II Vascular Ligation	T	29.6620	1690.23	348.23	338.05
0092	Level I Vascular Ligation	T	26.9952	1538.27	505.37	307.65
0093	Vascular Reconstruction/Fistula Repair without Device	T	24.0351	1369.59	277.34	273.92
0094	Level I Resuscitation and Cardioversion	S	2.6945	153.54	48.58	30.71
0095	Cardiac Rehabilitation	S	0.6044	34.44	15.49	6.89
0096	Non-Invasive Vascular Studies	S	1.7035	97.07	43.68	19.41
0097	Cardiac and Ambulatory Blood Pressure Monitoring	X	1.0180	58.01	23.79	11.60
0098	Injection of Sclerosing Solution	T	1.3424	76.49		15.30
0099	Electrocardiograms	S	0.3812	21.72		4.34
0100	Cardiac Stress Tests	X	2.4975	142.32	41.44	28.46
0101	Tilt Table Evaluation	S	4.3954	250.46	105.27	50.09
0103	Miscellaneous Vascular Procedures	T	13.1337	748.40	223.63	149.68
0104	Transcatheter Placement of Intracoronary Stents	T	81.1177	4622.33		924.47
0105	Revision/Removal of Pacemakers, AICD, or Vascular	T	21.5449	1227.69	370.40	245.54
0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes	T	55.1440	3142.27		628.45
0107	Insertion of Cardioverter-Defibrillator	T	315.2469	17963.71	3612.57	3592.74
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	T	423.3141	24121.71		4824.34
0109	Removal of Implanted Devices	T	7.5181	428.40	131.49	85.68
0110	Transfusion	S	3.7809	215.45		43.09
0111	Blood Product Exchange	S	12.7259	725.16	200.18	145.03
0112	Apheresis, Photopheresis, and Plasmapheresis	S	37.3315	2127.26	612.47	425.45
0113	Excision Lymphatic System	T	21.0044	1196.89		239.38
0114	Thyroid/Lymphadenectomy Procedures	T	39.6713	2260.59	485.91	452.12
0115	Cannula/Access Device Procedures	T	25.6621	1462.30	459.35	292.46

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0116	Chemotherapy Administration by Other Technique Except Infusion	S	1.1117	63.35		12.67
0117	Chemotherapy Administration by Infusion Only	S	2.9533	168.29	42.54	33.66
0119	Implantation of Infusion Pump	T	125.9746	7178.41		1435.68
0120	Infusion Therapy Except Chemotherapy	T	1.9620	111.80	28.21	22.36
0121	Level I Tube changes and Repositioning	T	2.2909	130.54	43.80	26.11
0122	Level II Tube changes and Repositioning	T	8.2869	472.21	96.84	94.44
0123	Bone Marrow Harvesting and Bone Marrow/Stem Cell Transplant	S	10.6755	608.32		121.66
0124	Revision of Implanted Infusion Pump	T	19.9665	1137.75		227.55
0125	Refilling of Infusion Pump	T	2.1652	123.38		24.68
0130	Level I Laparoscopy	T	31.6832	1805.40	659.53	361.08
0131	Level II Laparoscopy	T	42.7526	2436.17	1001.89	487.23
0132	Level III Laparoscopy	T	61.3208	3494.24	1239.22	698.85
0140	Esophageal Dilation without Endoscopy	T	6.4907	369.86	107.24	73.97
0141	Level I Upper GI Procedures	T	8.0725	460.00	143.38	92.00
0142	Small Intestine Endoscopy	T	8.7069	496.15	152.78	99.23
0143	Lower GI Endoscopy	T	8.5992	490.01	186.06	98.00
0146	Level I Sigmoidoscopy	T	4.3484	247.78	64.40	49.56
0147	Level II Sigmoidoscopy	T	8.0251	457.29		91.46
0148	Level I Anal/Rectal Procedure	T	4.3129	245.76	63.38	49.15
0149	Level III Anal/Rectal Procedure	T	17.7572	1011.86	293.06	202.37
0150	Level IV Anal/Rectal Procedure	T	23.1856	1321.19	437.12	264.24
0151	Endoscopic Retrograde Cholangio-Pancreatography (ERCP)	T	18.7294	1067.26	245.46	213.45
0152	Level I Percutaneous Abdominal and Biliary Procedures	T	12.4585	709.92		141.98
0153	Peritoneal and Abdominal Procedures	T	24.2544	1382.09	410.87	276.42
0154	Hernia/Hydrocele Procedures	T	28.0759	1599.85	464.85	319.97
0155	Level II Anal/Rectal Procedure	T	13.1091	747.00	188.89	149.40
0156	Level II Urinary and Anal Procedures	T	2.4782	141.22	40.52	28.24
0157	Colorectal Cancer Screening: Barium Enema	S	2.5110	143.08		28.62
0158	Colorectal Cancer Screening: Colonoscopy	T	7.7409	441.10		110.28
0159	Colorectal Cancer Screening: Flexible Sigmoidoscopy	S	2.8464	162.20		40.55
0160	Level I Cystourethroscopy and other Genitourinary Procedures	T	6.7674	385.63	105.06	77.13
0161	Level II Cystourethroscopy and other Genitourinary Procedures	T	17.8851	1019.15	249.36	203.83
0162	Level III Cystourethroscopy and other Genitourinary Procedures	T	23.0182	1311.65		262.33

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0163	Level IV Cystourethroscopy and other Genitourinary Procedures	T	36.0744	2055.63		411.13
0164	Level I Urinary and Anal Procedures	T	1.2563	71.59	17.59	14.32
0165	Level III Urinary and Anal Procedures	T	16.0415	914.09		182.82
0166	Level I Urethral Procedures	T	17.7694	1012.55	218.73	202.51
0167	Level III Urethral Procedures	T	28.4301	1620.03	549.80	324.01
0168	Level II Urethral Procedures	T	30.7725	1753.51	405.60	350.70
0169	Lithotripsy	T	44.6235	2542.78	1115.69	508.56
0170	Dialysis	S	6.2255	354.75		70.95
0180	Circumcision	T	19.7320	1124.39	304.87	224.88
0181	Penile Procedures	T	31.6828	1805.38	621.82	361.08
0183	Testes/Epididymis Procedures	T	23.0563	1313.82		262.76
0184	Prostate Biopsy	T	4.1543	236.72	96.27	47.34
0187	Miscellaneous Placement/Repositioning	T	3.8526	219.53		43.91
0188	Level II Female Reproductive Proc	T	1.1045	62.94		12.59
0189	Level III Female Reproductive Proc	T	2.1451	122.23		24.45
0190	Level I Hysteroscopy	T	20.5171	1169.13	424.28	233.83
0191	Level I Female Reproductive Proc	T	0.1831	10.43	2.93	2.09
0192	Level IV Female Reproductive Proc	T	3.8280	218.13		43.63
0193	Level V Female Reproductive Proc	T	13.3052	758.17	158.05	151.63
0194	Level VIII Female Reproductive Proc	T	19.1146	1089.21	397.84	217.84
0195	Level IX Female Reproductive Proc	T	26.4573	1507.62	483.80	301.52
0196	Dilation and Curettage	T	16.9266	964.53	338.23	192.91
0197	Infertility Procedures	T	2.2368	127.46		25.49
0198	Pregnancy and Neonatal Care Procedures	T	1.3503	76.94	32.19	15.39
0200	Level VII Female Reproductive Proc	T	14.7568	840.89	263.69	168.18
0201	Level VI Female Reproductive Proc	T	18.0011	1025.76	329.65	205.15
0202	Level X Female Reproductive Proc	T	39.6674	2260.37	1017.16	452.07
0203	Level IV Nerve Injections	T	10.9230	622.43	272.25	124.49
0204	Level I Nerve Injections	T	2.1801	124.23	40.13	24.85
0206	Level II Nerve Injections	T	5.4311	309.48	75.55	61.90
0207	Level III Nerve Injections	T	5.8248	331.91	86.92	66.38
0208	Laminotomies and Laminectomies	T	42.5700	2425.77		485.15
0209	Extended EEG Studies and Sleep Studies, Level II	S	11.6170	661.97	280.58	132.39
0212	Nervous System Injections	T	2.9465	167.90	74.67	33.58
0213	Extended EEG Studies and Sleep Studies, Level I	S	2.7461	156.48	64.89	31.30
0214	Electroencephalogram	S	2.2788	129.85	58.12	25.97
0215	Level I Nerve and Muscle Tests	S	0.6600	37.61	15.76	7.52
0216	Level III Nerve and Muscle Tests	S	2.6359	150.20		30.04
0218	Level II Nerve and Muscle Tests	S	1.1442	65.20		13.04
0220	Level I Nerve Procedures	T	17.2963	985.60		197.12

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0221	Level II Nerve Procedures	T	28.7081	1635.87	463.62	327.17
0222	Implantation of Neurological Device	T	217.1298	12372.71		2474.54
0223	Implantation or Revision of Pain Management Catheter	T	26.2731	1497.12		299.42
0224	Implantation of Reservoir/Pump/Shunt	T	38.8952	2216.37	453.41	443.27
0225	Level I Implantation of Neurostimulator Electrodes	S	210.5195	11996.03		2399.21
0226	Implantation of Drug Infusion Reservoir	T	43.4005	2473.09		494.62
0227	Implantation of Drug Infusion Device	T	150.3961	8570.02		1714.00
0228	Creation of Lumbar Subarachnoid Shunt	T	42.1332	2400.88	537.78	480.18
0229	Transcatherter Placement of Intravascular Shunts	T	62.1357	3540.68	771.23	708.14
0230	Level I Eye Tests & Treatments	S	0.8019	45.69	14.97	9.14
0231	Level III Eye Tests & Treatments	S	2.0073	114.38	44.61	22.88
0232	Level I Anterior Segment Eye Procedures	T	6.9120	393.87	103.17	78.77
0233	Level II Anterior Segment Eye Procedures	T	14.6847	836.78	266.33	167.36
0234	Level III Anterior Segment Eye Procedures	T	22.1360	1261.38	511.31	252.28
0235	Level I Posterior Segment Eye Procedures	T	5.1864	295.54	72.04	59.11
0236	Level II Posterior Segment Eye Procedures	T	21.3506	1216.62		243.32
0237	Level III Posterior Segment Eye Procedures	T	34.5277	1967.49	818.54	393.50
0238	Level I Repair and Plastic Eye Procedures	T	2.9594	168.64		33.73
0239	Level II Repair and Plastic Eye Procedures	T	6.7015	381.87		76.37
0240	Level III Repair and Plastic Eye Procedures	T	18.0715	1029.77	315.31	205.95
0241	Level IV Repair and Plastic Eye Procedures	T	23.5349	1341.09	384.47	268.22
0242	Level V Repair and Plastic Eye Procedures	T	30.2444	1723.42	597.36	344.68
0243	Strabismus/Muscle Procedures	T	22.4844	1281.23	431.39	256.25
0244	Corneal Transplant	T	39.6990	2262.17	803.26	452.43
0245	Level I Cataract Procedures without IOL Insert	T	13.9367	794.15	222.22	158.83
0246	Cataract Procedures with IOL Insert	T	23.3312	1329.48	495.96	265.90
0247	Laser Eye Procedures Except Retinal	T	5.0892	290.00	104.31	58.00
0248	Laser Retinal Procedures	T	4.9276	280.79	95.08	56.16
0249	Level II Cataract Procedures without IOL Insert	T	28.4617	1621.83	524.67	324.37
0250	Nasal Cauterization/Packing	T	1.3781	78.53	27.49	15.71
0251	Level I ENT Procedures	T	1.9352	110.27		22.05
0252	Level II ENT Procedures	T	6.5183	371.43	113.41	74.29

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0253	Level III ENT Procedures	T	15.9877	911.03	282.29	182.21
0254	Level IV ENT Procedures	T	23.3442	1330.22	321.35	266.04
0256	Level V ENT Procedures	T	36.9298	2104.37		420.87
0258	Tonsil and Adenoid Procedures	T	21.7774	1240.94	437.25	248.19
0259	Level VI ENT Procedures	T	444.1223	25307.42	9394.83	5061.48
0260	Level I Plain Film Except Teeth	X	0.7698	43.87	19.74	8.77
0261	Level II Plain Film Except Teeth Including Bone Density Measurement	X	1.3351	76.08		15.22
0262	Plain Film of Teeth	X	1.4556	82.94		16.59
0263	Level I Miscellaneous Radiology Procedures	X	1.8514	105.50	38.51	21.10
0264	Level II Miscellaneous Radiology Procedures	X	3.4194	194.85	79.41	38.97
0265	Level I Diagnostic Ultrasound	S	1.0473	59.68	26.85	11.94
0266	Level II Diagnostic Ultrasound	S	1.6275	92.74	41.73	18.55
0267	Level III Diagnostic Ultrasound	S	2.4250	138.18	62.18	27.64
0268	Ultrasound Guidance Procedures	S	1.1835	67.44		13.49
0269	Level III Echocardiogram Except Transesophageal	S	3.2554	185.50	83.47	37.10
0270	Transesophageal Echocardiogram	S	6.1046	347.86	146.79	69.57
0272	Level I Fluoroscopy	X	1.3880	79.09	35.59	15.82
0274	Myelography	S	3.2901	187.48	84.36	37.50
0275	Arthrography	S	3.5084	199.92	69.09	39.98
0276	Level I Digestive Radiology	S	1.5808	90.08	40.53	18.02
0277	Level II Digestive Radiology	S	2.4364	138.83	60.47	27.77
0278	Diagnostic Urography	S	2.8522	162.53	66.07	32.51
0279	Level II Angiography and Venography except Extremity	S	8.8113	502.09	150.03	100.42
0280	Level III Angiography and Venography except Extremity	S	20.1741	1149.58	353.85	229.92
0281	Venography of Extremity	S	7.2117	410.94	115.16	82.19
0282	Miscellaneous Computerized Axial Tomography	S	1.7145	97.70	43.96	19.54
0283	Computerized Axial Tomography with Contrast Material	S	4.7485	270.58	121.76	54.12
0284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contras	S	6.7851	386.64	173.98	77.33
0285	Myocardial Positron Emission Tomography (PET)	S	12.9121	735.77	318.72	147.15
0287	Complex Venography	S	8.3130	473.70	111.33	94.74
0288	Bone Density:Axial Skeleton	S	1.2735	72.57		14.51
0289	Needle Localization for Breast Biopsy	X	1.5701	89.47	21.05	17.89
0296	Level I Therapeutic Radiologic Procedures	S	2.4185	137.81	61.04	27.56

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0297	Level II Therapeutic Radiologic Procedures	S	5.2294	297.99	122.13	59.60
0299	Miscellaneous Radiation Treatment	S	5.8368	332.60		66.52
0300	Level I Radiation Therapy	S	1.5279	87.06		17.41
0301	Level II Radiation Therapy	S	2.1782	124.12		24.82
0302	Level III Radiation Therapy	S	5.4315	309.50	117.25	61.90
0303	Treatment Device Construction	X	2.8722	163.67	66.95	32.73
0304	Level I Therapeutic Radiation Treatment Preparation	X	1.7107	97.48	41.52	19.50
0305	Level II Therapeutic Radiation Treatment Preparation	X	3.9322	224.07	91.38	44.81
0310	Level III Therapeutic Radiation Treatment Preparation	X	14.2774	813.57	325.27	162.71
0312	Radioelement Applications	S	5.5783	317.87		63.57
0313	Brachytherapy	S	13.8770	790.75		158.15
0314	Hyperthermic Therapies	S	4.2608	242.79	98.36	48.56
0315	Level II Implantation of Neurostimulator	T	352.3658	20078.86		4015.77
0320	Electroconvulsive Therapy	S	5.3260	303.49	80.06	60.70
0321	Biofeedback and Other Training	S	1.4150	80.63	21.72	16.13
0322	Brief Individual Psychotherapy	S	1.2917	73.60		14.72
0323	Extended Individual Psychotherapy	S	1.7589	100.23	20.90	20.05
0324	Family Psychotherapy	S	2.8357	161.59		32.32
0325	Group Psychotherapy	S	1.4675	83.62	18.27	16.72
0330	Dental Procedures	S	14.0629	801.35		160.27
0332	Computerized Axial Tomography and Computerized Angiography without Contras	S	3.3910	193.23	86.95	38.65
0333	Computerized Axial Tomography and Computerized Angio w/o Contrast Material	S	5.6225	320.39	144.17	64.08
0335	Magnetic Resonance Imaging, Miscellaneous	S	6.0472	344.59	150.64	68.92
0336	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Cont	S	6.3150	359.85	161.93	71.97
0337	MRI and Magnetic Resonance Angiography without Contrast Material followed	S	9.1701	522.54	235.14	104.51
0339	Observation	S	7.1646	408.26		81.65
0340	Minor Ancillary Procedures	X	0.6328	36.06		7.21
0341	Skin Tests	X	0.1132	6.45	2.62	1.29
0342	Level I Pathology	X	0.2068	11.78	5.30	2.36
0343	Level II Pathology	X	0.4329	24.67	11.10	4.93
0344	Level III Pathology	X	0.6110	34.82	15.66	6.96
0345	Level I Transfusion Laboratory Procedures	X	0.2413	13.75	3.06	2.75

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0346	Level II Transfusion Laboratory Procedures	X	0.3586	20.43	5.15	4.09
0347	Level III Transfusion Laboratory Procedures	X	0.9386	53.48	13.20	10.70
0348	Fertility Laboratory Procedures	X	0.7675	43.73		8.75
0352	Level I Injections	X	0.1197	6.82		1.36
0353	Level II Allergy Injections	X	0.3981	22.68		4.54
0355	Level I Immunizations	K	0.3596	20.49		4.10
0356	Level II Immunizations	K	1.5752	89.76		17.95
0359	Level II Injections	X	0.8693	49.54		9.91
0360	Level I Alimentary Tests	X	1.6719	95.27	42.45	19.05
0361	Level II Alimentary Tests	X	3.6408	207.46	83.23	41.49
0362	Contact Lens and Spectacle Services	X	1.0861	61.89		12.38
0363	Level I Otorhinolaryngologic Function Tests	X	0.8653	49.31	17.44	9.86
0364	Level I Audiometry	X	0.4766	27.16	9.06	5.43
0365	Level II Audiometry	X	1.2743	72.61	18.95	14.52
0366	Level III Audiometry	X	1.8412	104.92	30.04	20.98
0367	Level I Pulmonary Test	X	0.5775	32.91	14.80	6.58
0368	Level II Pulmonary Tests	X	0.9465	53.93	24.26	10.79
0369	Level III Pulmonary Tests	X	2.7431	156.31	44.18	31.26
0370	Allergy Tests	X	0.9661	55.05	11.58	11.01
0371	Level I Allergy Injections	X	0.4310	24.56		4.91
0372	Therapeutic Phlebotomy	X	0.5656	32.23	10.09	6.45
0373	Neuropsychological Testing	X	2.3347	133.04		26.61
0374	Monitoring Psychiatric Drugs	X	1.0880	62.00		12.40
0375	Ancillary Outpatient Services When Patient Expires	T		3217.47		643.49
0376	Level II Cardiac Imaging	S	4.9171	280.19	121.42	56.04
0377	Level III Cardiac Imaging	S	7.0532	401.91	180.85	80.38
0378	Level II Pulmonary Imaging	S	5.5820	318.08	143.13	63.62
0379	Injection adenosine 6 MG	K	0.2163	12.33		2.47
0380	Dipyridamole injection	K	0.2053	11.70		2.34
0384	GI Procedures with Stents	T	27.0831	1543.28	335.19	308.66
0385	Level I Prosthetic Urological Procedures	S	69.6845	3970.83		794.17
0386	Level II Prosthetic Urological Procedures	S	113.9823	6495.05		1299.01
0387	Level II Hysteroscopy	T	30.3356	1728.61	655.55	345.72
0388	Discography	S	11.7568	669.94	301.47	133.99
0389	Non-imaging Nuclear Medicine	S	1.7805	101.46	44.54	20.29
0390	Level I Endocrine Imaging	S	2.8999	165.25	74.36	33.05
0391	Level II Endocrine Imaging	S	3.3043	188.29	84.73	37.66
0393	Red Cell/Plasma Studies	S	4.6873	267.10	120.19	53.42
0394	Hepatobiliary Imaging	S	4.5876	261.42	117.63	52.28
0395	GI Tract Imaging	S	3.9819	226.90	102.10	45.38

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0396	Bone Imaging	S	4.2024	239.47	107.76	47.89
0397	Vascular Imaging	S	2.5517	145.40	60.51	29.08
0398	Level I Cardiac Imaging	S	4.6280	263.72	118.67	52.74
0399	Nuclear Medicine Add-on Imaging	S	1.5961	90.95	40.92	18.19
0400	Hematopoietic Imaging	S	4.1858	238.52	104.32	47.70
0401	Level I Pulmonary Imaging	S	3.3594	191.43	86.14	38.29
0402	Brain Imaging	S	5.2120	297.00	133.65	59.40
0403	CSF Imaging	S	3.6801	209.70	94.36	41.94
0404	Renal and Genitourinary Studies Level I	S	3.9496	225.06	101.27	45.01
0405	Renal and Genitourinary Studies Level II	S	4.4571	253.98	114.29	50.80
0406	Tumor/Infection Imaging	S	4.5311	258.20	116.19	51.64
0407	Radionuclide Therapy	S	4.0836	232.70	97.77	46.54
0409	Red Blood Cell Tests	X	0.1272	7.25	2.22	1.45
0411	Respiratory Procedures	S	0.4194	23.90		4.78
0412	IMRT Treatment Delivery	S	5.4261	309.20		61.84
0415	Level II Endoscopy Lower Airway	T	21.9912	1253.12	459.92	250.62
0416	Level I Intravascular and Intracardiac Ultrasound and Flow Reserve	S	4.8182	274.56	99.43	54.91
0417	Computerized Reconstruction	S	4.6807	266.72		53.34
0418	Insertion of Left Ventricular Pacing Elect.	T	74.5141	4246.04		849.21
0421	Prolonged Physiologic Monitoring	X	1.8691	106.51		21.30
0422	Level II Upper GI Procedures	T	22.1959	1264.79	425.00	252.96
0423	Level II Percutaneous Abdominal and Biliary Procedures	T	30.7704	1753.39		350.68
0425	Level II Arthroplasty with Prosthesis	T	97.6127	5562.26	1378.01	1112.45
0426	Level II Strapping and Cast Application	S	1.9972	113.81		22.76
0600	Low Level Clinic Visits	V	0.9033	51.47		10.29
0601	Mid Level Clinic Visits	V	0.9847	56.11		11.22
0602	High Level Clinic Visits	V	1.3977	79.65		15.93
0610	Low Level Emergency Visits	V	1.3544	77.18	19.57	15.44
0611	Mid Level Emergency Visits	V	2.3926	136.34	36.16	27.27
0612	High Level Emergency Visits	V	4.1139	234.42	54.12	46.88
0620	Critical Care	S	9.0648	516.54	142.30	103.31
0648	Breast Reconstruction with Prosthesis	T	50.5103	2878.23		575.65
0651	Complex Interstitial Radiation Source Application	S	21.9176	1248.93		249.79
0652	Insertion of Intraperitoneal Catheters	T	27.7725	1582.56		316.51
0653	Vascular Reconstruction/Fistula Repair with Device	T	28.0840	1600.31		320.06
0654	Insertion/Replacement of a permanent dual chamber pacemaker	T	105.3805	6004.90		1200.98
0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker	T	135.1464	7701.05		1540.21

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0656	Transcatheter Placement of Intracoronary Drug-Eluting Stents	T	105.1296	5990.60		1198.12
0657	Placement of Tissue Clips	S	1.8392	104.80		20.96
0658	Percutaneous Breast Biopsies	T	6.6823	380.78		76.16
0659	Hyperbaric Oxygen	S	1.5926	90.75		18.15
0660	Level II Otorhinolaryngologic Function Tests	X	1.7060	97.21	30.66	19.44
0661	Level IV Pathology	X	3.5068	199.83	88.87	39.97
0662	CT Angiography	S	5.6204	320.27	144.12	64.05
0664	Level I Proton Beam Radiation Therapy	S	9.8560	561.62		112.32
0665	Bone Density:AppendicularSkeleton	S	0.7707	43.92		8.78
0668	Level I Angiography and Venography except Extremity	S	6.7346	383.76	114.67	76.75
0670	Level II Intravascular and Intracardiac Ultrasound and Flow Reserve	S	30.3817	1731.24	542.37	346.25
0671	Level II Echocardiogram Except Transesophageal	S	1.7087	97.37	43.81	19.47
0672	Level IV Posterior Segment Procedures	T	39.9292	2275.29	988.43	455.06
0673	Level IV Anterior Segment Eye Procedures	T	29.0816	1657.16	649.56	331.43
0674	Prostate Cryoablation	T	112.1858	6392.68		1278.54
0675	Prostatic Thermotherapy	T	46.1821	2631.59		526.32
0676	Level II Thrombolysis and Thrombectomy	T	4.2729	243.48		48.70
0677	Level I Thrombolysis and Thrombectomy	T	2.5535	145.51		29.10
0678	External Counterpulsation	T	1.7931	102.18		20.44
0679	Level II Resuscitation and Cardioversion	S	5.5971	318.94	95.30	63.79
0680	Insertion of Patient Activated Event Recorders	S	63.9488	3643.99		728.80
0681	Knee Arthroplasty	T	91.7896	5230.45	2081.48	1046.09
0682	Level V Debridement & Destruction	T	7.6149	433.92	171.85	86.78
0683	Level II Photochemotherapy	S	2.3761	135.40	30.42	27.08
0685	Level III Needle Biopsy/Aspiration Except Bone Marrow	T	5.8806	335.09	115.47	67.02
0686	Level III Skin Repair	T	5.6176	320.11	144.04	64.02
0687	Revision/Removal of Neurostimulator Electrodes	T	20.0762	1144.00	513.05	228.80
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver	T	41.7281	2377.79	1070.00	475.56
0689	Electronic Analysis of Cardioverter-defibrillators	S	0.5852	33.35		6.67
0690	Electronic Analysis of Pacemakers and other Cardiac Devices	S	0.3963	22.58	10.16	4.52
0691	Electronic Analysis of Programmable Shunts/Pumps	S	2.5289	144.10	64.84	28.82

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0692	Electronic Analysis of Neurostimulator Pulse Generators	S	2.0584	117.29	30.16	23.46
0693	Level II Breast Reconstruction	T	41.2736	2351.89	798.17	470.38
0694	Mohs Surgery	T	4.2031	239.51	64.93	47.90
0695	Level VII Debridement & Destruction	T	20.5193	1169.25	266.59	233.85
0697	Level I Echocardiogram Except Transesophageal	S	1.5184	86.52	38.93	17.30
0698	Level II Eye Tests & Treatments	S	1.4649	83.47	18.72	16.69
0699	Level IV Eye Tests & Treatments	T	9.7041	552.97		110.59
0700	Antepartum Manipulation	T	3.6661	208.91		41.78
0701	SR 89 chloride, per mCi	K	7.1278	406.16		81.23
0702	SM 153 lexidronam	K	15.9228	907.33		181.47
0703	Butorphanol tartrate	K		5.00		1.00
0704	IN 111 Satumomab pendetide per dose	K		1390.25		278.05
0705	Technetium TC99M tetrofosmin	K		104.58		20.92
0726	Dexrazoxane hcl injection	K		113.28		22.66
0728	Filgrastim injection	K		162.41		32.48
0729	Injection, Meropenem	K		36.26		7.25
0730	Pamidronate disodium	K		128.74		25.75
0731	Sargramostim injection	K		25.39		5.08
0732	Mesna injection	K		17.66		3.53
0733	Non esrd epoetin alpha inj	K		11.09		2.22
0734	Injection, darbepoetin alfa (for non-ESRD), per 1 mcg	K		3.66		0.73
0735	Ampho b cholesteryl sulfate	K		15.20		3.04
0736	Amphotericin b liposome inj	K		31.27		6.25
0737	Ammonia N-13, per dose	K	1.9280	109.86		21.97
0738	Rasburicase	G		106.04		21.21
0750	Dolasetron mesylate	K		14.38		2.88
0763	Dolasetron mesylate oral	K		63.28		12.66
0764	Granisetron HCl injection	K		16.20		3.24
0765	Granisetron HCl oral	K		39.04		7.81
0768	Ondansetron hcl injection	K		5.54		1.11
0769	Ondansetron hcl oral	K		26.12		5.22
0800	Leuprolide acetate	K		451.98		90.40
0802	Etoposide oral	K		21.91		4.38
0807	Aldesleukin/single use vial	K		680.35		136.07
0809	Bcg live intravesical vac	K		139.90		27.98
0810	Goserelin acetate implant	K		390.09		78.02
0811	Carboplatin injection	K		129.96		25.99
0812	Carmus bischl nitro inj	K		65.94		13.19
0813	Cisplatin injection	K		7.73		1.55
0814	Asparaginase injection	K		54.71		10.94

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0815	Cyclophosphamide inj	K		2.77		0.55
0816	Cyclophosphamide lyophilized	K		2.36		0.47
0817	Cytarabine hcl inj	K		1.55		0.31
0819	Dacarbazine inj	K		6.14		1.23
0820	Daunorubicin	K		35.94		7.19
0821	Daunorubicin citrate liposom	K		56.44		11.29
0822	Diethylstilbestrol injection	K		6.98		1.40
0823	Docetaxel	K		312.69		62.54
0824	Etoposide inj	K		0.83		0.17
0827	Floxuridine injection	K		66.24		13.25
0828	Gemcitabine HCL	K		105.73		21.15
0830	Irinotecan injection	K		127.33		25.47
0831	Ifosfomide injection	K		72.81		14.56
0832	Idarubicin hcl injection	K	1.1684	66.58		13.32
0834	Interferon alfa-2a inj	K		30.48		6.10
0836	Interferon alfa-2b inj recombinant, 1 million	K		13.00		2.60
0838	Interferon gamma 1-b inj	K		209.22		41.84
0840	Melphalan hydrochl	K		367.03		73.41
0842	Fludarabine phosphate inj	K		311.09		62.22
0843	Pegaspargase	K		1247.08		249.42
0844	Pentostatin injection	K		1683.24		336.65
0845	Phentolaine mesylate inj	K	0.3651	20.82		4.16
0846	Cilastatin sodium injection	K	0.1994	11.37		2.27
0847	Doxorubic hcl chemo	K		4.69		0.94
0848	Testosterone enanthate inj	K	0.6713	38.27		7.65
0849	Rituximab	K		437.83		87.57
0851	Thiotepa injection	K		45.31		9.06
0852	Topotecan	K		697.76		139.55
0855	Vinorelbine tartrate	K		95.23		19.05
0856	Porfimer sodium	K		2274.78		454.96
0857	Bleomycin sulfate injection	K		88.32		17.66
0858	Cladribine	K		24.84		4.97
0860	Plicamycin (mithramycin) inj	K		93.80		18.76
0861	Leuprolide acetate injection	K		14.48		2.90
0862	Mitomycin	K		30.91		6.18
0863	Paclitaxel injection	K		79.04		15.81
0864	Mitoxantrone hcl	K		313.96		62.79
0865	Interferon alfa-n3 inj, human leukocyte derived, 2	K		8.17		1.63
0866	Foscarnet sodium injection	K	0.2069	11.80		2.36
0867	Methacholine chloride, neb	K		0.47		0.09
0887	Azathioprine parenteral	K		30.18		6.04
0888	Cyclosporine oral	K	0.0312	1.78		0.36

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0890	Lymphocyte immune globulin	K		243.50		48.70
0891	Tacrolimus oral	K		3.05		0.61
0900	Alglucerase injection	K		37.53		7.51
0901	Alpha 1 proteinase inhibitor	K		3.43		0.69
0902	Botulinum toxin a, per unit	K		4.32		0.86
0903	Cytomegalovirus imm IV/vial	K		622.13		124.43
0905	Immune globulin	K		80.68		16.14
0906	RSV-ivig	K		16.55		3.31
0910	Interferon beta-1b	K		58.73		11.75
0911	Streptokinase	K	0.7618	43.41		8.68
0916	Injection imiglucerase /unit	K		3.75		0.75
0917	Adenosine injection	K	0.1528	8.71		1.74
0925	Factor viii	K		0.76		0.15
0926	Factor VIII (porcine)	K		1.78		0.36
0927	Factor viii recombinant	K		1.10		0.22
0928	Factor ix complex	K		0.32		0.06
0929	Anti-inhibitor per iu	K		1.29		0.26
0931	Factor IX non-recombinant	K		0.98		0.20
0932	Factor IX recombinant	K		0.98		0.20
0949	Plasma, Pooled Multiple Donor, Solvent/Detergent T	K	1.3689	78.00		15.60
0950	Blood (Whole) For Transfusion	K	1.9805	112.85		22.57
0952	Cryoprecipitate	K	0.8467	48.25		9.65
0954	RBC leukocytes reduced	K	2.9079	165.70		33.14
0955	Plasma, Fresh Frozen	K	1.3026	74.23		14.85
0956	Plasma Protein Fraction	K	1.1719	66.78		13.36
0957	Platelet Concentrate	K	0.8453	48.17		9.63
0958	Platelet Rich Plasma	K	2.6561	151.35		30.27
0959	Red Blood Cells	K	1.9881	113.29		22.66
0960	Washed Red Blood Cells	K	3.4014	193.82		38.76
0961	Infusion, Albumin (Human) 5%, 50 ml	K	0.3303	18.82		3.76
0963	Albumin (human), 5%	K	1.0624	60.54		12.11
0964	Albumin (human), 25%	K	0.2284	13.01		2.60
0965	Albumin (human), 25%	K	0.9181	52.32		10.46
0966	Plasmaprotein fract,5%	K	5.6751	323.38		64.68
0967	Split unit of blood	K	1.4533	82.81		16.56
0968	Platelets leukocyte reduced irradiated	K	2.7068	154.24		30.85
0969	Red blood cell leukocyte reduced irradiated	K	3.6080	205.59		41.12
1009	Cryoprecip reduced plasma	K	1.0793	61.50		12.30
1010	Blood, L/R, CMV-neg	K	2.9433	167.72		33.54
1011	Platelets, HLA-m, L/R, unit	K	9.9709	568.17		113.63
1013	Platelet concentrate, L/R, unit	K	1.5161	86.39		17.28
1016	Blood, L/R, froz/deglycerol/washed	K	4.7085	268.30		53.66

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1017	Platelets, aph/pher, L/R, CMV-neg, unit	K	8.3586	476.30		95.26
1018	Blood, L/R, irradiated	K	3.2064	182.71		36.54
1019	Platelets, aph/pher, L/R, irradiated, unit	K	10.3081	587.39		117.48
1020	Pit, pher,L/R,CMV,irrad	K	9.7863	557.65		111.53
1021	RBC, frz/deg/wsh, L/R, irrad	K	5.5861	318.31		63.66
1022	RBC, L/R, CMV neg, irrad	K	4.7977	273.39		54.68
1045	Iobenguane sulfate I-131	K		996.00		199.20
1046	Inj, moxifloxacin	K		8.75		1.75
1049	Thiamine hcl	K		0.95		0.19
1050	Pyridoxine hcl	K		2.64		0.53
1052	Injection, Voriconazole	K		4.54		0.91
1062	Acyclovir	K		0.03		0.01
1064	I-131 sodium iodide capsule	K	0.1153	6.57		1.31
1065	I-131 sodium iodide solution	K	0.1707	9.73		1.95
1070	Dopamine hcl	K		0.81		0.16
1079	CO 57/58	K		221.78		44.36
1080	I-131 tositumomab, dx	K		2241.00		448.20
1081	I-131 tositumomab, tx	K		19422.00		3884.40
1082	Treprostinil	K		54.02		10.80
1083	Injection, Adalimumab	K		620.64		124.13
1084	Denileukin diftitox	K		1232.88		246.58
1085	Injection, Gallium Nitrate	K		0.23		0.05
1086	Temozolomide,oral	K		6.42		1.28
1089	Cyanocobalamin cobalt co57	K		85.49		17.10
1091	IN 111 Oxyquinoline	K		373.50		74.70
1092	IN 111 Pentetate	K		224.10		44.82
1093	TC99M fanolesomab	K		1045.80		209.16
1095	Technetium TC 99M Depreotide	K	0.6631	37.79		7.56
1096	TC 99M Exametazime, per dose	K		778.13		155.63
1122	TC 99M arcitumomab, per vial	K		1079.00		215.80
1167	Epirubicin hcl	K		24.14		4.83
1178	Busulfan IV	K		24.35		4.87
1201	TC 99M SUCCIMER, PER Vial	K		118.52		23.70
1203	Verteporfin for injection	K		8.49		1.70
1207	Octreotide injection, depot	K		69.44		13.89
1305	Apligraf	K		1130.88		226.18
1409	Factor viia recombinant	K		1410.34		282.07
1501	New Technology - Level I ($0 - $50)	S		25.00		5.00
1502	New Technology - Level II ($50 - $100)	S		75.00		15.00
1503	New Technology - Level III ($100 - $200)	S		150.00		30.00
1504	New Technology - Level IV ($200 - $300)	S		250.00		50.00
1505	New Technology - Level V ($300 - $400)	S		350.00		70.00
1506	New Technology - Level VI ($400 - $500)	S		450.00		90.00

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1507	New Technology - Level VII ($500 - $600)	S		550.00		110.00
1508	New Technology - Level VIII ($600 - $700)	S		650.00		130.00
1509	New Technology - Level IX ($700 - $800)	S		750.00		150.00
1510	New Technology - Level X ($800 - $900)	S		850.00		170.00
1511	New Technology - Level XI ($900 - $1000)	S		950.00		190.00
1512	New Technology - Level XII ($1000 - $1100)	S		1050.00		210.00
1513	New Technology - Level XIII ($1100 - $1200)	S		1150.00		230.00
1514	New Technology-Level XIV ($1200- $1300)	S		1250.00		250.00
1515	New Technology - Level XV ($1300 - $1400)	S		1350.00		270.00
1516	New Technology - Level XVI ($1400 - $1500)	S		1450.00		290.00
1517	New Technology - Level XVII ($1500- $1600)	S		1550.00		310.00
1518	New Technology - Level XVIII ($1600- $1700)	S		1650.00		330.00
1519	New Technology - Level IXX ($1700- $1800)	S		1750.00		350.00
1520	New Technology - Level XX ($1800- $1900)	S		1850.00		370.00
1521	New Technology - Level XXI ($1900- $2000)	S		1950.00		390.00
1522	New Technology - Level XXII ($2000- $2500)	S		2250.00		450.00
1523	New Technology - Level XXIII ($2500- $3000)	S		2750.00		550.00
1524	New Technology - Level XIV ($3000- $3500)	S		3250.00		650.00
1525	New Technology - Level XXV ($3500- $4000)	S		3750.00		750.00
1526	New Technology - Level XXVI ($4000- $4500)	S		4250.00		850.00
1527	New Technology - Level XXVII ($4500- $5000)	S		4750.00		950.00
1528	New Technology - Level XXVIII ($5000- $5500)	S		5250.00		1050.00
1529	New Technology - Level XXIX ($5500- $6000)	S		5750.00		1150.00
1530	New Technology - Level XXX ($6000- $6500)	S		6250.00		1250.00
1531	New Technology - Level XXXI ($6500-	S		6750.00		1350.00

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
	$7000)					
1532	New Technology - Level XXXII ($7000-$7500)	S		7250.00		1450.00
1533	New Technology - Level XXXIII ($7500-$8000)	S		7750.00		1550.00
1534	New Technology - Level XXXIV ($8000-$8500)	S		8250.00		1650.00
1535	New Technology - Level XXXV ($8500-$9000)	S		8750.00		1750.00
1536	New Technology - Level XXXVI ($9000-$9500)	S		9250.00		1850.00
1537	New Technology - Level XXXVII ($9500-$10000)	S		9750.00		1950.00
1538	New Technology - Level I ($0 - $50)	T		25.00		5.00
1539	New Technology - Level II ($50 - $100)	T		75.00		15.00
1540	New Technology - Level III ($100 - $200)	T		150.00		30.00
1541	New Technology - Level IV ($200 - $300)	T		250.00		50.00
1542	New Technology - Level V ($300 - $400)	T		350.00		70.00
1543	New Technology - Level VI ($400 - $500)	T		450.00		90.00
1544	New Technology - Level VII ($500 - $600)	T		550.00		110.00
1545	New Technology - Level VIII ($600 - $700)	T		650.00		130.00
1546	New Technology - Level IX ($700 - $800)	T		750.00		150.00
1547	New Technology - Level X ($800 - $900)	T		850.00		170.00
1548	New Technology - Level XI ($900 - $1000)	T		950.00		190.00
1549	New Technology - Level XII ($1000 - $1100)	T		1050.00		210.00
1550	New Technology - Level XIII ($1100 - $1200)	T		1150.00		230.00
1551	New Technology-Level XIV ($1200-$1300)	T		1250.00		250.00
1552	New Technology - Level XV ($1300 - $1400)	T		1350.00		270.00
1553	New Technology - Level XVI ($1400 - $1500)	T		1450.00		290.00
1554	New Technology - Level XVII ($1500-$1600)	T		1550.00		310.00
1555	New Technology - Level XVIII ($1600-$1700)	T		1650.00		330.00
1556	New Technology - Level XIX ($1700-$1800)	T		1750.00		350.00
1557	New Technology - Level XX ($1800-$1900)	T		1850.00		370.00
1558	New Technology - Level XXI ($1900-	T		1950.00		390.00

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
	$2000)					
1559	New Technology - Level XXII ($2000-$2500)	T		2250.00		450.00
1560	New Technology - Level XXIII ($2500-$3000)	T		2750.00		550.00
1561	New Technology - Level XXIV ($3000-$3500)	T		3250.00		650.00
1562	New Technology - Level XXV ($3500-$4000)	T		3750.00		750.00
1563	New Technology - Level XXVI ($4000-$4500)	T		4250.00		850.00
1564	New Technology - Level XXVII ($4500-$5000)	T		4750.00		950.00
1565	New Technology - Level XXVIII ($5000-$5500)	T		5250.00		1050.00
1566	New Technology - Level XXIX ($5500-$6000)	T		5750.00		1150.00
1567	New Technology - Level XXX ($6000-$6500)	T		6250.00		1250.00
1568	New Technology - Level XXXI ($6500-$7000)	T		6750.00		1350.00
1569	New Technology - Level XXXII ($7000-$7500)	T		7250.00		1450.00
1570	New Technology - Level XXXIII ($7500-$8000)	T		7750.00		1550.00
1571	New Technology - Level XXXIV ($8000-$8500)	T		8250.00		1650.00
1572	New Technology - Level XXXV ($8500-$9000)	T		8750.00		1750.00
1573	New Technology - Level XXXVI ($9000-$9500)	T		9250.00		1850.00
1574	New Technology - Level XXXVII ($9500-$10000)	T		9750.00		1950.00
1600	Technetium TC 99m sestamibi	K		106.32		21.26
1602	Technetium tc 99m apcitide	K		415.00		83.00
1603	Thallous chloride TL 201	K		18.29		3.66
1604	IN 111 capromab pendetide, per dose	K		1915.23		383.05
1605	Abciximab injection	K		448.22		89.64
1606	Anistreplase	K		2353.53		470.71
1607	Eptifibatide injection	K		11.21		2.24
1608	Etanercept injection	K		135.56		27.11
1609	Rho(D) immune globulin h, sd	K		17.95		3.59
1611	Hylan G-F 20 injection	K		203.70		40.74
1612	Daclizumab, parenteral	K		393.78		78.76
1613	Trastuzumab	K		50.79		10.16
1615	Basiliximab	K		1461.34		292.27
1618	Vonwillebrandfactrcmplx, per iu	K		0.83		0.17

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1619	Gallium ga 67	K		27.10		5.42
1620	Technetium tc99m bicisate	K		370.60		74.12
1622	Technetium tc99m mertiatide	K		31.13		6.23
1624	Sodium phosphate p32	K		94.98		19.00
1625	Indium 111-in pentetreotide	K		1079.00		215.80
1628	Chromic phosphate p32	K	2.5841	147.25		29.45
1716	Brachytx source, Gold 198	H				
1717	Brachytx source, HDR Ir-192	H				
1718	Brachytx source, Iodine 125	H				
1719	Brachytx sour,Non-HDR Ir-192	H				
1720	Brachytx sour, Palladium 103	H				
1775	FDG, per dose (4-40 mCi/ml)	K	3.8803	221.11		44.22
1814	Retinal tamp, silicone oil	H				
1818	Integrated keratoprosthesis	H				
1819	Tissue localization-excision dev	H				
2616	Brachytx source, Yttrium-90	H				
2632	Brachytx sol, I-125, per mCi	H				
2633	Brachytx source, Cesium-131	H				
2634	Brachytx source, HA, I-125	H				
2635	Brachytx source, HA, P-103	H				
2636	Brachytx linear source, P-103	H				
7000	Amifostine	K		395.75		79.15
7003	Epoprostenol injection	K		15.78		3.16
7005	Gonadorelin hydroch	K	0.2998	17.08		3.42
7007	Inj milrinone lactate	K	0.1442	8.22		1.64
7011	Oprelvekin injection	K		248.16		49.63
7015	Busulfan, oral	K		2.08		0.42
7019	Aprotinin	K		12.51		2.50
7022	Elliotts b solution per ml	K		1.50		0.30
7024	Corticorelin ovine triflutat	K		353.70		70.74
7025	Digoxin immune FAB (ovine)	K		332.00		66.40
7026	Ethanolamine oleate	K		63.29		12.66
7027	Fomepizole	K		10.04		2.01
7028	Fosphenytoin	K		5.31		1.06
7030	Hemin	K		6.47		1.29
7031	Octreotide acetate injection	K		3.72		0.74
7034	Somatropin injection	K		280.87		56.17
7035	Teniposide	K		224.94		44.99
7036	Urokinase inj	K	2.1873	124.64		24.93
7037	Urofollitropin	K		56.59		11.32
7038	Monoclonal antibodies	K		747.31		149.46
7040	Pentastarch 10% solution	K		131.99		26.40
7041	Tirofiban hcl	K		8.24		1.65

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
7042	Capecitabine, oral	K		2.96		0.59
7043	Infliximab injection	K		57.40		11.48
7045	Trimetrexate glucoronate	K		142.50		28.50
7046	Doxorubicin hcl liposome inj	K		343.78		68.76
7048	Alteplase recombinant	K	0.3165	18.04		3.61
7049	Filgrastim injection	K		274.40		54.88
7051	Leuprolide acetate implant	K		4717.72		943.54
7308	Aminolevulinic acid hcl top	K		88.76		17.75
7316	Sodium hyaluronate injection	K	0.9466	53.94		10.79
9001	Linezolid injection	K		32.15		6.43
9002	Tenecteplase	K		2350.98		470.20
9003	Palivizumab	K		576.51		115.30
9004	Gemtuzumab ozogamicin	K		2183.81		436.76
9005	Reteplase injection	K		1192.09		238.42
9008	Baclofen Refill Kit-500mcg	K		10.21		2.04
9009	Baclofen refill kit - per 2000 mcg	K		37.64		7.53
9012	Arsenic Trioxide	K		34.10		6.82
9013	Co 57 cobaltous chloride	K	2.4999	142.45		28.49
9015	Mycophenolate mofetil oral	K		2.46		0.49
9018	Botulinum toxin B	K		7.68		1.54
9019	Caspofungin acetate	K		28.78		5.76
9020	Sirolimus tablet	K		6.23		1.25
9021	Immune globulin	K		0.75		0.15
9022	IM inj interferon beta 1-a	K		74.44		14.89
9023	Rho d immune globulin	K		30.38		6.08
9024	Amphotericin b lipid complex	K		19.09		3.82
9025	Rubidium-Rb-82	K		153.39		30.68
9026	High dose contrast MRI	K	0.4605	26.24		5.25
9027	Supp-paramagnetic contrast material	K	0.6245	35.59		7.12
9028	Tetracyclin injection	K	1.7547	99.99		20.00
9029	Amiodarone HCl	K	0.1931	11.00		2.20
9030	Amphotericin B	K	0.3622	20.64		4.13
9031	Arbutamine HCl injection	K	1.1947	68.08		13.62
9032	Baclofen 10 MG injection	K	0.1874	10.68		2.14
9033	Cidofovir injection	K	7.1527	407.58		81.52
9034	Brompheniramine maleate inj	K	1.0356	59.01		11.80
9035	Medroxyprogesterone injection	K	0.3082	17.56		3.51
9036	Dimethyl sulfoxide 50%	K	0.9360	53.34		10.67
9037	Methadone injection	K	0.2337	13.32		2.66
9038	Inj estrogen conjugate	K	0.7986	45.51		9.10
9040	Intraocular Fomivirsen na	K	16.4925	939.79		187.96
9041	Gamma globulin inj	K	0.5550	31.63		6.33
9042	Glucagon hydrochloride	K	0.8100	46.16		9.23

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
9044	Ibutilide fumarate injection	K	2.1724	123.79		24.76
9045	Iron dextran	K	0.2593	14.78		2.96
9046	Iron sucrose injection	K	0.0093	0.53		0.11
9047	Itraconazole injection	K	0.7389	42.10		8.42
9048	Inj desmopressin acetate	K	0.0794	4.52		0.90
9049	Inj protirelin	K	0.7161	40.81		8.16
9050	Na ferric gluconate complex	K	0.1058	6.03		1.21
9051	Urea injection	K	1.2239	69.74		13.95
9053	Nasal vaccine inhalation	K	1.6217	92.41		18.48
9054	Metabolically active tissue	K	0.1255	7.15		1.43
9055	Injectable human tissue	K	0.1412	8.05		1.61
9057	Lepirudin	K		130.30		26.06
9104	Anti-thymocycte globulin rabbit	K		312.41		62.48
9105	Hep B imm glob	K		118.32		23.66
9108	Thyrotropin alfa	K		617.50		123.50
9110	Alemtuzumab injection	K		541.45		108.29
9111	Inj, bivalirudin	K		1.52		0.30
9112	Perflutren lipid micro	K		129.69		25.94
9114	Nesiritide	K		132.47		26.49
9115	Inj, zoledronic acid	K		197.87		39.57
9117	Yttrium 90 ibritumomab tiuxetan	K		20948.25		4189.65
9118	In-111 ibritumomab tiuxetan	K		2419.78		483.96
9119	Pegfilgrastim	K		2448.50		489.70
9120	Inj, Fulvestrant	K		79.65		15.93
9121	Inj, Argatroban	K		12.45		2.49
9122	Triptorelin pamoate	K		362.78		72.56
9123	Transcyte	G		707.97		141.59
9124	Injection, daptomycin	G		0.28		0.06
9125	Risperidone, long acting	G		4.58		0.92
9200	Orcel	K		991.85		198.37
9201	Dermagraft	K		529.54		105.91
9202	Octafluoropropane	K		129.48		25.90
9203	Perflexane lipid micro	G		142.50		28.50
9204	Ziprasidone mesylate	G		18.22		3.64
9205	Oxaliplatin	G		81.61		16.32
9206	Integra	K		6.60		1.321
9207	Injection, bortezomib	G		27.53		5.51
9208	Injection, agalsidase beta	G		121.14		24.23
9209	Injection, laronidase	G		22.74		4.55
9210	Injection, palonosetron HCL	G		18.25		3.65
9211	Inj, alefacept, IV	G		560.00		112.00
9212	Inj, alefacept, IM	G		398.49		79.70
9213	Injection, Pemetrexed	G		40.54		8.11

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
9214	Injection, Bevacizumab	G		57.13		11.43
9215	Injection, Cetuximab	G		49.87		9.97
9216	Abarelix Injection	G		67.62		13.52
9217	Leuprolide acetate suspnsion	K		543.72		108.74
9218	Injection, Azacitidine	G		3.81		0.76
9219	Mycophenolic Acid	G		2.43		0.49
9220	Sodium hyaluronate	G		238.36		47.67
9221	Graftjacket Reg Matrix	G		1068.75		213.75
9222	Graftjacket SftTis	G		743.38		148.68
9300	Injection, Omalizumab	G		15.24		3.05
9400	Thallous chloride, brand	K		21.19		4.24
9401	Strontium-89 chloride, brand	K		406.16		81.23
9402	Th I131 so iodide cap, brand	K		6.57		1.31
9403	Dx I131 so iodide cap, brand	K		6.57		1.31
9404	Dx I131 so iodide sol, brand	K		9.73		1.95
9405	Th I131 so iodide sol, brand	K		9.73		1.95
9410	Dexrazoxane HCl inj, brand	K		123.93		24.79
9411	Pamidronate disodium, brand	K		160.65		32.13
9413	Sodium hyaluronate inj, brand	K		53.94		10.79
9414	Etoposide oral, brand	K		25.71		5.14
9415	Doxorubic hcl chemo, brand	K		6.94		1.39
9417	Bleomycin sulfate inj, brand	K		130.56		26.11
9418	Cisplatin inj, brand	K		11.42		2.28
9419	Inj cladribine, brand	K		36.72		7.34
9420	Cyclophosphamide inj, brand	K		4.10		0.82
9421	Cyclophosphamide lyo, brand	K		3.50		0.70
9422	Cytarabine hcl inj, brand	K		2.28		0.46
9423	Dacarbazine inj, brand	K		8.15		1.63
9424	Daunorubicin, brand	K		53.14		10.63
9425	Etoposide inj, brand	K		1.22		0.24
9426	Floxuridine inj, brand	K		97.92		19.58
9427	Ifosfomide inj, brand	K		90.80		18.16
9428	Mesna injection, brand	K		23.79		4.76
9429	Idarubicin hcl inj, brand	K		66.58		13.32
9430	Leuprolide acetate inj, bran	K		21.41		4.28
9431	Paclitaxel inj, brand	K		93.50		18.70
9432	Mitomycin inj, brand	K		45.70		9.14
9433	Thiotepa inj, brand	K		66.98		13.40
9435	Gonadorelin hydroch, brand	K		17.08		3.42
9436	Azathioprine parenteral,brand	K		44.61		8.92
9437	Carmus bischl nitro inj	K		79.42		15.88
9438	Cyclosporine oral, brand	K		1.78		0.36
9439	Diethylstilbestrol injection	K		10.32		2.06

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
9500	Platelets, irradiated	K	1.5559	88.66		17.73
9501	Platelets, pheresis, leukocytes reduced	K	8.3026	473.11		94.62
9502	Platelet pheresis irradiated	K	5.8578	333.80		66.76
9503	Fresh frozen plasma, ea unit	K	1.3397	76.34		15.27
9504	RBC deglycerolized	K	5.2108	296.93		59.39
9505	RBC irradiated	K	2.0849	118.80		23.76
9506	Granulocytes, pheresis	K	17.8797	1018.84		203.77
9507	Platelets, pheresis	K	7.6823	437.76		87.55
9508	Plasma, frozen w/in 8 hours	K	1.1117	63.35		12.67

Addendum B.--Payment Status by HCPCS Code and Related Information Calendar Year 2005

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0001F	D		Blood pressure, measured					
0001T	D		Endovas repr abdo ao aneurys					
0002F	D		Tobacco use, smoking, assess					
0003F	D		Tobacco use, non-smoking					
0003T	S		Cervicography	1501		25.00		5.00
0004F	D		Tobacco use txmnt counseling					
0005F	D		Tobacco use txmnt, pharmacol					
0005T	D		Perc cath stent/brain cv art					
0006F	D		Statin therapy, prescribed					
0006T	D		Perc cath stent/brain cv art					
0007F	D		Beta-blocker thx prescribed					
0007T	D		Perc cath stent/brain cv art					
0008F	D		Ace inhibitor thx prescribed					
0008T	T	NI	Upper gi endoscopy w/suture	0422	22.1959	1264.79	425.00	252.96
0009F	D		Assess anginal symptom/level					
0009T	D		Endometrial cryoablation					
00100	N		Anesth, salivary gland					
00102	N		Anesth, repair of cleft lip					
00103	N		Anesth, blepharoplasty					
00104	N		Anesth, electroshock					
0010F	D		Assess anginal symptom/level					
0010T	A		Tb test, gamma interferon					
0011F	D		Oral antiplat thx prescribed					
00120	N		Anesth, ear surgery					
00124	N		Anesth, ear exam					
00126	N		Anesth, tympanotomy					
0012T	D		Osteochondral knee autograft					
0013T	D		Osteochondral knee allograft					
00140	N		Anesth, procedures on eye					
00142	N		Anesth, lens surgery					
00144	N		Anesth, corneal transplant					
00145	N		Anesth, vitreoretinal surg					
00147	N		Anesth, iridectomy					
00148	N		Anesth, eye exam					
0014T	D		Meniscal transplant, knee					
00160	N		Anesth, nose/sinus surgery					
00162	N		Anesth, nose/sinus surgery					
00164	N		Anesth, biopsy of nose					
0016T	T		Thermotx choroid vasc lesion	0235	5.1864	295.54	72.04	59.11
00170	N		Anesth, procedure on mouth					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
00172	N		Anesth, cleft palate repair					
00174	N		Anesth, pharyngeal surgery					
00176	C		Anesth, pharyngeal surgery					
0017T	E		Photocoagulat macular drusen					
0018T	S		Transcranial magnetic stimul	0215	0.6600	37.61	15.76	7.52
00190	N		Anesth, face/skull bone surg					
00192	C		Anesth, facial bone surgery					
0019T	E		Extracorp shock wave tx, ms					
0020T	B		Extracorp shock wave tx, ft					
00210	N		Anesth, open head surgery					
00212	N		Anesth, skull drainage					
00214	C		Anesth, skull drainage					
00215	C		Anesth, skull repair/fract					
00216	N		Anesth, head vessel surgery					
00218	N		Anesth, special head surgery					
0021T	C		Fetal oximetry, trnsvag/cerv					
00220	N		Anesth, intrcrn nerve					
00222	N		Anesth, head nerve surgery					
0023T	A		Phenotype drug test, hiv 1					
0024T	C		Transcath cardiac reduction					
0026T	A		Measure remnant lipoproteins					
0027T	T		Endoscopic epidural lysis	1547		850.00		170.00
0028T	N		Dexa body composition study					
0029T	A		Magnetic tx for incontinence					
00300	N		Anesth, head/neck/ptrunk					
0030T	A		Antiprothrombin antibody					
0031T	N		Speculoscopy					
00320	N		Anesth, neck organ, 1 & over					
00322	N		Anesth, biopsy of thyroid					
00326	N		Anesth, larynx/trach, < 1 yr					
0032T	N		Speculoscopy w/direct sample					
0033T	C		Endovasc taa repr incl subcl					
0034T	C		Endovasc taa repr w/o subcl					
00350	N		Anesth, neck vessel surgery					
00352	N		Anesth, neck vessel surgery					
0035T	C		Insert endovasc prosth, taa					
0036T	C		Endovasc prosth, taa, add-on					
0037T	C		Artery transpose/endovas taa					
0038T	C		Rad endovasc taa rpr w/cover					
0039T	C		Rad s/i, endovasc taa repair					
00400	N		Anesth, skin, ext/per/atrunk					
00402	N		Anesth, surgery of breast					
00404	C		Anesth, surgery of breast					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
00406	C		Anesth, surgery of breast		.	.	.	.
0040T	C		Rad s/i, endovasc taa prosth		.	.	.	.
00410	N		Anesth, correct heart rhythm		.	.	.	.
0041T	A		Detect ur infect agnt w/cpas		.	.	.	.
0042T	N		Ct perfusion w/contrast, cbf		.	.	.	.
0043T	A		Co expired gas analysis		.	.	.	.
0044T	N		Whole body photography		.	.	.	.
00450	N		Anesth, surgery of shoulder		.	.	.	.
00452	C		Anesth, surgery of shoulder		.	.	.	.
00454	N		Anesth, collar bone biopsy		.	.	.	.
0045T	N		Whole body photography		.	.	.	.
0046T	T		Cath lavage, mammary duct(s	0021	14.8872	848.32	219.48	169.66
00470	N		Anesth, removal of rib		.	.	.	.
00472	N		Anesth, chest wall repair		.	.	.	.
00474	C		Anesth, surgery of rib(s)		.	.	.	.
0047T	T		Cath lavage, mammary duct(s)	0021	14.8872	848.32	219.48	169.66
0048T	C		Implant ventricular device		.	.	.	.
0049T	C		External circulation assist		.	.	.	.
00500	N		Anesth, esophageal surgery		.	.	.	.
0050T	C		Removal circulation assist		.	.	.	.
0051T	C		Implant total heart system		.	.	.	.
00520	N		Anesth, chest procedure		.	.	.	.
00522	N		Anesth, chest lining biopsy		.	.	.	.
00524	C		Anesth, chest drainage		.	.	.	.
00528	N		Anesth, chest partition view		.	.	.	.
00529	N		Anesth, chest partition view		.	.	.	.
0052T	C		Replace component heart syst		.	.	.	.
00530	N		Anesth, pacemaker insertion		.	.	.	.
00532	N		Anesth, vascular access		.	.	.	.
00534	N		Anesth, cardioverter/defib		.	.	.	.
00537	N		Anesth, cardiac electrophys		.	.	.	.
00539	N		Anesth, trach-bronch reconst		.	.	.	.
0053T	C		Replace component heart syst		.	.	.	.
00540	C		Anesth, chest surgery		.	.	.	.
00541	N		Anesth, one lung ventilation		.	.	.	.
00542	C		Anesth, release of lung		.	.	.	.
00546	C		Anesth, lung,chest wall surg		.	.	.	.
00548	N		Anesth, trachea,bronchi surg		.	.	.	.
0054T	B		Bone surgery using computer		.	.	.	.
00550	N		Anesth, sternal debridement		.	.	.	.
0055T	B		Bone surgery using computer		.	.	.	.
00560	C		Anesth, heart surg w/o pump		.	.	.	.
00561	C		Anesth, heart surg < age 1		.	.	.	.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
00562	C		Anesth, heart surg w/pump					
00563	N		Anesth, heart surg w/arrest					
00566	N		Anesth, cabg w/o pump					
0056T	B		Bone surgery using computer					
0057T	D		Uppr gi scope w/ thrml txmnt					
00580	C		Anesth, heart/lung transplnt					
0058T	X		Cryopreservation, ovary tiss	0348	0.7675	43.73		8.75
0059T	X		Cryopreservation, oocyte	0348	0.7675	43.73		8.75
00600	N		Anesth, spine, cord surgery					
00604	C		Anesth, sitting procedure					
0060T	B		Electrical impedance scan					
0061T	B		Destruction of tumor, breast					
00620	N		Anesth, spine, cord surgery					
00622	C		Anesth, removal of nerves					
0062T	T	NI	Rep intradisc annulus;1 lev	0203	10.9230	622.43	272.25	124.49
00630	N		Anesth, spine, cord surgery					
00632	C		Anesth, removal of nerves					
00634	C		Anesth for chemonucleolysis					
00635	N		Anesth, lumbar puncture					
0063T	T	NI	Rep intradisc annulus;>1lev	0203	10.9230	622.43	272.25	124.49
00640	N		Anesth, spine manipulation					
0064T	A		Spectroscop eval expired gas					
0065T	A		Ocular photoscreen bilat					
0066T	E		Ct colonography;screen					
00670	C		Anesth, spine, cord surgery					
0067T	S	NI	Ct colonography;dx	0332				
0068T	B	NI	Interp/rept heart sound					
0069T	N	NI	Analysis only heart sound					
00700	N		Anesth, abdominal wall surg					
00702	N		Anesth, for liver biopsy					
0070T	N	NI	Interp only heart sound					
0071T	T	NI	U/s leiomyomata ablate <200	0193	13.3052	758.17	158.05	151.63
0072T	T	NI	U/s leiomyomata ablate >200	0193	13.3052	758.17	158.05	151.63
00730	N		Anesth, abdominal wall surg					
0073T	S	NI	Delivery, comp imrt	0412	5.4261	309.20		61.84
00740	N		Anesth, upper gi visualize					
0074T	E	NI	Online physician e/m					
00750	N		Anesth, repair of hernia					
00752	N		Anesth, repair of hernia					
00754	N		Anesth, repair of hernia					
00756	N		Anesth, repair of hernia					
0075T	C	NI	Perq stent/chest vert art					
0076T	C	NI	S&i stent/chest vert art					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
00770	N		Anesth, blood vessel repair					
0077T	C	NI	Cereb therm perfusion probe					
0078T	C	NI	Endovasc aort repr w/device					
00790	N		Anesth, surg upper abdomen					
00792	C		Anesth, hemorr/excise liver					
00794	C		Anesth, pancreas removal					
00796	C		Anesth, for liver transplant					
00797	N		Anesth, surgery for obesity					
0079T	C	NI	Endovasc visc extnsn repr					
00800	N		Anesth, abdominal wall surg					
00802	C		Anesth, fat layer removal					
0080T	C	NI	Endovasc aort repr rad s&i					
00810	N		Anesth, low intestine scope					
0081T	C	NI	Endovasc visc extnsn s&i					
00820	N		Anesth, abdominal wall surg					
0082T	B	NI	Stereotactic rad delivery					
00830	N		Anesth, repair of hernia					
00832	N		Anesth, repair of hernia					
00834	N		Anesth, hernia repair< 1 yr					
00836	N		Anesth hernia repair preemie					
0083T	N	NI	Stereotactic rad tx mngmt					
00840	N		Anesth, surg lower abdomen					
00842	N		Anesth, amniocentesis					
00844	C		Anesth, pelvis surgery					
00846	C		Anesth, hysterectomy					
00848	C		Anesth, pelvic organ surg					
0084T	T	NI	Temp prostate urethral stent	0164	1.2563	71.59	17.59	14.32
00851	N		Anesth, tubal ligation					
0085T	X	NI	Breath test heart reject	0340	0.6328	36.06		7.21
00860	N		Anesth, surgery of abdomen					
00862	N		Anesth, kidney/ureter surg					
00864	C		Anesth, removal of bladder					
00865	C		Anesth, removal of prostate					
00866	C		Anesth, removal of adrenal					
00868	C		Anesth, kidney transplant					
0086T	N	NI	L ventricle fill pressure					
00870	N		Anesth, bladder stone surg					
00872	N		Anesth kidney stone destruct					
00873	N		Anesth kidney stone destruct					
0087T	X	NI	Sperm eval hyaluronan	0348	0.7675	43.73		8.75
00880	N		Anesth, abdomen vessel surg					
00882	C		Anesth, major vein ligation					
0088T	T	NI	Rf tongue base vol reduxn	0253	15.9877	911.03	282.29	182.21

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
00902	N		Anesth, anorectal surgery		.	.	.	.
00904	C		Anesth, perineal surgery		.	.	.	.
00906	N		Anesth, removal of vulva		.	.	.	.
00908	C		Anesth, removal of prostate		.	.	.	.
00910	N		Anesth, bladder surgery		.	.	.	.
00912	N		Anesth, bladder tumor surg		.	.	.	.
00914	N		Anesth, removal of prostate		.	.	.	.
00916	N		Anesth, bleeding control		.	.	.	.
00918	N		Anesth, stone removal		.	.	.	.
00920	N		Anesth, genitalia surgery		.	.	.	.
00921	N		Anesth, vasectomy		.	.	.	.
00922	N		Anesth, sperm duct surgery		.	.	.	.
00924	N		Anesth, testis exploration		.	.	.	.
00926	N		Anesth, removal of testis		.	.	.	.
00928	N		Anesth, removal of testis		.	.	.	.
00930	N		Anesth, testis suspension		.	.	.	.
00932	C		Anesth, amputation of penis		.	.	.	.
00934	C		Anesth, penis, nodes removal		.	.	.	.
00936	C		Anesth, penis, nodes removal		.	.	.	.
00938	N		Anesth, insert penis device		.	.	.	.
00940	N		Anesth, vaginal procedures		.	.	.	.
00942	N		Anesth, surg on vag/urethral		.	.	.	.
00944	C		Anesth, vaginal hysterectomy		.	.	.	.
00948	N		Anesth, repair of cervix		.	.	.	.
00950	N		Anesth, vaginal endoscopy		.	.	.	.
00952	N		Anesth, hysteroscope/graph		.	.	.	.
01112	N		Anesth, bone aspirate/bx		.	.	.	.
01120	N		Anesth, pelvis surgery		.	.	.	.
01130	N		Anesth, body cast procedure		.	.	.	.
01140	C		Anesth, amputation at pelvis		.	.	.	.
01150	C		Anesth, pelvic tumor surgery		.	.	.	.
01160	N		Anesth, pelvis procedure		.	.	.	.
01170	N		Anesth, pelvis surgery		.	.	.	.
01173	N		Anesth, fx repair, pelvis		.	.	.	.
01180	N		Anesth, pelvis nerve removal		.	.	.	.
01190	C		Anesth, pelvis nerve removal		.	.	.	.
01200	N		Anesth, hip joint procedure		.	.	.	.
01202	N		Anesth, arthroscopy of hip		.	.	.	.
01210	N		Anesth, hip joint surgery		.	.	.	.
01212	C		Anesth, hip disarticulation		.	.	.	.
01214	C		Anesth, hip arthroplasty		.	.	.	.
01215	N		Anesth, revise hip repair		.	.	.	.
01220	N		Anesth, procedure on femur		.	.	.	.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
01230	N		Anesth, surgery of femur					
01232	C		Anesth, amputation of femur					
01234	C		Anesth, radical femur surg					
01250	N		Anesth, upper leg surgery					
01260	N		Anesth, upper leg veins surg					
01270	N		Anesth, thigh arteries surg					
01272	C		Anesth, femoral artery surg					
01274	C		Anesth, femoral embolectomy					
01320	N		Anesth, knee area surgery					
01340	N		Anesth, knee area procedure					
01360	N		Anesth, knee area surgery					
01380	N		Anesth, knee joint procedure					
01382	N		Anesth, dx knee arthroscopy					
01390	N		Anesth, knee area procedure					
01392	N		Anesth, knee area surgery					
01400	N		Anesth, knee joint surgery					
01402	C		Anesth, knee arthroplasty					
01404	C		Anesth, amputation at knee					
01420	N		Anesth, knee joint casting					
01430	N		Anesth, knee veins surgery					
01432	N		Anesth, knee vessel surg					
01440	N		Anesth, knee arteries surg					
01442	C		Anesth, knee artery surg					
01444	C		Anesth, knee artery repair					
01462	N		Anesth, lower leg procedure					
01464	N		Anesth, ankle/ft arthroscopy					
01470	N		Anesth, lower leg surgery					
01472	N		Anesth, achilles tendon surg					
01474	N		Anesth, lower leg surgery					
01480	N		Anesth, lower leg bone surg					
01482	N		Anesth, radical leg surgery					
01484	N		Anesth, lower leg revision					
01486	C		Anesth, ankle replacement					
01490	N		Anesth, lower leg casting					
01500	N		Anesth, leg arteries surg					
01502	C		Anesth, lwr leg embolectomy					
01520	N		Anesth, lower leg vein surg					
01522	N		Anesth, lower leg vein surg					
01610	N		Anesth, surgery of shoulder					
01620	N		Anesth, shoulder procedure					
01622	N		Anes dx shoulder arthroscopy					
01630	N		Anesth, surgery of shoulder					
01632	C		Anesth, surgery of shoulder					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
01634	C		Anesth, shoulder joint amput					
01636	C		Anesth, forequarter amput					
01638	C		Anesth, shoulder replacement					
01650	N		Anesth, shoulder artery surg					
01652	C		Anesth, shoulder vessel surg					
01654	C		Anesth, shoulder vessel surg					
01656	C		Anesth, arm-leg vessel surg					
01670	N		Anesth, shoulder vein surg					
01680	N		Anesth, shoulder casting					
01682	N		Anesth, airplane cast					
01710	N		Anesth, elbow area surgery					
01712	N		Anesth, uppr arm tendon surg					
01714	N		Anesth, uppr arm tendon surg					
01716	N		Anesth, biceps tendon repair					
01730	N		Anesth, uppr arm procedure					
01732	N		Anesth, dx elbow arthroscopy					
01740	N		Anesth, upper arm surgery					
01742	N		Anesth, humerus surgery					
01744	N		Anesth, humerus repair					
01756	C		Anesth, radical humerus surg					
01758	N		Anesth, humeral lesion surg					
01760	N		Anesth, elbow replacement					
01770	N		Anesth, uppr arm artery surg					
01772	N		Anesth, uppr arm embolectomy					
01780	N		Anesth, upper arm vein surg					
01782	N		Anesth, uppr arm vein repair					
01810	N		Anesth, lower arm surgery					
01820	N		Anesth, lower arm procedure					
01829	N		Anesth, dx wrist arthroscopy					
01830	N		Anesth, lower arm surgery					
01832	N		Anesth, wrist replacement					
01840	N		Anesth, lwr arm artery surg					
01842	N		Anesth, lwr arm embolectomy					
01844	N		Anesth, vascular shunt surg					
01850	N		Anesth, lower arm vein surg					
01852	N		Anesth, lwr arm vein repair					
01860	N		Anesth, lower arm casting					
01905	N		Anes, spine inject, x-ray/re					
01916	N		Anesth, dx arteriography					
01920	N		Anesth, catheterize heart					
01922	N		Anesth, cat or MRI scan					
01924	N		Anes, ther interven rad, art					
01925	N		Anes, ther interven rad, car					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
01926	N		Anes, tx interv rad hrt/cran					
01930	N		Anes, ther interven rad, vei					
01931	N		Anes, ther interven rad, tip					
01932	N		Anes, tx interv rad, th vein					
01933	N		Anes, tx interv rad, cran v					
01951	N		Anesth, burn, less 4 percent					
01952	N		Anesth, burn, 4-9 percent					
01953	N		Anesth, burn, each 9 percent					
01958	N		Anesth, antepartum manipul					
01960	N		Anesth, vaginal delivery					
01961	N		Anesth, cs delivery					
01962	N		Anesth, emer hysterectomy					
01963	N		Anesth, cs hysterectomy					
01964	N		Anesth, abortion procedures					
01967	N		Anesth/analg, vag delivery					
01968	N		Anes/analg cs deliver add-on					
01969	N		Anesth/analg cs hyst add-on					
01990	C		Support for organ donor					
01991	N		Anesth, nerve block/inj					
01992	N		Anesth, n block/inj, prone					
01995	N		Regional anesthesia limb					
01996	N		Hosp manage cont drug admin					
01999	N		Unlisted anesth procedure					
0500F	E	NI	Initial prenatal care visit					
0501F	E	NI	Prenatal flow sheet					
0502F	E	NI	Subsequent prenatal care					
0503F	E	NI	Postpartum care visit					
1000F	E	NI	Tobacco use, smoking, assess					
1001F	E	NI	Tobacco use, non-smoking					
10021	T		Fna w/o image	0002	0.9553	54.44		10.89
10022	T		Fna w/image	0036	2.2377	127.51		25.50
1002F	E	NI	Assess anginal symptom/level					
10040	T		Acne surgery	0010	0.5940	33.85	9.65	6.77
10060	T		Drainage of skin abscess	0006	1.6854	96.04	23.26	19.21
10061	T		Drainage of skin abscess	0006	1.6854	96.04	23.26	19.21
10080	T		Drainage of pilonidal cyst	0006	1.6854	96.04	23.26	19.21
10081	T		Drainage of pilonidal cyst	0007	12.4496	709.42		141.88
10120	T		Remove foreign body	0006	1.6854	96.04	23.26	19.21
10121	T		Remove foreign body	0021	14.8872	848.32	219.48	169.66
10140	T		Drainage of hematoma/fluid	0007	12.4496	709.42		141.88
10160	T		Puncture drainage of lesion	0018	0.9669	55.10	16.04	11.02
10180	T		Complex drainage, wound	0007	12.4496	709.42		141.88
11000	T		Debride infected skin	0015	1.7248	98.28	20.35	19.66

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
11001	T		Debride infected skin add-on	0012	0.7477	42.61	11.18	8.52
11004	C	NI	Debride genitalia & perineum					
11005	C	NI	Debride abdom wall					
11006	C	NI	Debride genit/per/abdom wall					
11008	C	NI	Remove mesh from abd wall					
11010	T		Debride skin, fx	0019	4.1677	237.49	71.87	47.50
11011	T		Debride skin/muscle, fx	0019	4.1677	237.49	71.87	47.50
11012	T		Debride skin/muscle/bone, fx	0019	4.1677	237.49	71.87	47.50
11040	T		Debride skin, partial	0015	1.7248	98.28	20.35	19.66
11041	T		Debride skin, full	0015	1.7248	98.28	20.35	19.66
11042	T		Debride skin/tissue	0016	2.8321	161.38	57.31	32.28
11043	T		Debride tissue/muscle	0016	2.8321	161.38	57.31	32.28
11044	T		Debride tissue/muscle/bone	0682	7.6149	433.92	171.85	86.78
11055	T		Trim skin lesion	0012	0.7477	42.61	11.18	8.52
11056	T		Trim skin lesions, 2 to 4	0012	0.7477	42.61	11.18	8.52
11057	T		Trim skin lesions, over 4	0013	1.1380	64.85	14.20	12.97
11100	T		Biopsy, skin lesion	0018	0.9669	55.10	16.04	11.02
11101	T		Biopsy, skin add-on	0018	0.9669	55.10	16.04	11.02
11200	T		Removal of skin tags	0013	1.1380	64.85	14.20	12.97
11201	T		Remove skin tags add-on	0015	1.7248	98.28	20.35	19.66
11300	T		Shave skin lesion	0012	0.7477	42.61	11.18	8.52
11301	T		Shave skin lesion	0012	0.7477	42.61	11.18	8.52
11302	T		Shave skin lesion	0013	1.1380	64.85	14.20	12.97
11303	T		Shave skin lesion	0015	1.7248	98.28	20.35	19.66
11305	T		Shave skin lesion	0013	1.1380	64.85	14.20	12.97
11306	T		Shave skin lesion	0013	1.1380	64.85	14.20	12.97
11307	T		Shave skin lesion	0013	1.1380	64.85	14.20	12.97
11308	T		Shave skin lesion	0013	1.1380	64.85	14.20	12.97
11310	T		Shave skin lesion	0013	1.1380	64.85	14.20	12.97
11311	T		Shave skin lesion	0013	1.1380	64.85	14.20	12.97
11312	T		Shave skin lesion	0013	1.1380	64.85	14.20	12.97
11313	T		Shave skin lesion	0016	2.8321	161.38	57.31	32.28
11400	T		Exc tr-ext b9+marg 0.5 < cm	0019	4.1677	237.49	71.87	47.50
11401	T		Exc tr-ext b9+marg 0.6-1 cm	0019	4.1677	237.49	71.87	47.50
11402	T		Exc tr-ext b9+marg 1.1-2 cm	0019	4.1677	237.49	71.87	47.50
11403	T		Exc tr-ext b9+marg 2.1-3 cm	0020	7.6248	434.48	113.25	86.90
11404	T		Exc tr-ext b9+marg 3.1-4 cm	0021	14.8872	848.32	219.48	169.66
11406	T		Exc tr-ext b9+marg > 4.0 cm	0021	14.8872	848.32	219.48	169.66
11420	T		Exc h-f-nk-sp b9+marg 0.5 <	0020	7.6248	434.48	113.25	86.90
11421	T		Exc h-f-nk-sp b9+marg 0.6-1	0020	7.6248	434.48	113.25	86.90
11422	T		Exc h-f-nk-sp b9+marg 1.1-2	0020	7.6248	434.48	113.25	86.90
11423	T		Exc h-f-nk-sp b9+marg 2.1-3	0020	7.6248	434.48	113.25	86.90
11424	T		Exc h-f-nk-sp b9+marg 3.1-4	0021	14.8872	848.32	219.48	169.66

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
11426	T		Exc h-f-nk-sp b9+marg > 4 cm	0022	19.3700	1103.76	354.45	220.75
11440	T		Exc face-mm b9+marg 0.5 < cm	0019	4.1677	237.49	71.87	47.50
11441	T		Exc face-mm b9+marg 0.6-1 cm	0019	4.1677	237.49	71.87	47.50
11442	T		Exc face-mm b9+marg 1.1-2 cm	0020	7.6248	434.48	113.25	86.90
11443	T		Exc face-mm b9+marg 2.1-3 cm	0020	7.6248	434.48	113.25	86.90
11444	T		Exc face-mm b9+marg 3.1-4 cm	0020	7.6248	434.48	113.25	86.90
11446	T		Exc face-mm b9+marg > 4 cm	0022	19.3700	1103.76	354.45	220.75
11450	T		Removal, sweat gland lesion	0022	19.3700	1103.76	354.45	220.75
11451	T		Removal, sweat gland lesion	0022	19.3700	1103.76	354.45	220.75
11462	T		Removal, sweat gland lesion	0022	19.3700	1103.76	354.45	220.75
11463	T		Removal, sweat gland lesion	0022	19.3700	1103.76	354.45	220.75
11470	T		Removal, sweat gland lesion	0022	19.3700	1103.76	354.45	220.75
11471	T		Removal, sweat gland lesion	0022	19.3700	1103.76	354.45	220.75
11600	T		Exc tr-ext mlg+marg 0.5 < cm	0019	4.1677	237.49	71.87	47.50
11601	T		Exc tr-ext mlg+marg 0.6-1 cm	0019	4.1677	237.49	71.87	47.50
11602	T		Exc tr-ext mlg+marg 1.1-2 cm	0019	4.1677	237.49	71.87	47.50
11603	T		Exc tr-ext mlg+marg 2.1-3 cm	0020	7.6248	434.48	113.25	86.90
11604	T		Exc tr-ext mlg+marg 3.1-4 cm	0020	7.6248	434.48	113.25	86.90
11606	T		Exc tr-ext mlg+marg > 4 cm	0021	14.8872	848.32	219.48	169.66
11620	T		Exc h-f-nk-sp mlg+marg 0.5 <	0020	7.6248	434.48	113.25	86.90
11621	T		Exc h-f-nk-sp mlg+marg 0.6-1	0019	4.1677	237.49	71.87	47.50
11622	T		Exc h-f-nk-sp mlg+marg 1.1-2	0020	7.6248	434.48	113.25	86.90
11623	T		Exc h-f-nk-sp mlg+marg 2.1-3	0021	14.8872	848.32	219.48	169.66
11624	T		Exc h-f-nk-sp mlg+marg 3.1-4	0021	14.8872	848.32	219.48	169.66
11626	T		Exc h-f-nk-sp mlg+mar > 4 cm	0022	19.3700	1103.76	354.45	220.75
11640	T		Exc face-mm malig+marg 0.5 <	0019	4.1677	237.49	71.87	47.50
11641	T		Exc face-mm malig+marg 0.6-1	0019	4.1677	237.49	71.87	47.50
11642	T		Exc face-mm malig+marg 1.1-2	0020	7.6248	434.48	113.25	86.90
11643	T		Exc face-mm malig+marg 2.1-3	0020	7.6248	434.48	113.25	86.90
11644	T		Exc face-mm malig+marg 3.1-4	0021	14.8872	848.32	219.48	169.66
11646	T		Exc face-mm mlg+marg > 4 cm	0022	19.3700	1103.76	354.45	220.75
11719	T		Trim nail(s)	0009	0.6817	38.85	8.34	7.77
11720	T		Debride nail, 1-5	0009	0.6817	38.85	8.34	7.77
11721	T		Debride nail, 6 or more	0009	0.6817	38.85	8.34	7.77
11730	T		Removal of nail plate	0013	1.1380	64.85	14.20	12.97
11732	T		Remove nail plate, add-on	0012	0.7477	42.61	11.18	8.52
11740	T		Drain blood from under nail	0009	0.6817	38.85	8.34	7.77
11750	T		Removal of nail bed	0019	4.1677	237.49	71.87	47.50
11752	T		Remove nail bed/finger tip	0022	19.3700	1103.76	354.45	220.75
11755	T		Biopsy, nail unit	0019	4.1677	237.49	71.87	47.50
11760	T		Repair of nail bed	0024	1.7742	101.10	33.10	20.22
11762	T		Reconstruction of nail bed	0024	1.7742	101.10	33.10	20.22
11765	T		Excision of nail fold, toe	0015	1.7248	98.28	20.35	19.66

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11770	T		Removal of pilonidal lesion	0022	19.3700	1103.76	354.45	220.75
11771	T		Removal of pilonidal lesion	0022	19.3700	1103.76	354.45	220.75
11772	T		Removal of pilonidal lesion	0022	19.3700	1103.76	354.45	220.75
11900	T		Injection into skin lesions	0012	0.7477	42.61	11.18	8.52
11901	T		Added skin lesions injection	0012	0.7477	42.61	11.18	8.52
11920	T		Correct skin color defects	0024	1.7742	101.10	33.10	20.22
11921	T		Correct skin color defects	0024	1.7742	101.10	33.10	20.22
11922	T		Correct skin color defects	0024	1.7742	101.10	33.10	20.22
11950	T		Therapy for contour defects	0024	1.7742	101.10	33.10	20.22
11951	T		Therapy for contour defects	0024	1.7742	101.10	33.10	20.22
11952	T		Therapy for contour defects	0024	1.7742	101.10	33.10	20.22
11954	T		Therapy for contour defects	0024	1.7742	101.10	33.10	20.22
11960	T		Insert tissue expander(s)	0027	16.8355	959.34	329.72	191.87
11970	T		Replace tissue expander	0027	16.8355	959.34	329.72	191.87
11971	T		Remove tissue expander(s)	0022	19.3700	1103.76	354.45	220.75
11975	E		Insert contraceptive cap					
11976	T		Removal of contraceptive cap	0019	4.1677	237.49	71.87	47.50
11977	E		Removal/reinsert contra cap					
11980	X		Implant hormone pellet(s)	0340	0.6328	36.06		7.21
11981	X		Insert drug implant device	0340	0.6328	36.06		7.21
11982	X		Remove drug implant device	0340	0.6328	36.06		7.21
11983	X		Remove/insert drug implant	0340	0.6328	36.06		7.21
12001	T		Repair superficial wound(s)	0024	1.7742	101.10	33.10	20.22
12002	T		Repair superficial wound(s)	0024	1.7742	101.10	33.10	20.22
12004	T		Repair superficial wound(s)	0024	1.7742	101.10	33.10	20.22
12005	T		Repair superficial wound(s)	0024	1.7742	101.10	33.10	20.22
12006	T		Repair superficial wound(s)	0024	1.7742	101.10	33.10	20.22
12007	T		Repair superficial wound(s)	0024	1.7742	101.10	33.10	20.22
12011	T		Repair superficial wound(s)	0024	1.7742	101.10	33.10	20.22
12013	T		Repair superficial wound(s)	0024	1.7742	101.10	33.10	20.22
12014	T		Repair superficial wound(s)	0024	1.7742	101.10	33.10	20.22
12015	T		Repair superficial wound(s)	0024	1.7742	101.10	33.10	20.22
12016	T		Repair superficial wound(s)	0024	1.7742	101.10	33.10	20.22
12017	T		Repair superficial wound(s)	0024	1.7742	101.10	33.10	20.22
12018	T		Repair superficial wound(s)	0024	1.7742	101.10	33.10	20.22
12020	T		Closure of split wound	0024	1.7742	101.10	33.10	20.22
12021	T		Closure of split wound	0024	1.7742	101.10	33.10	20.22
12031	T		Layer closure of wound(s)	0024	1.7742	101.10	33.10	20.22
12032	T		Layer closure of wound(s)	0024	1.7742	101.10	33.10	20.22
12034	T		Layer closure of wound(s)	0024	1.7742	101.10	33.10	20.22
12035	T		Layer closure of wound(s)	0024	1.7742	101.10	33.10	20.22
12036	T		Layer closure of wound(s)	0024	1.7742	101.10	33.10	20.22
12037	T		Layer closure of wound(s)	0025	4.7315	269.62	101.85	53.92

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12041	T		Layer closure of wound(s)	0024	1.7742	101.10	33.10	20.22
12042	T		Layer closure of wound(s)	0024	1.7742	101.10	33.10	20.22
12044	T		Layer closure of wound(s)	0024	1.7742	101.10	33.10	20.22
12045	T		Layer closure of wound(s)	0024	1.7742	101.10	33.10	20.22
12046	T		Layer closure of wound(s)	0024	1.7742	101.10	33.10	20.22
12047	T		Layer closure of wound(s)	0025	4.7315	269.62	101.85	53.92
12051	T		Layer closure of wound(s)	0024	1.7742	101.10	33.10	20.22
12052	T		Layer closure of wound(s)	0024	1.7742	101.10	33.10	20.22
12053	T		Layer closure of wound(s)	0024	1.7742	101.10	33.10	20.22
12054	T		Layer closure of wound(s)	0024	1.7742	101.10	33.10	20.22
12055	T		Layer closure of wound(s)	0024	1.7742	101.10	33.10	20.22
12056	T		Layer closure of wound(s)	0024	1.7742	101.10	33.10	20.22
12057	T		Layer closure of wound(s)	0025	4.7315	269.62	101.85	53.92
13100	T		Repair of wound or lesion	0025	4.7315	269.62	101.85	53.92
13101	T		Repair of wound or lesion	0025	4.7315	269.62	101.85	53.92
13102	T		Repair wound/lesion add-on	0024	1.7742	101.10	33.10	20.22
13120	T		Repair of wound or lesion	0024	1.7742	101.10	33.10	20.22
13121	T		Repair of wound or lesion	0024	1.7742	101.10	33.10	20.22
13122	T		Repair wound/lesion add-on	0024	1.7742	101.10	33.10	20.22
13131	T		Repair of wound or lesion	0024	1.7742	101.10	33.10	20.22
13132	T		Repair of wound or lesion	0024	1.7742	101.10	33.10	20.22
13133	T		Repair wound/lesion add-on	0024	1.7742	101.10	33.10	20.22
13150	T		Repair of wound or lesion	0025	4.7315	269.62	101.85	53.92
13151	T		Repair of wound or lesion	0024	1.7742	101.10	33.10	20.22
13152	T		Repair of wound or lesion	0025	4.7315	269.62	101.85	53.92
13153	T		Repair wound/lesion add-on	0024	1.7742	101.10	33.10	20.22
13160	T		Late closure of wound	0027	16.8355	959.34	329.72	191.87
14000	T		Skin tissue rearrangement	0027	16.8355	959.34	329.72	191.87
14001	T		Skin tissue rearrangement	0027	16.8355	959.34	329.72	191.87
14020	T		Skin tissue rearrangement	0027	16.8355	959.34	329.72	191.87
14021	T		Skin tissue rearrangement	0027	16.8355	959.34	329.72	191.87
14040	T		Skin tissue rearrangement	0027	16.8355	959.34	329.72	191.87
14041	T		Skin tissue rearrangement	0027	16.8355	959.34	329.72	191.87
14060	T		Skin tissue rearrangement	0027	16.8355	959.34	329.72	191.87
14061	T		Skin tissue rearrangement	0027	16.8355	959.34	329.72	191.87
14300	T		Skin tissue rearrangement	0027	16.8355	959.34	329.72	191.87
14350	T		Skin tissue rearrangement	0027	16.8355	959.34	329.72	191.87
15000	T		Skin graft	0025	4.7315	269.62	101.85	53.92
15001	T		Skin graft add-on	0025	4.7315	269.62	101.85	53.92
15050	T		Skin pinch graft	0025	4.7315	269.62	101.85	53.92
15100	T		Skin split graft	0027	16.8355	959.34	329.72	191.87
15101	T		Skin split graft add-on	0027	16.8355	959.34	329.72	191.87
15120	T		Skin split graft	0027	16.8355	959.34	329.72	191.87

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
15121	T		Skin split graft add-on	0027	16.8355	959.34	329.72	191.87
15200	T		Skin full graft	0027	16.8355	959.34	329.72	191.87
15201	T		Skin full graft add-on	0025	4.7315	269.62	101.85	53.92
15220	T		Skin full graft	0027	16.8355	959.34	329.72	191.87
15221	T		Skin full graft add-on	0025	4.7315	269.62	101.85	53.92
15240	T		Skin full graft	0027	16.8355	959.34	329.72	191.87
15241	T		Skin full graft add-on	0025	4.7315	269.62	101.85	53.92
15260	T		Skin full graft	0027	16.8355	959.34	329.72	191.87
15261	T		Skin full graft add-on	0025	4.7315	269.62	101.85	53.92
15342	T		Cultured skin graft, 25 cm	0024	1.7742	101.10	33.10	20.22
15343	T		Culture skn graft addl 25 cm	0024	1.7742	101.10	33.10	20.22
15350	T		Skin homograft	0686	5.6176	320.11	144.04	64.02
15351	T		Skin homograft add-on	0027	16.8355	959.34	329.72	191.87
15400	T		Skin heterograft	0025	4.7315	269.62	101.85	53.92
15401	T		Skin heterograft add-on	0025	4.7315	269.62	101.85	53.92
15570	T		Form skin pedicle flap	0027	16.8355	959.34	329.72	191.87
15572	T		Form skin pedicle flap	0027	16.8355	959.34	329.72	191.87
15574	T		Form skin pedicle flap	0027	16.8355	959.34	329.72	191.87
15576	T		Form skin pedicle flap	0027	16.8355	959.34	329.72	191.87
15600	T		Skin graft	0027	16.8355	959.34	329.72	191.87
15610	T		Skin graft	0027	16.8355	959.34	329.72	191.87
15620	T		Skin graft	0027	16.8355	959.34	329.72	191.87
15630	T		Skin graft	0027	16.8355	959.34	329.72	191.87
15650	T		Transfer skin pedicle flap	0027	16.8355	959.34	329.72	191.87
15732	T		Muscle-skin graft, head/neck	0027	16.8355	959.34	329.72	191.87
15734	T		Muscle-skin graft, trunk	0027	16.8355	959.34	329.72	191.87
15736	T		Muscle-skin graft, arm	0027	16.8355	959.34	329.72	191.87
15738	T		Muscle-skin graft, leg	0027	16.8355	959.34	329.72	191.87
15740	T		Island pedicle flap graft	0027	16.8355	959.34	329.72	191.87
15750	T		Neurovascular pedicle graft	0027	16.8355	959.34	329.72	191.87
15756	C		Free myo/skin flap microvasc					
15757	C		Free skin flap, microvasc					
15758	C		Free fascial flap, microvasc					
15760	T		Composite skin graft	0027	16.8355	959.34	329.72	191.87
15770	T		Derma-fat-fascia graft	0027	16.8355	959.34	329.72	191.87
15775	T		Hair transplant punch grafts	0025	4.7315	269.62	101.85	53.92
15776	T		Hair transplant punch grafts	0025	4.7315	269.62	101.85	53.92
15780	T		Abrasion treatment of skin	0022	19.3700	1103.76	354.45	220.75
15781	T		Abrasion treatment of skin	0019	4.1677	237.49	71.87	47.50
15782	T		Abrasion treatment of skin	0019	4.1677	237.49	71.87	47.50
15783	T		Abrasion treatment of skin	0016	2.8321	161.38	57.31	32.28
15786	T		Abrasion, lesion, single	0013	1.1380	64.85	14.20	12.97
15787	T		Abrasion, lesions, add-on	0013	1.1380	64.85	14.20	12.97

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
15788	T		Chemical peel, face, epiderm	0012	0.7477	42.61	11.18	8.52
15789	T		Chemical peel, face, dermal	0015	1.7248	98.28	20.35	19.66
15792	T		Chemical peel, nonfacial	0013	1.1380	64.85	14.20	12.97
15793	T		Chemical peel, nonfacial	0012	0.7477	42.61	11.18	8.52
15810	T		Salabrasion	0016	2.8321	161.38	57.31	32.28
15811	T		Salabrasion	0016	2.8321	161.38	57.31	32.28
15819	T		Plastic surgery, neck	0025	4.7315	269.62	101.85	53.92
15820	T		Revision of lower eyelid	0027	16.8355	959.34	329.72	191.87
15821	T		Revision of lower eyelid	0027	16.8355	959.34	329.72	191.87
15822	T		Revision of upper eyelid	0027	16.8355	959.34	329.72	191.87
15823	T		Revision of upper eyelid	0027	16.8355	959.34	329.72	191.87
15824	T		Removal of forehead wrinkles	0027	16.8355	959.34	329.72	191.87
15825	T		Removal of neck wrinkles	0027	16.8355	959.34	329.72	191.87
15826	T		Removal of brow wrinkles	0027	16.8355	959.34	329.72	191.87
15828	T		Removal of face wrinkles	0027	16.8355	959.34	329.72	191.87
15829	T		Removal of skin wrinkles	0027	16.8355	959.34	329.72	191.87
15831	T		Excise excessive skin tissue	0022	19.3700	1103.76	354.45	220.75
15832	T		Excise excessive skin tissue	0022	19.3700	1103.76	354.45	220.75
15833	T		Excise excessive skin tissue	0022	19.3700	1103.76	354.45	220.75
15834	T		Excise excessive skin tissue	0022	19.3700	1103.76	354.45	220.75
15835	T		Excise excessive skin tissue	0025	4.7315	269.62	101.85	53.92
15836	T		Excise excessive skin tissue	0021	14.8872	848.32	219.48	169.66
15837	T		Excise excessive skin tissue	0021	14.8872	848.32	219.48	169.66
15838	T		Excise excessive skin tissue	0021	14.8872	848.32	219.48	169.66
15839	T		Excise excessive skin tissue	0021	14.8872	848.32	219.48	169.66
15840	T		Graft for face nerve palsy	0027	16.8355	959.34	329.72	191.87
15841	T		Graft for face nerve palsy	0027	16.8355	959.34	329.72	191.87
15842	T		Flap for face nerve palsy	0027	16.8355	959.34	329.72	191.87
15845	T		Skin and muscle repair, face	0027	16.8355	959.34	329.72	191.87
15850	T		Removal of sutures	0016	2.8321	161.38	57.31	32.28
15851	T		Removal of sutures	0016	2.8321	161.38	57.31	32.28
15852	X		Dressing change not for burn	0340	0.6328	36.06		7.21
15860	X		Test for blood flow in graft	0359	0.8693	49.54		9.91
15876	T		Suction assisted lipectomy	0027	16.8355	959.34	329.72	191.87
15877	T		Suction assisted lipectomy	0027	16.8355	959.34	329.72	191.87
15878	T		Suction assisted lipectomy	0027	16.8355	959.34	329.72	191.87
15879	T		Suction assisted lipectomy	0027	16.8355	959.34	329.72	191.87
15920	T		Removal of tail bone ulcer	0019	4.1677	237.49	71.87	47.50
15922	T		Removal of tail bone ulcer	0027	16.8355	959.34	329.72	191.87
15931	T		Remove sacrum pressure sore	0022	19.3700	1103.76	354.45	220.75
15933	T		Remove sacrum pressure sore	0022	19.3700	1103.76	354.45	220.75
15934	T		Remove sacrum pressure sore	0027	16.8355	959.34	329.72	191.87
15935	T		Remove sacrum pressure sore	0027	16.8355	959.34	329.72	191.87

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
15936	T		Remove sacrum pressure sore	0027	16.8355	959.34	329.72	191.87
15937	T		Remove sacrum pressure sore	0027	16.8355	959.34	329.72	191.87
15940	T		Remove hip pressure sore	0022	19.3700	1103.76	354.45	220.75
15941	T		Remove hip pressure sore	0022	19.3700	1103.76	354.45	220.75
15944	T		Remove hip pressure sore	0027	16.8355	959.34	329.72	191.87
15945	T		Remove hip pressure sore	0027	16.8355	959.34	329.72	191.87
15946	T		Remove hip pressure sore	0027	16.8355	959.34	329.72	191.87
15950	T		Remove thigh pressure sore	0022	19.3700	1103.76	354.45	220.75
15951	T		Remove thigh pressure sore	0022	19.3700	1103.76	354.45	220.75
15952	T		Remove thigh pressure sore	0027	16.8355	959.34	329.72	191.87
15953	T		Remove thigh pressure sore	0027	16.8355	959.34	329.72	191.87
15956	T		Remove thigh pressure sore	0027	16.8355	959.34	329.72	191.87
15958	T		Remove thigh pressure sore	0027	16.8355	959.34	329.72	191.87
15999	T		Removal of pressure sore	0019	4.1677	237.49	71.87	47.50
16000	T		Initial treatment of burn(s)	0012	0.7477	42.61	11.18	8.52
16010	T		Treatment of burn(s)	0016	2.8321	161.38	57.31	32.28
16015	T		Treatment of burn(s)	0017	17.3894	990.90	227.84	198.18
16020	T		Treatment of burn(s)	0013	1.1380	64.85	14.20	12.97
16025	T		Treatment of burn(s)	0013	1.1380	64.85	14.20	12.97
16030	T		Treatment of burn(s)	0015	1.7248	98.28	20.35	19.66
16035	C		Incision of burn scab, initi		.	.	.	.
16036	C		Escharotomy; add'l incision		.	.	.	.
17000	T		Destroy benign/premlg lesion	0010	0.5940	33.85	9.65	6.77
17003	T		Destroy lesions, 2-14	0010	0.5940	33.85	9.65	6.77
17004	T		Destroy lesions, 15 or more	0011	2.4040	136.99	27.88	27.40
17106	T		Destruction of skin lesions	0011	2.4040	136.99	27.88	27.40
17107	T		Destruction of skin lesions	0011	2.4040	136.99	27.88	27.40
17108	T		Destruction of skin lesions	0011	2.4040	136.99	27.88	27.40
17110	T		Destruct lesion, 1-14	0010	0.5940	33.85	9.65	6.77
17111	T		Destruct lesion, 15 or more	0010	0.5940	33.85	9.65	6.77
17250	T		Chemical cautery, tissue	0013	1.1380	64.85	14.20	12.97
17260	T		Destruction of skin lesions	0015	1.7248	98.28	20.35	19.66
17261	T		Destruction of skin lesions	0015	1.7248	98.28	20.35	19.66
17262	T		Destruction of skin lesions	0015	1.7248	98.28	20.35	19.66
17263	T		Destruction of skin lesions	0015	1.7248	98.28	20.35	19.66
17264	T		Destruction of skin lesions	0015	1.7248	98.28	20.35	19.66
17266	T		Destruction of skin lesions	0016	2.8321	161.38	57.31	32.28
17270	T		Destruction of skin lesions	0015	1.7248	98.28	20.35	19.66
17271	T		Destruction of skin lesions	0013	1.1380	64.85	14.20	12.97
17272	T		Destruction of skin lesions	0015	1.7248	98.28	20.35	19.66
17273	T		Destruction of skin lesions	0015	1.7248	98.28	20.35	19.66
17274	T		Destruction of skin lesions	0016	2.8321	161.38	57.31	32.28
17276	T		Destruction of skin lesions	0016	2.8321	161.38	57.31	32.28

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
17280	T		Destruction of skin lesions	0015	1.7248	98.28	20.35	19.66
17281	T		Destruction of skin lesions	0015	1.7248	98.28	20.35	19.66
17282	T		Destruction of skin lesions	0015	1.7248	98.28	20.35	19.66
17283	T		Destruction of skin lesions	0015	1.7248	98.28	20.35	19.66
17284	T		Destruction of skin lesions	0016	2.8321	161.38	57.31	32.28
17286	T		Destruction of skin lesions	0015	1.7248	98.28	20.35	19.66
17304	T		1 stage mohs, up to 5 spec	0694	4.2031	239.51	64.93	47.90
17305	T		2 stage mohs, up to 5 spec	0694	4.2031	239.51	64.93	47.90
17306	T		3 stage mohs, up to 5 spec	0694	4.2031	239.51	64.93	47.90
17307	T		Mohs addl stage up to 5 spec	0694	4.2031	239.51	64.93	47.90
17310	T		Mohs any stage > 5 spec each	0694	4.2031	239.51	64.93	47.90
17340	T		Cryotherapy of skin	0012	0.7477	42.61	11.18	8.52
17360	T		Skin peel therapy	0013	1.1380	64.85	14.20	12.97
17380	T		Hair removal by electrolysis	0013	1.1380	64.85	14.20	12.97
17999	T		Skin tissue procedure	0006	1.6854	96.04	23.26	19.21
19000	T		Drainage of breast lesion	0004	1.7081	97.33	22.36	19.47
19001	T		Drain breast lesion add-on	0004	1.7081	97.33	22.36	19.47
19020	T		Incision of breast lesion	0007	12.4496	709.42		141.88
19030	N		Injection for breast x-ray					
19100	T		Bx breast percut w/o image	0005	3.7391	213.07	71.59	42.61
19101	T		Biopsy of breast, open	0028	18.7869	1070.53	303.74	214.11
19102	T		Bx breast percut w/image	0005	3.7391	213.07	71.59	42.61
19103	T		Bx breast percut w/device	0658	6.6823	380.78		76.16
19110	T		Nipple exploration	0028	18.7869	1070.53	303.74	214.11
19112	T		Excise breast duct fistula	0028	18.7869	1070.53	303.74	214.11
19120	T		Removal of breast lesion	0028	18.7869	1070.53	303.74	214.11
19125	T		Excision, breast lesion	0028	18.7869	1070.53	303.74	214.11
19126	T		Excision, addl breast lesion	0028	18.7869	1070.53	303.74	214.11
19140	T		Removal of breast tissue	0028	18.7869	1070.53	303.74	214.11
19160	T		Partial mastectomy	0028	18.7869	1070.53	303.74	214.11
19162	T		P-mastectomy w/In removal	0693	41.2736	2351.89	798.17	470.38
19180	T		Removal of breast	0029	31.3655	1787.30	632.64	357.46
19182	T		Removal of breast	0029	31.3655	1787.30	632.64	357.46
19200	C		Removal of breast					
19220	C		Removal of breast					
19240	T		Removal of breast	0030	39.2810	2238.35	763.55	447.67
19260	T		Removal of chest wall lesion	0021	14.8872	848.32	219.48	169.66
19271	C		Revision of chest wall					
19272	C		Extensive chest wall surgery					
19290	N		Place needle wire, breast					
19291	N		Place needle wire, breast					
19295	S		Place breast clip, percut	0657	1.8392	104.80		20.96
19296	S	NI	Place po breast cath for rad	1524		3250.00		650.00

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
19297	S	NI	Place breast cath for rad	1523		2750.00		550.00
19298	S	NI	Place breast rad tube/caths	1524		3250.00		650.00
19316	T		Suspension of breast	0029	31.3655	1787.30	632.64	357.46
19318	T		Reduction of large breast	0693	41.2736	2351.89	798.17	470.38
19324	T		Enlarge breast	0693	41.2736	2351.89	798.17	470.38
19325	T		Enlarge breast with implant	0648	50.5103	2878.23		575.65
19328	T		Removal of breast implant	0029	31.3655	1787.30	632.64	357.46
19330	T		Removal of implant material	0029	31.3655	1787.30	632.64	357.46
19340	T		Immediate breast prosthesis	0030	39.2810	2238.35	763.55	447.67
19342	T		Delayed breast prosthesis	0648	50.5103	2878.23		575.65
19350	T		Breast reconstruction	0028	18.7869	1070.53	303.74	214.11
19355	T		Correct inverted nipple(s)	0029	31.3655	1787.30	632.64	357.46
19357	T		Breast reconstruction	0648	50.5103	2878.23		575.65
19361	C		Breast reconstruction					
19364	C		Breast reconstruction					
19366	T		Breast reconstruction	0029	31.3655	1787.30	632.64	357.46
19367	C		Breast reconstruction					
19368	C		Breast reconstruction					
19369	C		Breast reconstruction					
19370	T		Surgery of breast capsule	0029	31.3655	1787.30	632.64	357.46
19371	T		Removal of breast capsule	0029	31.3655	1787.30	632.64	357.46
19380	T		Revise breast reconstruction	0030	39.2810	2238.35	763.55	447.67
19396	T		Design custom breast implant	0029	31.3655	1787.30	632.64	357.46
19499	T		Breast surgery procedure	0028	18.7869	1070.53	303.74	214.11
20000	T		Incision of abscess	0006	1.6854	96.04	23.26	19.21
20005	T		Incision of deep abscess	0049	20.2046	1151.32		230.26
2000F	E	NI	Blood pressure, measured					
20100	T		Explore wound, neck	0023	3.2236	183.69	40.37	36.74
20101	T		Explore wound, chest	0027	16.8355	959.34	329.72	191.87
20102	T		Explore wound, abdomen	0027	16.8355	959.34	329.72	191.87
20103	T		Explore wound, extremity	0023	3.2236	183.69	40.37	36.74
20150	T		Excise epiphyseal bar	0051	35.8607	2043.45		408.69
20200	T		Muscle biopsy	0021	14.8872	848.32	219.48	169.66
20205	T		Deep muscle biopsy	0021	14.8872	848.32	219.48	169.66
20206	T		Needle biopsy, muscle	0005	3.7391	213.07	71.59	42.61
20220	T		Bone biopsy, trocar/needle	0019	4.1677	237.49	71.87	47.50
20225	T		Bone biopsy, trocar/needle	0020	7.6248	434.48	113.25	86.90
20240	T		Bone biopsy, excisional	0022	19.3700	1103.76	354.45	220.75
20245	T		Bone biopsy, excisional	0022	19.3700	1103.76	354.45	220.75
20250	T		Open bone biopsy	0049	20.2046	1151.32		230.26
20251	T		Open bone biopsy	0049	20.2046	1151.32		230.26
20500	T		Injection of sinus tract	0251	1.9352	110.27		22.05
20501	N		Inject sinus tract for x-ray					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
20520	T		Removal of foreign body	0019	4.1677	237.49	71.87	47.50
20525	T		Removal of foreign body	0022	19.3700	1103.76	354.45	220.75
20526	T		Ther injection, carp tunnel	0204	2.1801	124.23	40.13	24.85
20550	T		Inj tendon sheath/ligament	0204	2.1801	124.23	40.13	24.85
20551	T		Inj tendon origin/insertion	0204	2.1801	124.23	40.13	24.85
20552	T		Inj trigger point, 1/2 muscl	0204	2.1801	124.23	40.13	24.85
20553	T		Inject trigger points, =/> 3	0204	2.1801	124.23	40.13	24.85
20600	T		Drain/inject, joint/bursa	0204	2.1801	124.23	40.13	24.85
20605	T		Drain/inject, joint/bursa	0204	2.1801	124.23	40.13	24.85
20610	T		Drain/inject, joint/bursa	0204	2.1801	124.23	40.13	24.85
20612	T		Aspirate/inj ganglion cyst	0204	2.1801	124.23	40.13	24.85
20615	T		Treatment of bone cyst	0004	1.7081	97.33	22.36	19.47
20650	T		Insert and remove bone pin	0049	20.2046	1151.32		230.26
20660	C		Apply, rem fixation device					
20661	C		Application of head brace					
20662	C		Application of pelvis brace					
20663	C		Application of thigh brace					
20664	C		Halo brace application					
20665	X		Removal of fixation device	0340	0.6328	36.06		7.21
20670	T		Removal of support implant	0021	14.8872	848.32	219.48	169.66
20680	T		Removal of support implant	0022	19.3700	1103.76	354.45	220.75
20690	T		Apply bone fixation device	0050	24.6002	1401.79		280.36
20692	T		Apply bone fixation device	0050	24.6002	1401.79		280.36
20693	T		Adjust bone fixation device	0049	20.2046	1151.32		230.26
20694	T		Remove bone fixation device	0049	20.2046	1151.32		230.26
20802	C		Replantation, arm, complete					
20805	C		Replant forearm, complete					
20808	C		Replantation hand, complete					
20816	C		Replantation digit, complete					
20822	C		Replantation digit, complete					
20824	C		Replantation thumb, complete					
20827	C		Replantation thumb, complete					
20838	C		Replantation foot, complete					
20900	T		Removal of bone for graft	0050	24.6002	1401.79		280.36
20902	T		Removal of bone for graft	0050	24.6002	1401.79		280.36
20910	T		Remove cartilage for graft	0027	16.8355	959.34	329.72	191.87
20912	T		Remove cartilage for graft	0027	16.8355	959.34	329.72	191.87
20920	T		Removal of fascia for graft	0027	16.8355	959.34	329.72	191.87
20922	T		Removal of fascia for graft	0027	16.8355	959.34	329.72	191.87
20924	T		Removal of tendon for graft	0050	24.6002	1401.79		280.36
20926	T		Removal of tissue for graft	0027	16.8355	959.34	329.72	191.87
20930	C		Spinal bone allograft					
20931	C		Spinal bone allograft					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
20936	C		Spinal bone autograft					
20937	C		Spinal bone autograft					
20938	C		Spinal bone autograft					
20950	T		Fluid pressure, muscle	0006	1.6854	96.04	23.26	19.21
20955	C		Fibula bone graft, microvasc					
20956	C		Iliac bone graft, microvasc					
20957	C		Mt bone graft, microvasc					
20962	C		Other bone graft, microvasc					
20969	C		Bone/skin graft, microvasc					
20970	C		Bone/skin graft, iliac crest					
20972	C		Bone/skin graft, metatarsal					
20973	C		Bone/skin graft, great toe					
20974	A		Electrical bone stimulation					
20975	X		Electrical bone stimulation	0340	0.6328	36.06		7.21
20979	A		Us bone stimulation					
20982	T		Ablate, bone tumor(s) perq	1557		1850.00		370.00
20999	T		Musculoskeletal surgery	0049	20.2046	1151.32		230.26
21010	T		Incision of jaw joint	0254	23.3442	1330.22	321.35	266.04
21015	T		Resection of facial tumor	0253	15.9877	911.03	282.29	182.21
21025	T		Excision of bone, lower jaw	0256	36.9298	2104.37		420.87
21026	T		Excision of facial bone(s)	0256	36.9298	2104.37		420.87
21029	T		Contour of face bone lesion	0256	36.9298	2104.37		420.87
21030	T		Excise max/zygoma b9 tumor	0254	23.3442	1330.22	321.35	266.04
21031	T		Remove exostosis, mandible	0254	23.3442	1330.22	321.35	266.04
21032	T		Remove exostosis, maxilla	0254	23.3442	1330.22	321.35	266.04
21034	T		Excise max/zygoma mlg tumor	0256	36.9298	2104.37		420.87
21040	T		Excise mandible lesion	0254	23.3442	1330.22	321.35	266.04
21044	T		Removal of jaw bone lesion	0256	36.9298	2104.37		420.87
21045	C		Extensive jaw surgery					
21046	T		Remove mandible cyst complex	0256	36.9298	2104.37		420.87
21047	T		Excise lwr jaw cyst w/repair	0256	36.9298	2104.37		420.87
21048	T		Remove maxilla cyst complex	0256	36.9298	2104.37		420.87
21049	T		Excis uppr jaw cyst w/repair	0256	36.9298	2104.37		420.87
21050	T		Removal of jaw joint	0256	36.9298	2104.37		420.87
21060	T		Remove jaw joint cartilage	0256	36.9298	2104.37		420.87
21070	T		Remove coronoid process	0256	36.9298	2104.37		420.87
21076	T		Prepare face/oral prosthesis	0254	23.3442	1330.22	321.35	266.04
21077	T		Prepare face/oral prosthesis	0256	36.9298	2104.37		420.87
21079	T		Prepare face/oral prosthesis	0256	36.9298	2104.37		420.87
21080	T		Prepare face/oral prosthesis	0256	36.9298	2104.37		420.87
21081	T		Prepare face/oral prosthesis	0256	36.9298	2104.37		420.87
21082	T		Prepare face/oral prosthesis	0256	36.9298	2104.37		420.87
21083	T		Prepare face/oral prosthesis	0256	36.9298	2104.37		420.87

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21084	T		Prepare face/oral prosthesis	0256	36.9298	2104.37		420.87
21085	T		Prepare face/oral prosthesis	0253	15.9877	911.03	282.29	182.21
21086	T		Prepare face/oral prosthesis	0256	36.9298	2104.37		420.87
21087	T		Prepare face/oral prosthesis	0256	36.9298	2104.37		420.87
21088	T		Prepare face/oral prosthesis	0256	36.9298	2104.37		420.87
21089	T		Prepare face/oral prosthesis	0251	1.9352	110.27		22.05
21100	T		Maxillofacial fixation	0256	36.9298	2104.37		420.87
21110	T		Interdental fixation	0252	6.5183	371.43	113.41	74.29
21116	N		Injection, jaw joint x-ray					
21120	T		Reconstruction of chin	0254	23.3442	1330.22	321.35	266.04
21121	T		Reconstruction of chin	0254	23.3442	1330.22	321.35	266.04
21122	T		Reconstruction of chin	0254	23.3442	1330.22	321.35	266.04
21123	T		Reconstruction of chin	0254	23.3442	1330.22	321.35	266.04
21125	T		Augmentation, lower jaw bone	0254	23.3442	1330.22	321.35	266.04
21127	T		Augmentation, lower jaw bone	0256	36.9298	2104.37		420.87
21137	T		Reduction of forehead	0254	23.3442	1330.22	321.35	266.04
21138	T		Reduction of forehead	0256	36.9298	2104.37		420.87
21139	T		Reduction of forehead	0256	36.9298	2104.37		420.87
21141	C		Reconstruct midface, lefort					
21142	C		Reconstruct midface, lefort					
21143	C		Reconstruct midface, lefort					
21145	C		Reconstruct midface, lefort					
21146	C		Reconstruct midface, lefort					
21147	C		Reconstruct midface, lefort					
21150	C		Reconstruct midface, lefort					
21151	C		Reconstruct midface, lefort					
21154	C		Reconstruct midface, lefort					
21155	C		Reconstruct midface, lefort					
21159	C		Reconstruct midface, lefort					
21160	C		Reconstruct midface, lefort					
21172	C		Reconstruct orbit/forehead					
21175	C		Reconstruct orbit/forehead					
21179	C		Reconstruct entire forehead					
21180	C		Reconstruct entire forehead					
21181	T		Contour cranial bone lesion	0254	23.3442	1330.22	321.35	266.04
21182	C		Reconstruct cranial bone					
21183	C		Reconstruct cranial bone					
21184	C		Reconstruct cranial bone					
21188	C		Reconstruction of midface					
21193	C		Reconst lwr jaw w/o graft					
21194	C		Reconst lwr jaw w/graft					
21195	C		Reconst lwr jaw w/o fixation					
21196	C		Reconst lwr jaw w/fixation					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21198	T		Reconstr lwr jaw segment	0256	36.9298	2104.37		420.87
21199	T		Reconstr lwr jaw w/advance	0256	36.9298	2104.37		420.87
21206	T		Reconstruct upper jaw bone	0256	36.9298	2104.37		420.87
21208	T		Augmentation of facial bones	0256	36.9298	2104.37		420.87
21209	T		Reduction of facial bones	0256	36.9298	2104.37		420.87
21210	T		Face bone graft	0256	36.9298	2104.37		420.87
21215	T		Lower jaw bone graft	0256	36.9298	2104.37		420.87
21230	T		Rib cartilage graft	0256	36.9298	2104.37		420.87
21235	T		Ear cartilage graft	0254	23.3442	1330.22	321.35	266.04
21240	T		Reconstruction of jaw joint	0256	36.9298	2104.37		420.87
21242	T		Reconstruction of jaw joint	0256	36.9298	2104.37		420.87
21243	T		Reconstruction of jaw joint	0256	36.9298	2104.37		420.87
21244	T		Reconstruction of lower jaw	0256	36.9298	2104.37		420.87
21245	T		Reconstruction of jaw	0256	36.9298	2104.37		420.87
21246	T		Reconstruction of jaw	0256	36.9298	2104.37		420.87
21247	C		Reconstruct lower jaw bone					
21248	T		Reconstruction of jaw	0256	36.9298	2104.37		420.87
21249	T		Reconstruction of jaw	0256	36.9298	2104.37		420.87
21255	C		Reconstruct lower jaw bone					
21256	C		Reconstruction of orbit					
21260	T		Revise eye sockets	0256	36.9298	2104.37		420.87
21261	T		Revise eye sockets	0256	36.9298	2104.37		420.87
21263	T		Revise eye sockets	0256	36.9298	2104.37		420.87
21267	T		Revise eye sockets	0256	36.9298	2104.37		420.87
21268	C		Revise eye sockets					
21270	T		Augmentation, cheek bone	0256	36.9298	2104.37		420.87
21275	T		Revision, orbitofacial bones	0256	36.9298	2104.37		420.87
21280	T		Revision of eyelid	0256	36.9298	2104.37		420.87
21282	T		Revision of eyelid	0253	15.9877	911.03	282.29	182.21
21295	T		Revision of jaw muscle/bone	0252	6.5183	371.43	113.41	74.29
21296	T		Revision of jaw muscle/bone	0254	23.3442	1330.22	321.35	266.04
21299	T		Cranio/maxillofacial surgery	0251	1.9352	110.27		22.05
21300	T		Treatment of skull fracture	0253	15.9877	911.03	282.29	182.21
21310	T		Treatment of nose fracture	0251	1.9352	110.27		22.05
21315	T		Treatment of nose fracture	0251	1.9352	110.27		22.05
21320	T		Treatment of nose fracture	0252	6.5183	371.43	113.41	74.29
21325	T		Treatment of nose fracture	0254	23.3442	1330.22	321.35	266.04
21330	T		Treatment of nose fracture	0254	23.3442	1330.22	321.35	266.04
21335	T		Treatment of nose fracture	0254	23.3442	1330.22	321.35	266.04
21336	T		Treat nasal septal fracture	0046	35.1105	2000.70	535.76	400.14
21337	T		Treat nasal septal fracture	0253	15.9877	911.03	282.29	182.21
21338	T		Treat nasoethmoid fracture	0254	23.3442	1330.22	321.35	266.04
21339	T		Treat nasoethmoid fracture	0254	23.3442	1330.22	321.35	266.04

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21340	T		Treatment of nose fracture	0256	36.9298	2104.37		420.87
21343	C		Treatment of sinus fracture					
21344	C		Treatment of sinus fracture					
21345	T		Treat nose/jaw fracture	0254	23.3442	1330.22	321.35	266.04
21346	C		Treat nose/jaw fracture					
21347	C		Treat nose/jaw fracture					
21348	C		Treat nose/jaw fracture					
21355	T		Treat cheek bone fracture	0256	36.9298	2104.37		420.87
21356	T		Treat cheek bone fracture	0254	23.3442	1330.22	321.35	266.04
21360	C		Treat cheek bone fracture					
21365	C		Treat cheek bone fracture					
21366	C		Treat cheek bone fracture					
21385	C		Treat eye socket fracture					
21386	C		Treat eye socket fracture					
21387	C		Treat eye socket fracture					
21390	T		Treat eye socket fracture	0256	36.9298	2104.37		420.87
21395	C		Treat eye socket fracture					
21400	T		Treat eye socket fracture	0252	6.5183	371.43	113.41	74.29
21401	T		Treat eye socket fracture	0253	15.9877	911.03	282.29	182.21
21406	T		Treat eye socket fracture	0256	36.9298	2104.37		420.87
21407	T		Treat eye socket fracture	0256	36.9298	2104.37		420.87
21408	C		Treat eye socket fracture					
21421	T		Treat mouth roof fracture	0254	23.3442	1330.22	321.35	266.04
21422	C		Treat mouth roof fracture					
21423	C		Treat mouth roof fracture					
21431	C		Treat craniofacial fracture					
21432	C		Treat craniofacial fracture					
21433	C		Treat craniofacial fracture					
21435	C		Treat craniofacial fracture					
21436	C		Treat craniofacial fracture					
21440	T		Treat dental ridge fracture	0254	23.3442	1330.22	321.35	266.04
21445	T		Treat dental ridge fracture	0254	23.3442	1330.22	321.35	266.04
21450	T		Treat lower jaw fracture	0251	1.9352	110.27		22.05
21451	T		Treat lower jaw fracture	0252	6.5183	371.43	113.41	74.29
21452	T		Treat lower jaw fracture	0253	15.9877	911.03	282.29	182.21
21453	T		Treat lower jaw fracture	0256	36.9298	2104.37		420.87
21454	T		Treat lower jaw fracture	0254	23.3442	1330.22	321.35	266.04
21461	T		Treat lower jaw fracture	0256	36.9298	2104.37		420.87
21462	T		Treat lower jaw fracture	0256	36.9298	2104.37		420.87
21465	T		Treat lower jaw fracture	0256	36.9298	2104.37		420.87
21470	T		Treat lower jaw fracture	0256	36.9298	2104.37		420.87
21480	T		Reset dislocated jaw	0251	1.9352	110.27		22.05
21485	T		Reset dislocated jaw	0253	15.9877	911.03	282.29	182.21

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21490	T		Repair dislocated jaw	0256	36.9298	2104.37		420.87
21493	T		Treat hyoid bone fracture	0252	6.5183	371.43	113.41	74.29
21494	T		Treat hyoid bone fracture	0252	6.5183	371.43	113.41	74.29
21495	C		Treat hyoid bone fracture					
21497	T		Interdental wiring	0253	15.9877	911.03	282.29	182.21
21499	T		Head surgery procedure	0251	1.9352	110.27		22.05
21501	T		Drain neck/chest lesion	0008	19.3572	1103.03		220.61
21502	T		Drain chest lesion	0049	20.2046	1151.32		230.26
21510	C		Drainage of bone lesion					
21550	T		Biopsy of neck/chest	0021	14.8872	848.32	219.48	169.66
21555	T		Remove lesion, neck/chest	0022	19.3700	1103.76	354.45	220.75
21556	T		Remove lesion, neck/chest	0022	19.3700	1103.76	354.45	220.75
21557	T		Remove tumor, neck/chest	0022	19.3700	1103.76	354.45	220.75
21600	T		Partial removal of rib	0050	24.6002	1401.79		280.36
21610	T		Partial removal of rib	0050	24.6002	1401.79		280.36
21615	C		Removal of rib					
21616	C		Removal of rib and nerves					
21620	C		Partial removal of sternum					
21627	C		Sternal debridement					
21630	C		Extensive sternum surgery					
21632	C		Extensive sternum surgery					
21685	T		Hyoid myotomy & suspension	0252	6.5183	371.43	113.41	74.29
21700	T		Revision of neck muscle	0049	20.2046	1151.32		230.26
21705	C		Revision of neck muscle/rib					
21720	T		Revision of neck muscle	0049	20.2046	1151.32		230.26
21725	T		Revision of neck muscle	0006	1.6854	96.04	23.26	19.21
21740	C		Reconstruction of sternum					
21742	T		Repair stern/nuss w/o scope	0051	35.8607	2043.45		408.69
21743	T		Repair sternum/nuss w/scope	0051	35.8607	2043.45		408.69
21750	C		Repair of sternum separation					
21800	T		Treatment of rib fracture	0043	1.8527	105.57		21.11
21805	T		Treatment of rib fracture	0046	35.1105	2000.70	535.76	400.14
21810	C		Treatment of rib fracture(s)					
21820	T		Treat sternum fracture	0043	1.8527	105.57		21.11
21825	C		Treat sternum fracture					
21899	T		Neck/chest surgery procedure	0251	1.9352	110.27		22.05
21920	T		Biopsy soft tissue of back	0020	7.6248	434.48	113.25	86.90
21925	T		Biopsy soft tissue of back	0022	19.3700	1103.76	354.45	220.75
21930	T		Remove lesion, back or flank	0022	19.3700	1103.76	354.45	220.75
21935	T		Remove tumor, back	0022	19.3700	1103.76	354.45	220.75
22100	T		Remove part of neck vertebra	0208	42.5700	2425.77		485.15
22101	T		Remove part, thorax vertebra	0208	42.5700	2425.77		485.15
22102	T		Remove part, lumbar vertebra	0208	42.5700	2425.77		485.15

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
22103	T		Remove extra spine segment	0208	42.5700	2425.77		485.15
22110	C		Remove part of neck vertebra					
22112	C		Remove part, thorax vertebra					
22114	C		Remove part, lumbar vertebra					
22116	C		Remove extra spine segment					
22210	C		Revision of neck spine					
22212	C		Revision of thorax spine					
22214	C		Revision of lumbar spine					
22216	C		Revise, extra spine segment					
22220	C		Revision of neck spine					
22222	T		Revision of thorax spine	0208	42.5700	2425.77		485.15
22224	C		Revision of lumbar spine					
22226	C		Revise, extra spine segment					
22305	T		Treat spine process fracture	0043	1.8527	105.57		21.11
22310	T		Treat spine fracture	0043	1.8527	105.57		21.11
22315	T		Treat spine fracture	0043	1.8527	105.57		21.11
22318	C		Treat odontoid fx w/o graft					
22319	C		Treat odontoid fx w/graft					
22325	C		Treat spine fracture					
22326	C		Treat neck spine fracture					
22327	C		Treat thorax spine fracture					
22328	C		Treat each add spine fx					
22505	T		Manipulation of spine	0045	14.2091	809.68	268.47	161.94
22520	T		Percut vertebroplasty thor	0050	24.6002	1401.79		280.36
22521	T		Percut vertebroplasty lumb	0050	24.6002	1401.79		280.36
22522	T		Percut vertebroplasty add'l	0050	24.6002	1401.79		280.36
22532	C		Lat thorax spine fusion					
22533	C		Lat lumbar spine fusion					
22534	C		Lat thor/lumb, add'l seg					
22548	C		Neck spine fusion					
22554	C		Neck spine fusion					
22556	C		Thorax spine fusion					
22558	C		Lumbar spine fusion					
22585	C		Additional spinal fusion					
22590	C		Spine & skull spinal fusion					
22595	C		Neck spinal fusion					
22600	C		Neck spine fusion					
22610	C		Thorax spine fusion					
22612	T		Lumbar spine fusion	0208	42.5700	2425.77		485.15
22614	T		Spine fusion, extra segment	0208	42.5700	2425.77		485.15
22630	C		Lumbar spine fusion					
22632	C		Spine fusion, extra segment					
22800	C		Fusion of spine					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
22802	C		Fusion of spine		.	.	.	.
22804	C		Fusion of spine		.	.	.	.
22808	C		Fusion of spine		.	.	.	.
22810	C		Fusion of spine		.	.	.	.
22812	C		Fusion of spine		.	.	.	.
22818	C		Kyphectomy, 1-2 segments		.	.	.	.
22819	C		Kyphectomy, 3 or more		.	.	.	.
22830	C		Exploration of spinal fusion		.	.	.	.
22840	C		Insert spine fixation device		.	.	.	.
22841	C		Insert spine fixation device		.	.	.	.
22842	C		Insert spine fixation device		.	.	.	.
22843	C		Insert spine fixation device		.	.	.	.
22844	C		Insert spine fixation device		.	.	.	.
22845	C		Insert spine fixation device		.	.	.	.
22846	C		Insert spine fixation device		.	.	.	.
22847	C		Insert spine fixation device		.	.	.	.
22848	C		Insert pelv fixation device		.	.	.	.
22849	C		Reinsert spinal fixation		.	.	.	.
22850	C		Remove spine fixation device		.	.	.	.
22851	C		Apply spine prosth device		.	.	.	.
22852	C		Remove spine fixation device		.	.	.	.
22855	C		Remove spine fixation device		.	.	.	.
22899	T		Spine surgery procedure	0043	1.8527	105.57	.	21.11
22900	T		Remove abdominal wall lesion	0022	19.3700	1103.76	354.45	220.75
22999	T		Abdomen surgery procedure	0019	4.1677	237.49	71.87	47.50
23000	T		Removal of calcium deposits	0021	14.8872	848.32	219.48	169.66
23020	T		Release shoulder joint	0051	35.8607	2043.45	.	408.69
23030	T		Drain shoulder lesion	0008	19.3572	1103.03	.	220.61
23031	T		Drain shoulder bursa	0008	19.3572	1103.03	.	220.61
23035	T		Drain shoulder bone lesion	0049	20.2046	1151.32	.	230.26
23040	T		Exploratory shoulder surgery	0050	24.6002	1401.79	.	280.36
23044	T		Exploratory shoulder surgery	0050	24.6002	1401.79	.	280.36
23065	T		Biopsy shoulder tissues	0021	14.8872	848.32	219.48	169.66
23066	T		Biopsy shoulder tissues	0022	19.3700	1103.76	354.45	220.75
23075	T		Removal of shoulder lesion	0021	14.8872	848.32	219.48	169.66
23076	T		Removal of shoulder lesion	0022	19.3700	1103.76	354.45	220.75
23077	T		Remove tumor of shoulder	0022	19.3700	1103.76	354.45	220.75
23100	T		Biopsy of shoulder joint	0049	20.2046	1151.32	.	230.26
23101	T		Shoulder joint surgery	0050	24.6002	1401.79	.	280.36
23105	T		Remove shoulder joint lining	0050	24.6002	1401.79	.	280.36
23106	T		Incision of collarbone joint	0050	24.6002	1401.79	.	280.36
23107	T		Explore treat shoulder joint	0050	24.6002	1401.79	.	280.36
23120	T		Partial removal, collar bone	0051	35.8607	2043.45	.	408.69

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
23125	T		Removal of collar bone	0051	35.8607	2043.45		408.69
23130	T		Remove shoulder bone, part	0051	35.8607	2043.45		408.69
23140	T		Removal of bone lesion	0049	20.2046	1151.32		230.26
23145	T		Removal of bone lesion	0050	24.6002	1401.79		280.36
23146	T		Removal of bone lesion	0050	24.6002	1401.79		280.36
23150	T		Removal of humerus lesion	0050	24.6002	1401.79		280.36
23155	T		Removal of humerus lesion	0050	24.6002	1401.79		280.36
23156	T		Removal of humerus lesion	0050	24.6002	1401.79		280.36
23170	T		Remove collar bone lesion	0050	24.6002	1401.79		280.36
23172	T		Remove shoulder blade lesion	0050	24.6002	1401.79		280.36
23174	T		Remove humerus lesion	0050	24.6002	1401.79		280.36
23180	T		Remove collar bone lesion	0050	24.6002	1401.79		280.36
23182	T		Remove shoulder blade lesion	0050	24.6002	1401.79		280.36
23184	T		Remove humerus lesion	0050	24.6002	1401.79		280.36
23190	T		Partial removal of scapula	0050	24.6002	1401.79		280.36
23195	T		Removal of head of humerus	0050	24.6002	1401.79		280.36
23200	C		Removal of collar bone					
23210	C		Removal of shoulder blade					
23220	C		Partial removal of humerus					
23221	C		Partial removal of humerus					
23222	C		Partial removal of humerus					
23330	T		Remove shoulder foreign body	0020	7.6248	434.48	113.25	86.90
23331	T		Remove shoulder foreign body	0022	19.3700	1103.76	354.45	220.75
23332	C		Remove shoulder foreign body					
23350	N		Injection for shoulder x-ray					
23395	T		Muscle transfer,shoulder/arm	0051	35.8607	2043.45		408.69
23397	T		Muscle transfers	0052	43.5754	2483.06		496.61
23400	T		Fixation of shoulder blade	0050	24.6002	1401.79		280.36
23405	T		Incision of tendon & muscle	0050	24.6002	1401.79		280.36
23406	T		Incise tendon(s) & muscle(s)	0050	24.6002	1401.79		280.36
23410	T		Repair rotator cuff, acute	0052	43.5754	2483.06		496.61
23412	T		Repair rotator cuff, chronic	0052	43.5754	2483.06		496.61
23415	T		Release of shoulder ligament	0051	35.8607	2043.45		408.69
23420	T		Repair of shoulder	0052	43.5754	2483.06		496.61
23430	T		Repair biceps tendon	0052	43.5754	2483.06		496.61
23440	T		Remove/transplant tendon	0052	43.5754	2483.06		496.61
23450	T		Repair shoulder capsule	0052	43.5754	2483.06		496.61
23455	T		Repair shoulder capsule	0052	43.5754	2483.06		496.61
23460	T		Repair shoulder capsule	0052	43.5754	2483.06		496.61
23462	T		Repair shoulder capsule	0052	43.5754	2483.06		496.61
23465	T		Repair shoulder capsule	0052	43.5754	2483.06		496.61
23466	T		Repair shoulder capsule	0052	43.5754	2483.06		496.61
23470	T		Reconstruct shoulder joint	0425	97.6127	5562.26	1378.01	1112.45

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
23472	C		Reconstruct shoulder joint					
23480	T		Revision of collar bone	0051	35.8607	2043.45		408.69
23485	T		Revision of collar bone	0051	35.8607	2043.45		408.69
23490	T		Reinforce clavicle	0051	35.8607	2043.45		408.69
23491	T		Reinforce shoulder bones	0051	35.8607	2043.45		408.69
23500	T		Treat clavicle fracture	0043	1.8527	105.57		21.11
23505	T		Treat clavicle fracture	0043	1.8527	105.57		21.11
23515	T		Treat clavicle fracture	0046	35.1105	2000.70	535.76	400.14
23520	T		Treat clavicle dislocation	0043	1.8527	105.57		21.11
23525	T		Treat clavicle dislocation	0043	1.8527	105.57		21.11
23530	T		Treat clavicle dislocation	0046	35.1105	2000.70	535.76	400.14
23532	T		Treat clavicle dislocation	0046	35.1105	2000.70	535.76	400.14
23540	T		Treat clavicle dislocation	0043	1.8527	105.57		21.11
23545	T		Treat clavicle dislocation	0043	1.8527	105.57		21.11
23550	T		Treat clavicle dislocation	0046	35.1105	2000.70	535.76	400.14
23552	T		Treat clavicle dislocation	0046	35.1105	2000.70	535.76	400.14
23570	T		Treat shoulder blade fx	0043	1.8527	105.57		21.11
23575	T		Treat shoulder blade fx	0043	1.8527	105.57		21.11
23585	T		Treat scapula fracture	0046	35.1105	2000.70	535.76	400.14
23600	T		Treat humerus fracture	0043	1.8527	105.57		21.11
23605	T		Treat humerus fracture	0043	1.8527	105.57		21.11
23615	T		Treat humerus fracture	0046	35.1105	2000.70	535.76	400.14
23616	T		Treat humerus fracture	0046	35.1105	2000.70	535.76	400.14
23620	T		Treat humerus fracture	0043	1.8527	105.57		21.11
23625	T		Treat humerus fracture	0043	1.8527	105.57		21.11
23630	T		Treat humerus fracture	0046	35.1105	2000.70	535.76	400.14
23650	T		Treat shoulder dislocation	0043	1.8527	105.57		21.11
23655	T		Treat shoulder dislocation	0045	14.2091	809.68	268.47	161.94
23660	T		Treat shoulder dislocation	0046	35.1105	2000.70	535.76	400.14
23665	T		Treat dislocation/fracture	0043	1.8527	105.57		21.11
23670	T		Treat dislocation/fracture	0046	35.1105	2000.70	535.76	400.14
23675	T		Treat dislocation/fracture	0043	1.8527	105.57		21.11
23680	T		Treat dislocation/fracture	0046	35.1105	2000.70	535.76	400.14
23700	T		Fixation of shoulder	0045	14.2091	809.68	268.47	161.94
23800	T		Fusion of shoulder joint	0051	35.8607	2043.45		408.69
23802	T		Fusion of shoulder joint	0051	35.8607	2043.45		408.69
23900	C		Amputation of arm & girdle					
23920	C		Amputation at shoulder joint					
23921	T		Amputation follow-up surgery	0025	4.7315	269.62	101.85	53.92
23929	T		Shoulder surgery procedure	0043	1.8527	105.57		21.11
23930	T		Drainage of arm lesion	0008	19.3572	1103.03		220.61
23931	T		Drainage of arm bursa	0007	12.4496	709.42		141.88
23935	T		Drain arm/elbow bone lesion	0049	20.2046	1151.32		230.26

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
24000	T		Exploratory elbow surgery	0050	24.6002	1401.79		280.36
24006	T		Release elbow joint	0050	24.6002	1401.79		280.36
24065	T		Biopsy arm/elbow soft tissue	0021	14.8872	848.32	219.48	169.66
24066	T		Biopsy arm/elbow soft tissue	0021	14.8872	848.32	219.48	169.66
24075	T		Remove arm/elbow lesion	0021	14.8872	848.32	219.48	169.66
24076	T		Remove arm/elbow lesion	0022	19.3700	1103.76	354.45	220.75
24077	T		Remove tumor of arm/elbow	0022	19.3700	1103.76	354.45	220.75
24100	T		Biopsy elbow joint lining	0049	20.2046	1151.32		230.26
24101	T		Explore/treat elbow joint	0050	24.6002	1401.79		280.36
24102	T		Remove elbow joint lining	0050	24.6002	1401.79		280.36
24105	T		Removal of elbow bursa	0049	20.2046	1151.32		230.26
24110	T		Remove humerus lesion	0049	20.2046	1151.32		230.26
24115	T		Remove/graft bone lesion	0050	24.6002	1401.79		280.36
24116	T		Remove/graft bone lesion	0050	24.6002	1401.79		280.36
24120	T		Remove elbow lesion	0049	20.2046	1151.32		230.26
24125	T		Remove/graft bone lesion	0050	24.6002	1401.79		280.36
24126	T		Remove/graft bone lesion	0050	24.6002	1401.79		280.36
24130	T		Removal of head of radius	0050	24.6002	1401.79		280.36
24134	T		Removal of arm bone lesion	0050	24.6002	1401.79		280.36
24136	T		Remove radius bone lesion	0050	24.6002	1401.79		280.36
24138	T		Remove elbow bone lesion	0050	24.6002	1401.79		280.36
24140	T		Partial removal of arm bone	0050	24.6002	1401.79		280.36
24145	T		Partial removal of radius	0050	24.6002	1401.79		280.36
24147	T		Partial removal of elbow	0050	24.6002	1401.79		280.36
24149	T		Radical resection of elbow	0050	24.6002	1401.79		280.36
24150	T		Extensive humerus surgery	0052	43.5754	2483.06		496.61
24151	T		Extensive humerus surgery	0052	43.5754	2483.06		496.61
24152	T		Extensive radius surgery	0052	43.5754	2483.06		496.61
24153	T		Extensive radius surgery	0052	43.5754	2483.06		496.61
24155	T		Removal of elbow joint	0051	35.8607	2043.45		408.69
24160	T		Remove elbow joint implant	0050	24.6002	1401.79		280.36
24164	T		Remove radius head implant	0050	24.6002	1401.79		280.36
24200	T		Removal of arm foreign body	0019	4.1677	237.49	71.87	47.50
24201	T		Removal of arm foreign body	0021	14.8872	848.32	219.48	169.66
24220	N		Injection for elbow x-ray					
24300	T		Manipulate elbow w/anesth	0045	14.2091	809.68	268.47	161.94
24301	T		Muscle/tendon transfer	0050	24.6002	1401.79		280.36
24305	T		Arm tendon lengthening	0050	24.6002	1401.79		280.36
24310	T		Revision of arm tendon	0049	20.2046	1151.32		230.26
24320	T		Repair of arm tendon	0051	35.8607	2043.45		408.69
24330	T		Revision of arm muscles	0051	35.8607	2043.45		408.69
24331	T		Revision of arm muscles	0051	35.8607	2043.45		408.69
24332	T		Tenolysis, triceps	0049	20.2046	1151.32		230.26

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
24340	T		Repair of biceps tendon	0051	35.8607	2043.45		408.69
24341	T		Repair arm tendon/muscle	0051	35.8607	2043.45		408.69
24342	T		Repair of ruptured tendon	0051	35.8607	2043.45		408.69
24343	T		Repr elbow lat ligmnt w/tiss	0050	24.6002	1401.79		280.36
24344	T		Reconstruct elbow lat ligmnt	0051	35.8607	2043.45		408.69
24345	T		Repr elbw med ligmnt w/tissu	0050	24.6002	1401.79		280.36
24346	T		Reconstruct elbow med ligmnt	0051	35.8607	2043.45		408.69
24350	T		Repair of tennis elbow	0050	24.6002	1401.79		280.36
24351	T		Repair of tennis elbow	0050	24.6002	1401.79		280.36
24352	T		Repair of tennis elbow	0050	24.6002	1401.79		280.36
24354	T		Repair of tennis elbow	0050	24.6002	1401.79		280.36
24356	T		Revision of tennis elbow	0050	24.6002	1401.79		280.36
24360	T		Reconstruct elbow joint	0047	31.0492	1769.28	537.03	353.86
24361	T		Reconstruct elbow joint	0425	97.6127	5562.26	1378.01	1112.45
24362	T		Reconstruct elbow joint	0048	40.3978	2301.99	570.30	460.40
24363	T		Replace elbow joint	0425	97.6127	5562.26	1378.01	1112.45
24365	T		Reconstruct head of radius	0047	31.0492	1769.28	537.03	353.86
24366	T		Reconstruct head of radius	0425	97.6127	5562.26	1378.01	1112.45
24400	T		Revision of humerus	0050	24.6002	1401.79		280.36
24410	T		Revision of humerus	0050	24.6002	1401.79		280.36
24420	T		Revision of humerus	0051	35.8607	2043.45		408.69
24430	T		Repair of humerus	0051	35.8607	2043.45		408.69
24435	T		Repair humerus with graft	0051	35.8607	2043.45		408.69
24470	T		Revision of elbow joint	0051	35.8607	2043.45		408.69
24495	T		Decompression of forearm	0050	24.6002	1401.79		280.36
24498	T		Reinforce humerus	0051	35.8607	2043.45		408.69
24500	T		Treat humerus fracture	0043	1.8527	105.57		21.11
24505	T		Treat humerus fracture	0043	1.8527	105.57		21.11
24515	T		Treat humerus fracture	0046	35.1105	2000.70	535.76	400.14
24516	T		Treat humerus fracture	0046	35.1105	2000.70	535.76	400.14
24530	T		Treat humerus fracture	0043	1.8527	105.57		21.11
24535	T		Treat humerus fracture	0043	1.8527	105.57		21.11
24538	T		Treat humerus fracture	0046	35.1105	2000.70	535.76	400.14
24545	T		Treat humerus fracture	0046	35.1105	2000.70	535.76	400.14
24546	T		Treat humerus fracture	0046	35.1105	2000.70	535.76	400.14
24560	T		Treat humerus fracture	0043	1.8527	105.57		21.11
24565	T		Treat humerus fracture	0043	1.8527	105.57		21.11
24566	T		Treat humerus fracture	0046	35.1105	2000.70	535.76	400.14
24575	T		Treat humerus fracture	0046	35.1105	2000.70	535.76	400.14
24576	T		Treat humerus fracture	0043	1.8527	105.57		21.11
24577	T		Treat humerus fracture	0043	1.8527	105.57		21.11
24579	T		Treat humerus fracture	0046	35.1105	2000.70	535.76	400.14
24582	T		Treat humerus fracture	0046	35.1105	2000.70	535.76	400.14

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
24586	T		Treat elbow fracture	0046	35.1105	2000.70	535.76	400.14
24587	T		Treat elbow fracture	0046	35.1105	2000.70	535.76	400.14
24600	T		Treat elbow dislocation	0043	1.8527	105.57		21.11
24605	T		Treat elbow dislocation	0045	14.2091	809.68	268.47	161.94
24615	T		Treat elbow dislocation	0046	35.1105	2000.70	535.76	400.14
24620	T		Treat elbow fracture	0043	1.8527	105.57		21.11
24635	T		Treat elbow fracture	0046	35.1105	2000.70	535.76	400.14
24640	T		Treat elbow dislocation	0043	1.8527	105.57		21.11
24650	T		Treat radius fracture	0043	1.8527	105.57		21.11
24655	T		Treat radius fracture	0043	1.8527	105.57		21.11
24665	T		Treat radius fracture	0046	35.1105	2000.70	535.76	400.14
24666	T		Treat radius fracture	0046	35.1105	2000.70	535.76	400.14
24670	T		Treat ulnar fracture	0043	1.8527	105.57		21.11
24675	T		Treat ulnar fracture	0043	1.8527	105.57		21.11
24685	T		Treat ulnar fracture	0046	35.1105	2000.70	535.76	400.14
24800	T		Fusion of elbow joint	0051	35.8607	2043.45		408.69
24802	T		Fusion/graft of elbow joint	0051	35.8607	2043.45		408.69
24900	C		Amputation of upper arm					
24920	C		Amputation of upper arm					
24925	T		Amputation follow-up surgery	0049	20.2046	1151.32		230.26
24930	C		Amputation follow-up surgery					
24931	C		Amputate upper arm & implant					
24935	T		Revision of amputation	0052	43.5754	2483.06		496.61
24940	C		Revision of upper arm					
24999	T		Upper arm/elbow surgery	0043	1.8527	105.57		21.11
25000	T		Incision of tendon sheath	0049	20.2046	1151.32		230.26
25001	T		Incise flexor carpi radialis	0049	20.2046	1151.32		230.26
25020	T		Decompress forearm 1 space	0049	20.2046	1151.32		230.26
25023	T		Decompress forearm 1 space	0050	24.6002	1401.79		280.36
25024	T		Decompress forearm 2 spaces	0050	24.6002	1401.79		280.36
25025	T		Decompress forearm 2 spaces	0050	24.6002	1401.79		280.36
25028	T		Drainage of forearm lesion	0049	20.2046	1151.32		230.26
25031	T		Drainage of forearm bursa	0049	20.2046	1151.32		230.26
25035	T		Treat forearm bone lesion	0049	20.2046	1151.32		230.26
25040	T		Explore/treat wrist joint	0050	24.6002	1401.79		280.36
25065	T		Biopsy forearm soft tissues	0021	14.8872	848.32	219.48	169.66
25066	T		Biopsy forearm soft tissues	0022	19.3700	1103.76	354.45	220.75
25075	T		Removal forearm lesion subcu	0021	14.8872	848.32	219.48	169.66
25076	T		Removal forearm lesion deep	0022	19.3700	1103.76	354.45	220.75
25077	T		Remove tumor, forearm/wrist	0022	19.3700	1103.76	354.45	220.75
25085	T		Incision of wrist capsule	0049	20.2046	1151.32		230.26
25100	T		Biopsy of wrist joint	0049	20.2046	1151.32		230.26
25101	T		Explore/treat wrist joint	0050	24.6002	1401.79		280.36

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
25105	T		Remove wrist joint lining	0050	24.6002	1401.79		280.36
25107	T		Remove wrist joint cartilage	0050	24.6002	1401.79		280.36
25110	T		Remove wrist tendon lesion	0049	20.2046	1151.32		230.26
25111	T		Remove wrist tendon lesion	0053	15.5097	883.79	253.49	176.76
25112	T		Reremove wrist tendon lesion	0053	15.5097	883.79	253.49	176.76
25115	T		Remove wrist/forearm lesion	0049	20.2046	1151.32		230.26
25116	T		Remove wrist/forearm lesion	0049	20.2046	1151.32		230.26
25118	T		Excise wrist tendon sheath	0050	24.6002	1401.79		280.36
25119	T		Partial removal of ulna	0050	24.6002	1401.79		280.36
25120	T		Removal of forearm lesion	0050	24.6002	1401.79		280.36
25125	T		Remove/graft forearm lesion	0050	24.6002	1401.79		280.36
25126	T		Remove/graft forearm lesion	0050	24.6002	1401.79		280.36
25130	T		Removal of wrist lesion	0050	24.6002	1401.79		280.36
25135	T		Remove & graft wrist lesion	0050	24.6002	1401.79		280.36
25136	T		Remove & graft wrist lesion	0050	24.6002	1401.79		280.36
25145	T		Remove forearm bone lesion	0050	24.6002	1401.79		280.36
25150	T		Partial removal of ulna	0050	24.6002	1401.79		280.36
25151	T		Partial removal of radius	0050	24.6002	1401.79		280.36
25170	T		Extensive forearm surgery	0052	43.5754	2483.06		496.61
25210	T		Removal of wrist bone	0054	24.8731	1417.34		283.47
25215	T		Removal of wrist bones	0054	24.8731	1417.34		283.47
25230	T		Partial removal of radius	0050	24.6002	1401.79		280.36
25240	T		Partial removal of ulna	0050	24.6002	1401.79		280.36
25246	N		Injection for wrist x-ray					
25248	T		Remove forearm foreign body	0049	20.2046	1151.32		230.26
25250	T		Removal of wrist prosthesis	0050	24.6002	1401.79		280.36
25251	T		Removal of wrist prosthesis	0050	24.6002	1401.79		280.36
25259	T		Manipulate wrist w/anesthes	0043	1.8527	105.57		21.11
25260	T		Repair forearm tendon/muscle	0050	24.6002	1401.79		280.36
25263	T		Repair forearm tendon/muscle	0050	24.6002	1401.79		280.36
25265	T		Repair forearm tendon/muscle	0050	24.6002	1401.79		280.36
25270	T		Repair forearm tendon/muscle	0050	24.6002	1401.79		280.36
25272	T		Repair forearm tendon/muscle	0050	24.6002	1401.79		280.36
25274	T		Repair forearm tendon/muscle	0050	24.6002	1401.79		280.36
25275	T		Repair forearm tendon sheath	0050	24.6002	1401.79		280.36
25280	T		Revise wrist/forearm tendon	0050	24.6002	1401.79		280.36
25290	T		Incise wrist/forearm tendon	0050	24.6002	1401.79		280.36
25295	T		Release wrist/forearm tendon	0049	20.2046	1151.32		230.26
25300	T		Fusion of tendons at wrist	0050	24.6002	1401.79		280.36
25301	T		Fusion of tendons at wrist	0050	24.6002	1401.79		280.36
25310	T		Transplant forearm tendon	0051	35.8607	2043.45		408.69
25312	T		Transplant forearm tendon	0051	35.8607	2043.45		408.69
25315	T		Revise palsy hand tendon(s)	0051	35.8607	2043.45		408.69

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
25316	T		Revise palsy hand tendon(s)	0051	35.8607	2043.45		408.69
25320	T		Repair/revise wrist joint	0051	35.8607	2043.45		408.69
25332	T		Revise wrist joint	0047	31.0492	1769.28	537.03	353.86
25335	T		Realignment of hand	0051	35.8607	2043.45		408.69
25337	T		Reconstruct ulna/radioulnar	0051	35.8607	2043.45		408.69
25350	T		Revision of radius	0051	35.8607	2043.45		408.69
25355	T		Revision of radius	0051	35.8607	2043.45		408.69
25360	T		Revision of ulna	0050	24.6002	1401.79		280.36
25365	T		Revise radius & ulna	0050	24.6002	1401.79		280.36
25370	T		Revise radius or ulna	0051	35.8607	2043.45		408.69
25375	T		Revise radius & ulna	0051	35.8607	2043.45		408.69
25390	T		Shorten radius or ulna	0050	24.6002	1401.79		280.36
25391	T		Lengthen radius or ulna	0051	35.8607	2043.45		408.69
25392	T		Shorten radius & ulna	0050	24.6002	1401.79		280.36
25393	T		Lengthen radius & ulna	0051	35.8607	2043.45		408.69
25394	T		Repair carpal bone, shorten	0053	15.5097	883.79	253.49	176.76
25400	T		Repair radius or ulna	0050	24.6002	1401.79		280.36
25405	T		Repair/graft radius or ulna	0050	24.6002	1401.79		280.36
25415	T		Repair radius & ulna	0050	24.6002	1401.79		280.36
25420	T		Repair/graft radius & ulna	0051	35.8607	2043.45		408.69
25425	T		Repair/graft radius or ulna	0051	35.8607	2043.45		408.69
25426	T		Repair/graft radius & ulna	0051	35.8607	2043.45		408.69
25430	T		Vasc graft into carpal bone	0054	24.8731	1417.34		283.47
25431	T		Repair nonunion carpal bone	0054	24.8731	1417.34		283.47
25440	T		Repair/graft wrist bone	0051	35.8607	2043.45		408.69
25441	T		Reconstruct wrist joint	0425	97.6127	5562.26	1378.01	1112.45
25442	T		Reconstruct wrist joint	0425	97.6127	5562.26	1378.01	1112.45
25443	T		Reconstruct wrist joint	0048	40.3978	2301.99	570.30	460.40
25444	T		Reconstruct wrist joint	0048	40.3978	2301.99	570.30	460.40
25445	T		Reconstruct wrist joint	0048	40.3978	2301.99	570.30	460.40
25446	T		Wrist replacement	0425	97.6127	5562.26	1378.01	1112.45
25447	T		Repair wrist joint(s)	0047	31.0492	1769.28	537.03	353.86
25449	T		Remove wrist joint implant	0047	31.0492	1769.28	537.03	353.86
25450	T		Revision of wrist joint	0051	35.8607	2043.45		408.69
25455	T		Revision of wrist joint	0051	35.8607	2043.45		408.69
25490	T		Reinforce radius	0051	35.8607	2043.45		408.69
25491	T		Reinforce ulna	0051	35.8607	2043.45		408.69
25492	T		Reinforce radius and ulna	0051	35.8607	2043.45		408.69
25500	T		Treat fracture of radius	0043	1.8527	105.57		21.11
25505	T		Treat fracture of radius	0043	1.8527	105.57		21.11
25515	T		Treat fracture of radius	0046	35.1105	2000.70	535.76	400.14
25520	T		Treat fracture of radius	0043	1.8527	105.57		21.11
25525	T		Treat fracture of radius	0046	35.1105	2000.70	535.76	400.14

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
25526	T		Treat fracture of radius	0046	35.1105	2000.70	535.76	400.14
25530	T		Treat fracture of ulna	0043	1.8527	105.57		21.11
25535	T		Treat fracture of ulna	0043	1.8527	105.57		21.11
25545	T		Treat fracture of ulna	0046	35.1105	2000.70	535.76	400.14
25560	T		Treat fracture radius & ulna	0043	1.8527	105.57		21.11
25565	T		Treat fracture radius & ulna	0043	1.8527	105.57		21.11
25574	T		Treat fracture radius & ulna	0046	35.1105	2000.70	535.76	400.14
25575	T		Treat fracture radius/ulna	0046	35.1105	2000.70	535.76	400.14
25600	T		Treat fracture radius/ulna	0043	1.8527	105.57		21.11
25605	T		Treat fracture radius/ulna	0043	1.8527	105.57		21.11
25611	T		Treat fracture radius/ulna	0046	35.1105	2000.70	535.76	400.14
25620	T		Treat fracture radius/ulna	0046	35.1105	2000.70	535.76	400.14
25622	T		Treat wrist bone fracture	0043	1.8527	105.57		21.11
25624	T		Treat wrist bone fracture	0043	1.8527	105.57		21.11
25628	T		Treat wrist bone fracture	0046	35.1105	2000.70	535.76	400.14
25630	T		Treat wrist bone fracture	0043	1.8527	105.57		21.11
25635	T		Treat wrist bone fracture	0043	1.8527	105.57		21.11
25645	T		Treat wrist bone fracture	0046	35.1105	2000.70	535.76	400.14
25650	T		Treat wrist bone fracture	0043	1.8527	105.57		21.11
25651	T		Pin ulnar styloid fracture	0046	35.1105	2000.70	535.76	400.14
25652	T		Treat fracture ulnar styloid	0046	35.1105	2000.70	535.76	400.14
25660	T		Treat wrist dislocation	0043	1.8527	105.57		21.11
25670	T		Treat wrist dislocation	0046	35.1105	2000.70	535.76	400.14
25671	T		Pin radioulnar dislocation	0046	35.1105	2000.70	535.76	400.14
25675	T		Treat wrist dislocation	0043	1.8527	105.57		21.11
25676	T		Treat wrist dislocation	0046	35.1105	2000.70	535.76	400.14
25680	T		Treat wrist fracture	0043	1.8527	105.57		21.11
25685	T		Treat wrist fracture	0046	35.1105	2000.70	535.76	400.14
25690	T		Treat wrist dislocation	0043	1.8527	105.57		21.11
25695	T		Treat wrist dislocation	0046	35.1105	2000.70	535.76	400.14
25800	T		Fusion of wrist joint	0051	35.8607	2043.45		408.69
25805	T		Fusion/graft of wrist joint	0051	35.8607	2043.45		408.69
25810	T		Fusion/graft of wrist joint	0051	35.8607	2043.45		408.69
25820	T		Fusion of hand bones	0053	15.5097	883.79	253.49	176.76
25825	T		Fuse hand bones with graft	0054	24.8731	1417.34		283.47
25830	T		Fusion, radioulnar jnt/ulna	0051	35.8607	2043.45		408.69
25900	C		Amputation of forearm					
25905	C		Amputation of forearm					
25907	T		Amputation follow-up surgery	0049	20.2046	1151.32		230.26
25909	C		Amputation follow-up surgery					
25915	C		Amputation of forearm					
25920	C		Amputate hand at wrist					
25922	T		Amputate hand at wrist	0049	20.2046	1151.32		230.26

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
25924	C		Amputation follow-up surgery		.	.	.	.
25927	C		Amputation of hand		.	.	.	.
25929	T		Amputation follow-up surgery	0027	16.8355	959.34	329.72	191.87
25931	C		Amputation follow-up surgery		.	.	.	.
25999	T		Forearm or wrist surgery	0043	1.8527	105.57	.	21.11
26010	T		Drainage of finger abscess	0006	1.6854	96.04	23.26	19.21
26011	T		Drainage of finger abscess	0007	12.4496	709.42	.	141.88
26020	T		Drain hand tendon sheath	0053	15.5097	883.79	253.49	176.76
26025	T		Drainage of palm bursa	0053	15.5097	883.79	253.49	176.76
26030	T		Drainage of palm bursa(s)	0053	15.5097	883.79	253.49	176.76
26034	T		Treat hand bone lesion	0053	15.5097	883.79	253.49	176.76
26035	T		Decompress fingers/hand	0053	15.5097	883.79	253.49	176.76
26037	T		Decompress fingers/hand	0053	15.5097	883.79	253.49	176.76
26040	T		Release palm contracture	0054	24.8731	1417.34	.	283.47
26045	T		Release palm contracture	0054	24.8731	1417.34	.	283.47
26055	T		Incise finger tendon sheath	0053	15.5097	883.79	253.49	176.76
26060	T		Incision of finger tendon	0053	15.5097	883.79	253.49	176.76
26070	T		Explore/treat hand joint	0053	15.5097	883.79	253.49	176.76
26075	T		Explore/treat finger joint	0053	15.5097	883.79	253.49	176.76
26080	T		Explore/treat finger joint	0053	15.5097	883.79	253.49	176.76
26100	T		Biopsy hand joint lining	0053	15.5097	883.79	253.49	176.76
26105	T		Biopsy finger joint lining	0053	15.5097	883.79	253.49	176.76
26110	T		Biopsy finger joint lining	0053	15.5097	883.79	253.49	176.76
26115	T		Removal hand lesion subcut	0022	19.3700	1103.76	354.45	220.75
26116	T		Removal hand lesion, deep	0022	19.3700	1103.76	354.45	220.75
26117	T		Remove tumor, hand/finger	0022	19.3700	1103.76	354.45	220.75
26121	T		Release palm contracture	0054	24.8731	1417.34	.	283.47
26123	T		Release palm contracture	0054	24.8731	1417.34	.	283.47
26125	T		Release palm contracture	0054	24.8731	1417.34	.	283.47
26130	T		Remove wrist joint lining	0053	15.5097	883.79	253.49	176.76
26135	T		Revise finger joint, each	0054	24.8731	1417.34	.	283.47
26140	T		Revise finger joint, each	0053	15.5097	883.79	253.49	176.76
26145	T		Tendon excision, palm/finger	0053	15.5097	883.79	253.49	176.76
26160	T		Remove tendon sheath lesion	0053	15.5097	883.79	253.49	176.76
26170	T		Removal of palm tendon, each	0053	15.5097	883.79	253.49	176.76
26180	T		Removal of finger tendon	0053	15.5097	883.79	253.49	176.76
26185	T		Remove finger bone	0053	15.5097	883.79	253.49	176.76
26200	T		Remove hand bone lesion	0053	15.5097	883.79	253.49	176.76
26205	T		Remove/graft bone lesion	0054	24.8731	1417.34	.	283.47
26210	T		Removal of finger lesion	0053	15.5097	883.79	253.49	176.76
26215	T		Remove/graft finger lesion	0053	15.5097	883.79	253.49	176.76
26230	T		Partial removal of hand bone	0053	15.5097	883.79	253.49	176.76
26235	T		Partial removal, finger bone	0053	15.5097	883.79	253.49	176.76

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
26236	T		Partial removal, finger bone	0053	15.5097	883.79	253.49	176.76
26250	T		Extensive hand surgery	0053	15.5097	883.79	253.49	176.76
26255	T		Extensive hand surgery	0054	24.8731	1417.34		283.47
26260	T		Extensive finger surgery	0053	15.5097	883.79	253.49	176.76
26261	T		Extensive finger surgery	0053	15.5097	883.79	253.49	176.76
26262	T		Partial removal of finger	0053	15.5097	883.79	253.49	176.76
26320	T		Removal of implant from hand	0021	14.8872	848.32	219.48	169.66
26340	T		Manipulate finger w/anesth	0043	1.8527	105.57		21.11
26350	T		Repair finger/hand tendon	0054	24.8731	1417.34		283.47
26352	T		Repair/graft hand tendon	0054	24.8731	1417.34		283.47
26356	T		Repair finger/hand tendon	0054	24.8731	1417.34		283.47
26357	T		Repair finger/hand tendon	0054	24.8731	1417.34		283.47
26358	T		Repair/graft hand tendon	0054	24.8731	1417.34		283.47
26370	T		Repair finger/hand tendon	0054	24.8731	1417.34		283.47
26372	T		Repair/graft hand tendon	0054	24.8731	1417.34		283.47
26373	T		Repair finger/hand tendon	0054	24.8731	1417.34		283.47
26390	T		Revise hand/finger tendon	0054	24.8731	1417.34		283.47
26392	T		Repair/graft hand tendon	0054	24.8731	1417.34		283.47
26410	T		Repair hand tendon	0053	15.5097	883.79	253.49	176.76
26412	T		Repair/graft hand tendon	0054	24.8731	1417.34		283.47
26415	T		Excision, hand/finger tendon	0054	24.8731	1417.34		283.47
26416	T		Graft hand or finger tendon	0054	24.8731	1417.34		283.47
26418	T		Repair finger tendon	0053	15.5097	883.79	253.49	176.76
26420	T		Repair/graft finger tendon	0054	24.8731	1417.34		283.47
26426	T		Repair finger/hand tendon	0054	24.8731	1417.34		283.47
26428	T		Repair/graft finger tendon	0054	24.8731	1417.34		283.47
26432	T		Repair finger tendon	0053	15.5097	883.79	253.49	176.76
26433	T		Repair finger tendon	0053	15.5097	883.79	253.49	176.76
26434	T		Repair/graft finger tendon	0054	24.8731	1417.34		283.47
26437	T		Realignment of tendons	0053	15.5097	883.79	253.49	176.76
26440	T		Release palm/finger tendon	0053	15.5097	883.79	253.49	176.76
26442	T		Release palm & finger tendon	0054	24.8731	1417.34		283.47
26445	T		Release hand/finger tendon	0053	15.5097	883.79	253.49	176.76
26449	T		Release forearm/hand tendon	0054	24.8731	1417.34		283.47
26450	T		Incision of palm tendon	0053	15.5097	883.79	253.49	176.76
26455	T		Incision of finger tendon	0053	15.5097	883.79	253.49	176.76
26460	T		Incise hand/finger tendon	0053	15.5097	883.79	253.49	176.76
26471	T		Fusion of finger tendons	0053	15.5097	883.79	253.49	176.76
26474	T		Fusion of finger tendons	0053	15.5097	883.79	253.49	176.76
26476	T		Tendon lengthening	0053	15.5097	883.79	253.49	176.76
26477	T		Tendon shortening	0053	15.5097	883.79	253.49	176.76
26478	T		Lengthening of hand tendon	0053	15.5097	883.79	253.49	176.76
26479	T		Shortening of hand tendon	0053	15.5097	883.79	253.49	176.76

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
26480	T		Transplant hand tendon	0054	24.8731	1417.34		283.47
26483	T		Transplant/graft hand tendon	0054	24.8731	1417.34		283.47
26485	T		Transplant palm tendon	0054	24.8731	1417.34		283.47
26489	T		Transplant/graft palm tendon	0054	24.8731	1417.34		283.47
26490	T		Revise thumb tendon	0054	24.8731	1417.34		283.47
26492	T		Tendon transfer with graft	0054	24.8731	1417.34		283.47
26494	T		Hand tendon/muscle transfer	0054	24.8731	1417.34		283.47
26496	T		Revise thumb tendon	0054	24.8731	1417.34		283.47
26497	T		Finger tendon transfer	0054	24.8731	1417.34		283.47
26498	T		Finger tendon transfer	0054	24.8731	1417.34		283.47
26499	T		Revision of finger	0054	24.8731	1417.34		283.47
26500	T		Hand tendon reconstruction	0053	15.5097	883.79	253.49	176.76
26502	T		Hand tendon reconstruction	0054	24.8731	1417.34		283.47
26504	T		Hand tendon reconstruction	0054	24.8731	1417.34		283.47
26508	T		Release thumb contracture	0053	15.5097	883.79	253.49	176.76
26510	T		Thumb tendon transfer	0054	24.8731	1417.34		283.47
26516	T		Fusion of knuckle joint	0054	24.8731	1417.34		283.47
26517	T		Fusion of knuckle joints	0054	24.8731	1417.34		283.47
26518	T		Fusion of knuckle joints	0054	24.8731	1417.34		283.47
26520	T		Release knuckle contracture	0053	15.5097	883.79	253.49	176.76
26525	T		Release finger contracture	0053	15.5097	883.79	253.49	176.76
26530	T		Revise knuckle joint	0047	31.0492	1769.28	537.03	353.86
26531	T		Revise knuckle with implant	0048	40.3978	2301.99	570.30	460.40
26535	T		Revise finger joint	0047	31.0492	1769.28	537.03	353.86
26536	T		Revise/implant finger joint	0048	40.3978	2301.99	570.30	460.40
26540	T		Repair hand joint	0053	15.5097	883.79	253.49	176.76
26541	T		Repair hand joint with graft	0054	24.8731	1417.34		283.47
26542	T		Repair hand joint with graft	0053	15.5097	883.79	253.49	176.76
26545	T		Reconstruct finger joint	0054	24.8731	1417.34		283.47
26546	T		Repair nonunion hand	0054	24.8731	1417.34		283.47
26548	T		Reconstruct finger joint	0054	24.8731	1417.34		283.47
26550	T		Construct thumb replacement	0054	24.8731	1417.34		283.47
26551	C		Great toe-hand transfer					
26553	C		Single transfer, toe-hand					
26554	C		Double transfer, toe-hand					
26555	T		Positional change of finger	0054	24.8731	1417.34		283.47
26556	C		Toe joint transfer					
26560	T		Repair of web finger	0053	15.5097	883.79	253.49	176.76
26561	T		Repair of web finger	0054	24.8731	1417.34		283.47
26562	T		Repair of web finger	0054	24.8731	1417.34		283.47
26565	T		Correct metacarpal flaw	0054	24.8731	1417.34		283.47
26567	T		Correct finger deformity	0054	24.8731	1417.34		283.47
26568	T		Lengthen metacarpal/finger	0054	24.8731	1417.34		283.47

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
26580	T		Repair hand deformity	0054	24.8731	1417.34		283.47
26587	T		Reconstruct extra finger	0053	15.5097	883.79	253.49	176.76
26590	T		Repair finger deformity	0054	24.8731	1417.34		283.47
26591	T		Repair muscles of hand	0054	24.8731	1417.34		283.47
26593	T		Release muscles of hand	0053	15.5097	883.79	253.49	176.76
26596	T		Excision constricting tissue	0054	24.8731	1417.34		283.47
26600	T		Treat metacarpal fracture	0043	1.8527	105.57		21.11
26605	T		Treat metacarpal fracture	0043	1.8527	105.57		21.11
26607	T		Treat metacarpal fracture	0043	1.8527	105.57		21.11
26608	T		Treat metacarpal fracture	0046	35.1105	2000.70	535.76	400.14
26615	T		Treat metacarpal fracture	0046	35.1105	2000.70	535.76	400.14
26641	T		Treat thumb dislocation	0043	1.8527	105.57		21.11
26645	T		Treat thumb fracture	0043	1.8527	105.57		21.11
26650	T		Treat thumb fracture	0046	35.1105	2000.70	535.76	400.14
26665	T		Treat thumb fracture	0046	35.1105	2000.70	535.76	400.14
26670	T		Treat hand dislocation	0043	1.8527	105.57		21.11
26675	T		Treat hand dislocation	0043	1.8527	105.57		21.11
26676	T		Pin hand dislocation	0046	35.1105	2000.70	535.76	400.14
26685	T		Treat hand dislocation	0046	35.1105	2000.70	535.76	400.14
26686	T		Treat hand dislocation	0046	35.1105	2000.70	535.76	400.14
26700	T		Treat knuckle dislocation	0043	1.8527	105.57		21.11
26705	T		Treat knuckle dislocation	0043	1.8527	105.57		21.11
26706	T		Pin knuckle dislocation	0043	1.8527	105.57		21.11
26715	T		Treat knuckle dislocation	0046	35.1105	2000.70	535.76	400.14
26720	T		Treat finger fracture, each	0043	1.8527	105.57		21.11
26725	T		Treat finger fracture, each	0043	1.8527	105.57		21.11
26727	T		Treat finger fracture, each	0046	35.1105	2000.70	535.76	400.14
26735	T		Treat finger fracture, each	0046	35.1105	2000.70	535.76	400.14
26740	T		Treat finger fracture, each	0043	1.8527	105.57		21.11
26742	T		Treat finger fracture, each	0043	1.8527	105.57		21.11
26746	T		Treat finger fracture, each	0046	35.1105	2000.70	535.76	400.14
26750	T		Treat finger fracture, each	0043	1.8527	105.57		21.11
26755	T		Treat finger fracture, each	0043	1.8527	105.57		21.11
26756	T		Pin finger fracture, each	0046	35.1105	2000.70	535.76	400.14
26765	T		Treat finger fracture, each	0046	35.1105	2000.70	535.76	400.14
26770	T		Treat finger dislocation	0043	1.8527	105.57		21.11
26775	T		Treat finger dislocation	0045	14.2091	809.68	268.47	161.94
26776	T		Pin finger dislocation	0046	35.1105	2000.70	535.76	400.14
26785	T		Treat finger dislocation	0046	35.1105	2000.70	535.76	400.14
26820	T		Thumb fusion with graft	0054	24.8731	1417.34		283.47
26841	T		Fusion of thumb	0054	24.8731	1417.34		283.47
26842	T		Thumb fusion with graft	0054	24.8731	1417.34		283.47
26843	T		Fusion of hand joint	0054	24.8731	1417.34		283.47

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
26844	T		Fusion/graft of hand joint	0054	24.8731	1417.34		283.47
26850	T		Fusion of knuckle	0054	24.8731	1417.34		283.47
26852	T		Fusion of knuckle with graft	0054	24.8731	1417.34		283.47
26860	T		Fusion of finger joint	0054	24.8731	1417.34		283.47
26861	T		Fusion of finger jnt, add-on	0054	24.8731	1417.34		283.47
26862	T		Fusion/graft of finger joint	0054	24.8731	1417.34		283.47
26863	T		Fuse/graft added joint	0054	24.8731	1417.34		283.47
26910	T		Amputate metacarpal bone	0054	24.8731	1417.34		283.47
26951	T		Amputation of finger/thumb	0053	15.5097	883.79	253.49	176.76
26952	T		Amputation of finger/thumb	0053	15.5097	883.79	253.49	176.76
26989	T		Hand/finger surgery	0043	1.8527	105.57		21.11
26990	T		Drainage of pelvis lesion	0049	20.2046	1151.32		230.26
26991	T		Drainage of pelvis bursa	0049	20.2046	1151.32		230.26
26992	C		Drainage of bone lesion					
27000	T		Incision of hip tendon	0049	20.2046	1151.32		230.26
27001	T		Incision of hip tendon	0050	24.6002	1401.79		280.36
27003	T		Incision of hip tendon	0050	24.6002	1401.79		280.36
27005	C		Incision of hip tendon					
27006	C		Incision of hip tendons					
27025	C		Incision of hip/thigh fascia					
27030	C		Drainage of hip joint					
27033	T		Exploration of hip joint	0051	35.8607	2043.45		408.69
27035	T		Denervation of hip joint	0052	43.5754	2483.06		496.61
27036	C		Excision of hip joint/muscle					
27040	T		Biopsy of soft tissues	0020	7.6248	434.48	113.25	86.90
27041	T		Biopsy of soft tissues	0020	7.6248	434.48	113.25	86.90
27047	T		Remove hip/pelvis lesion	0022	19.3700	1103.76	354.45	220.75
27048	T		Remove hip/pelvis lesion	0022	19.3700	1103.76	354.45	220.75
27049	T		Remove tumor, hip/pelvis	0022	19.3700	1103.76	354.45	220.75
27050	T		Biopsy of sacroiliac joint	0049	20.2046	1151.32		230.26
27052	T		Biopsy of hip joint	0049	20.2046	1151.32		230.26
27054	C		Removal of hip joint lining					
27060	T		Removal of ischial bursa	0049	20.2046	1151.32		230.26
27062	T		Remove femur lesion/bursa	0049	20.2046	1151.32		230.26
27065	T		Removal of hip bone lesion	0049	20.2046	1151.32		230.26
27066	T		Removal of hip bone lesion	0050	24.6002	1401.79		280.36
27067	T		Remove/graft hip bone lesion	0050	24.6002	1401.79		280.36
27070	C		Partial removal of hip bone					
27071	C		Partial removal of hip bone					
27075	C		Extensive hip surgery					
27076	C		Extensive hip surgery					
27077	C		Extensive hip surgery					
27078	C		Extensive hip surgery					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27079	C		Extensive hip surgery					
27080	T		Removal of tail bone	0050	24.6002	1401.79		280.36
27086	T		Remove hip foreign body	0020	7.6248	434.48	113.25	86.90
27087	T		Remove hip foreign body	0049	20.2046	1151.32		230.26
27090	C		Removal of hip prosthesis					
27091	C		Removal of hip prosthesis					
27093	N		Injection for hip x-ray					
27095	N		Injection for hip x-ray					
27096	B		Inject sacroiliac joint					
27097	T		Revision of hip tendon	0050	24.6002	1401.79		280.36
27098	T		Transfer tendon to pelvis	0050	24.6002	1401.79		280.36
27100	T		Transfer of abdominal muscle	0051	35.8607	2043.45		408.69
27105	T		Transfer of spinal muscle	0051	35.8607	2043.45		408.69
27110	T		Transfer of iliopsoas muscle	0051	35.8607	2043.45		408.69
27111	T		Transfer of iliopsoas muscle	0051	35.8607	2043.45		408.69
27120	C		Reconstruction of hip socket					
27122	C		Reconstruction of hip socket					
27125	C		Partial hip replacement					
27130	C		Total hip arthroplasty					
27132	C		Total hip arthroplasty					
27134	C		Revise hip joint replacement					
27137	C		Revise hip joint replacement					
27138	C		Revise hip joint replacement					
27140	C		Transplant femur ridge					
27146	C		Incision of hip bone					
27147	C		Revision of hip bone					
27151	C		Incision of hip bones					
27156	C		Revision of hip bones					
27158	C		Revision of pelvis					
27161	C		Incision of neck of femur					
27165	C		Incision/fixation of femur					
27170	C		Repair/graft femur head/neck					
27175	C		Treat slipped epiphysis					
27176	C		Treat slipped epiphysis					
27177	C		Treat slipped epiphysis					
27178	C		Treat slipped epiphysis					
27179	C		Revise head/neck of femur					
27181	C		Treat slipped epiphysis					
27185	C		Revision of femur epiphysis					
27187	C		Reinforce hip bones					
27193	T		Treat pelvic ring fracture	0043	1.8527	105.57		21.11
27194	T		Treat pelvic ring fracture	0045	14.2091	809.68	268.47	161.94
27200	T		Treat tail bone fracture	0043	1.8527	105.57		21.11

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27202	T		Treat tail bone fracture	0046	35.1105	2000.70	535.76	400.14
27215	C		Treat pelvic fracture(s)					
27216	T		Treat pelvic ring fracture	0050	24.6002	1401.79		280.36
27217	C		Treat pelvic ring fracture					
27218	C		Treat pelvic ring fracture					
27220	T		Treat hip socket fracture	0043	1.8527	105.57		21.11
27222	C		Treat hip socket fracture					
27226	C		Treat hip wall fracture					
27227	C		Treat hip fracture(s)					
27228	C		Treat hip fracture(s)					
27230	T		Treat thigh fracture	0043	1.8527	105.57		21.11
27232	C		Treat thigh fracture					
27235	T		Treat thigh fracture	0050	24.6002	1401.79		280.36
27236	C		Treat thigh fracture					
27238	T		Treat thigh fracture	0043	1.8527	105.57		21.11
27240	C		Treat thigh fracture					
27244	C		Treat thigh fracture					
27245	C		Treat thigh fracture					
27246	T		Treat thigh fracture	0043	1.8527	105.57		21.11
27248	C		Treat thigh fracture					
27250	T		Treat hip dislocation	0043	1.8527	105.57		21.11
27252	T		Treat hip dislocation	0045	14.2091	809.68	268.47	161.94
27253	C		Treat hip dislocation					
27254	C		Treat hip dislocation					
27256	T		Treat hip dislocation	0043	1.8527	105.57		21.11
27257	T		Treat hip dislocation	0045	14.2091	809.68	268.47	161.94
27258	C		Treat hip dislocation					
27259	C		Treat hip dislocation					
27265	T		Treat hip dislocation	0043	1.8527	105.57		21.11
27266	T		Treat hip dislocation	0045	14.2091	809.68	268.47	161.94
27275	T		Manipulation of hip joint	0045	14.2091	809.68	268.47	161.94
27280	C		Fusion of sacroiliac joint					
27282	C		Fusion of pubic bones					
27284	C		Fusion of hip joint					
27286	C		Fusion of hip joint					
27290	C		Amputation of leg at hip					
27295	C		Amputation of leg at hip					
27299	T		Pelvis/hip joint surgery	0043	1.8527	105.57		21.11
27301	T		Drain thigh/knee lesion	0008	19.3572	1103.03		220.61
27303	C		Drainage of bone lesion					
27305	T		Incise thigh tendon & fascia	0049	20.2046	1151.32		230.26
27306	T		Incision of thigh tendon	0049	20.2046	1151.32		230.26
27307	T		Incision of thigh tendons	0049	20.2046	1151.32		230.26

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27310	T		Exploration of knee joint	0050	24.6002	1401.79		280.36
27315	T		Partial removal, thigh nerve	0220	17.2963	985.60		197.12
27320	T		Partial removal, thigh nerve	0220	17.2963	985.60		197.12
27323	T		Biopsy, thigh soft tissues	0021	14.8872	848.32	219.48	169.66
27324	T		Biopsy, thigh soft tissues	0022	19.3700	1103.76	354.45	220.75
27327	T		Removal of thigh lesion	0022	19.3700	1103.76	354.45	220.75
27328	T		Removal of thigh lesion	0022	19.3700	1103.76	354.45	220.75
27329	T		Remove tumor, thigh/knee	0022	19.3700	1103.76	354.45	220.75
27330	T		Biopsy, knee joint lining	0050	24.6002	1401.79		280.36
27331	T		Explore/treat knee joint	0050	24.6002	1401.79		280.36
27332	T		Removal of knee cartilage	0050	24.6002	1401.79		280.36
27333	T		Removal of knee cartilage	0050	24.6002	1401.79		280.36
27334	T		Remove knee joint lining	0050	24.6002	1401.79		280.36
27335	T		Remove knee joint lining	0050	24.6002	1401.79		280.36
27340	T		Removal of kneecap bursa	0049	20.2046	1151.32		230.26
27345	T		Removal of knee cyst	0049	20.2046	1151.32		230.26
27347	T		Remove knee cyst	0049	20.2046	1151.32		230.26
27350	T		Removal of kneecap	0050	24.6002	1401.79		280.36
27355	T		Remove femur lesion	0050	24.6002	1401.79		280.36
27356	T		Remove femur lesion/graft	0050	24.6002	1401.79		280.36
27357	T		Remove femur lesion/graft	0050	24.6002	1401.79		280.36
27358	T		Remove femur lesion/fixation	0050	24.6002	1401.79		280.36
27360	T		Partial removal, leg bone(s)	0050	24.6002	1401.79		280.36
27365	C		Extensive leg surgery					
27370	N		Injection for knee x-ray					
27372	T		Removal of foreign body	0022	19.3700	1103.76	354.45	220.75
27380	T		Repair of kneecap tendon	0049	20.2046	1151.32		230.26
27381	T		Repair/graft kneecap tendon	0049	20.2046	1151.32		230.26
27385	T		Repair of thigh muscle	0049	20.2046	1151.32		230.26
27386	T		Repair/graft of thigh muscle	0049	20.2046	1151.32		230.26
27390	T		Incision of thigh tendon	0049	20.2046	1151.32		230.26
27391	T		Incision of thigh tendons	0049	20.2046	1151.32		230.26
27392	T		Incision of thigh tendons	0049	20.2046	1151.32		230.26
27393	T		Lengthening of thigh tendon	0050	24.6002	1401.79		280.36
27394	T		Lengthening of thigh tendons	0050	24.6002	1401.79		280.36
27395	T		Lengthening of thigh tendons	0051	35.8607	2043.45		408.69
27396	T		Transplant of thigh tendon	0050	24.6002	1401.79		280.36
27397	T		Transplants of thigh tendons	0051	35.8607	2043.45		408.69
27400	T		Revise thigh muscles/tendons	0051	35.8607	2043.45		408.69
27403	T		Repair of knee cartilage	0050	24.6002	1401.79		280.36
27405	T		Repair of knee ligament	0051	35.8607	2043.45		408.69
27407	T		Repair of knee ligament	0051	35.8607	2043.45		408.69
27409	T		Repair of knee ligaments	0051	35.8607	2043.45		408.69

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27412	T	NI	Autochondrocyte implant knee	0042	43.5802	2483.33	804.74	496.67
27415	T	NI	Osteochondral knee allograft	0042	43.5802	2483.33	804.74	496.67
27418	T		Repair degenerated kneecap	0051	35.8607	2043.45		408.69
27420	T		Revision of unstable kneecap	0051	35.8607	2043.45		408.69
27422	T		Revision of unstable kneecap	0051	35.8607	2043.45		408.69
27424	T		Revision/removal of kneecap	0051	35.8607	2043.45		408.69
27425	T		Lat retinacular release open	0050	24.6002	1401.79		280.36
27427	T		Reconstruction, knee	0052	43.5754	2483.06		496.61
27428	T		Reconstruction, knee	0052	43.5754	2483.06		496.61
27429	T		Reconstruction, knee	0052	43.5754	2483.06		496.61
27430	T		Revision of thigh muscles	0051	35.8607	2043.45		408.69
27435	T		Incision of knee joint	0051	35.8607	2043.45		408.69
27437	T		Revise kneecap	0047	31.0492	1769.28	537.03	353.86
27438	T		Revise kneecap with implant	0048	40.3978	2301.99	570.30	460.40
27440	T		Revision of knee joint	0047	31.0492	1769.28	537.03	353.86
27441	T		Revision of knee joint	0047	31.0492	1769.28	537.03	353.86
27442	T		Revision of knee joint	0047	31.0492	1769.28	537.03	353.86
27443	T		Revision of knee joint	0047	31.0492	1769.28	537.03	353.86
27445	C		Revision of knee joint					
27446	T		Revision of knee joint	0681	91.7896	5230.45	2081.48	1046.09
27447	C		Total knee arthroplasty					
27448	C		Incision of thigh					
27450	C		Incision of thigh					
27454	C		Realignment of thigh bone					
27455	C		Realignment of knee					
27457	C		Realignment of knee					
27465	C		Shortening of thigh bone					
27466	C		Lengthening of thigh bone					
27468	C		Shorten/lengthen thighs					
27470	C		Repair of thigh					
27472	C		Repair/graft of thigh					
27475	C		Surgery to stop leg growth					
27477	C		Surgery to stop leg growth					
27479	C		Surgery to stop leg growth					
27485	C		Surgery to stop leg growth					
27486	C		Revise/replace knee joint					
27487	C		Revise/replace knee joint					
27488	C		Removal of knee prosthesis					
27495	C		Reinforce thigh					
27496	T		Decompression of thigh/knee	0049	20.2046	1151.32		230.26
27497	T		Decompression of thigh/knee	0049	20.2046	1151.32		230.26
27498	T		Decompression of thigh/knee	0049	20.2046	1151.32		230.26
27499	T		Decompression of thigh/knee	0049	20.2046	1151.32		230.26

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27500	T		Treatment of thigh fracture	0043	1.8527	105.57		21.11
27501	T		Treatment of thigh fracture	0043	1.8527	105.57		21.11
27502	T		Treatment of thigh fracture	0043	1.8527	105.57		21.11
27503	T		Treatment of thigh fracture	0043	1.8527	105.57		21.11
27506	C		Treatment of thigh fracture					
27507	C		Treatment of thigh fracture					
27508	T		Treatment of thigh fracture	0043	1.8527	105.57		21.11
27509	T		Treatment of thigh fracture	0046	35.1105	2000.70	535.76	400.14
27510	T		Treatment of thigh fracture	0043	1.8527	105.57		21.11
27511	C		Treatment of thigh fracture					
27513	C		Treatment of thigh fracture					
27514	C		Treatment of thigh fracture					
27516	T		Treat thigh fx growth plate	0043	1.8527	105.57		21.11
27517	T		Treat thigh fx growth plate	0043	1.8527	105.57		21.11
27519	C		Treat thigh fx growth plate					
27520	T		Treat kneecap fracture	0043	1.8527	105.57		21.11
27524	T		Treat kneecap fracture	0046	35.1105	2000.70	535.76	400.14
27530	T		Treat knee fracture	0043	1.8527	105.57		21.11
27532	T		Treat knee fracture	0043	1.8527	105.57		21.11
27535	C		Treat knee fracture					
27536	C		Treat knee fracture					
27538	T		Treat knee fracture(s)	0043	1.8527	105.57		21.11
27540	C		Treat knee fracture					
27550	T		Treat knee dislocation	0043	1.8527	105.57		21.11
27552	T		Treat knee dislocation	0045	14.2091	809.68	268.47	161.94
27556	C		Treat knee dislocation					
27557	C		Treat knee dislocation					
27558	C		Treat knee dislocation					
27560	T		Treat kneecap dislocation	0043	1.8527	105.57		21.11
27562	T		Treat kneecap dislocation	0045	14.2091	809.68	268.47	161.94
27566	T		Treat kneecap dislocation	0046	35.1105	2000.70	535.76	400.14
27570	T		Fixation of knee joint	0045	14.2091	809.68	268.47	161.94
27580	C		Fusion of knee					
27590	C		Amputate leg at thigh					
27591	C		Amputate leg at thigh					
27592	C		Amputate leg at thigh					
27594	T		Amputation follow-up surgery	0049	20.2046	1151.32		230.26
27596	C		Amputation follow-up surgery					
27598	C		Amputate lower leg at knee					
27599	T		Leg surgery procedure	0043	1.8527	105.57		21.11
27600	T		Decompression of lower leg	0049	20.2046	1151.32		230.26
27601	T		Decompression of lower leg	0049	20.2046	1151.32		230.26
27602	T		Decompression of lower leg	0049	20.2046	1151.32		230.26

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27603	T		Drain lower leg lesion	0007	12.4496	709.42		141.88
27604	T		Drain lower leg bursa	0049	20.2046	1151.32		230.26
27605	T		Incision of achilles tendon	0055	19.3444	1102.30	355.34	220.46
27606	T		Incision of achilles tendon	0049	20.2046	1151.32		230.26
27607	T		Treat lower leg bone lesion	0049	20.2046	1151.32		230.26
27610	T		Explore/treat ankle joint	0050	24.6002	1401.79		280.36
27612	T		Exploration of ankle joint	0050	24.6002	1401.79		280.36
27613	T		Biopsy lower leg soft tissue	0020	7.6248	434.48	113.25	86.90
27614	T		Biopsy lower leg soft tissue	0022	19.3700	1103.76	354.45	220.75
27615	T		Remove tumor, lower leg	0046	35.1105	2000.70	535.76	400.14
27618	T		Remove lower leg lesion	0021	14.8872	848.32	219.48	169.66
27619	T		Remove lower leg lesion	0022	19.3700	1103.76	354.45	220.75
27620	T		Explore/treat ankle joint	0050	24.6002	1401.79		280.36
27625	T		Remove ankle joint lining	0050	24.6002	1401.79		280.36
27626	T		Remove ankle joint lining	0050	24.6002	1401.79		280.36
27630	T		Removal of tendon lesion	0049	20.2046	1151.32		230.26
27635	T		Remove lower leg bone lesion	0050	24.6002	1401.79		280.36
27637	T		Remove/graft leg bone lesion	0050	24.6002	1401.79		280.36
27638	T		Remove/graft leg bone lesion	0050	24.6002	1401.79		280.36
27640	T		Partial removal of tibia	0051	35.8607	2043.45		408.69
27641	T		Partial removal of fibula	0050	24.6002	1401.79		280.36
27645	C		Extensive lower leg surgery					
27646	C		Extensive lower leg surgery					
27647	T		Extensive ankle/heel surgery	0051	35.8607	2043.45		408.69
27648	N		Injection for ankle x-ray					
27650	T		Repair achilles tendon	0051	35.8607	2043.45		408.69
27652	T		Repair/graft achilles tendon	0051	35.8607	2043.45		408.69
27654	T		Repair of achilles tendon	0051	35.8607	2043.45		408.69
27656	T		Repair leg fascia defect	0049	20.2046	1151.32		230.26
27658	T		Repair of leg tendon, each	0049	20.2046	1151.32		230.26
27659	T		Repair of leg tendon, each	0049	20.2046	1151.32		230.26
27664	T		Repair of leg tendon, each	0049	20.2046	1151.32		230.26
27665	T		Repair of leg tendon, each	0050	24.6002	1401.79		280.36
27675	T		Repair lower leg tendons	0049	20.2046	1151.32		230.26
27676	T		Repair lower leg tendons	0050	24.6002	1401.79		280.36
27680	T		Release of lower leg tendon	0050	24.6002	1401.79		280.36
27681	T		Release of lower leg tendons	0050	24.6002	1401.79		280.36
27685	T		Revision of lower leg tendon	0050	24.6002	1401.79		280.36
27686	T		Revise lower leg tendons	0050	24.6002	1401.79		280.36
27687	T		Revision of calf tendon	0050	24.6002	1401.79		280.36
27690	T		Revise lower leg tendon	0051	35.8607	2043.45		408.69
27691	T		Revise lower leg tendon	0051	35.8607	2043.45		408.69
27692	T		Revise additional leg tendon	0051	35.8607	2043.45		408.69

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27695	T		Repair of ankle ligament	0050	24.6002	1401.79		280.36
27696	T		Repair of ankle ligaments	0050	24.6002	1401.79		280.36
27698	T		Repair of ankle ligament	0050	24.6002	1401.79		280.36
27700	T		Revision of ankle joint	0047	31.0492	1769.28	537.03	353.86
27702	C		Reconstruct ankle joint					
27703	C		Reconstruction, ankle joint					
27704	T		Removal of ankle implant	0049	20.2046	1151.32		230.26
27705	T		Incision of tibia	0051	35.8607	2043.45		408.69
27707	T		Incision of fibula	0049	20.2046	1151.32		230.26
27709	T		Incision of tibia & fibula	0050	24.6002	1401.79		280.36
27712	C		Realignment of lower leg					
27715	C		Revision of lower leg					
27720	C		Repair of tibia					
27722	C		Repair/graft of tibia					
27724	C		Repair/graft of tibia					
27725	C		Repair of lower leg					
27727	C		Repair of lower leg					
27730	T		Repair of tibia epiphysis	0050	24.6002	1401.79		280.36
27732	T		Repair of fibula epiphysis	0050	24.6002	1401.79		280.36
27734	T		Repair lower leg epiphyses	0050	24.6002	1401.79		280.36
27740	T		Repair of leg epiphyses	0050	24.6002	1401.79		280.36
27742	T		Repair of leg epiphyses	0051	35.8607	2043.45		408.69
27745	T		Reinforce tibia	0051	35.8607	2043.45		408.69
27750	T		Treatment of tibia fracture	0043	1.8527	105.57		21.11
27752	T		Treatment of tibia fracture	0043	1.8527	105.57		21.11
27756	T		Treatment of tibia fracture	0046	35.1105	2000.70	535.76	400.14
27758	T		Treatment of tibia fracture	0046	35.1105	2000.70	535.76	400.14
27759	T		Treatment of tibia fracture	0046	35.1105	2000.70	535.76	400.14
27760	T		Treatment of ankle fracture	0043	1.8527	105.57		21.11
27762	T		Treatment of ankle fracture	0043	1.8527	105.57		21.11
27766	T		Treatment of ankle fracture	0046	35.1105	2000.70	535.76	400.14
27780	T		Treatment of fibula fracture	0043	1.8527	105.57		21.11
27781	T		Treatment of fibula fracture	0043	1.8527	105.57		21.11
27784	T		Treatment of fibula fracture	0046	35.1105	2000.70	535.76	400.14
27786	T		Treatment of ankle fracture	0043	1.8527	105.57		21.11
27788	T		Treatment of ankle fracture	0043	1.8527	105.57		21.11
27792	T		Treatment of ankle fracture	0046	35.1105	2000.70	535.76	400.14
27808	T		Treatment of ankle fracture	0043	1.8527	105.57		21.11
27810	T		Treatment of ankle fracture	0043	1.8527	105.57		21.11
27814	T		Treatment of ankle fracture	0046	35.1105	2000.70	535.76	400.14
27816	T		Treatment of ankle fracture	0043	1.8527	105.57		21.11
27818	T		Treatment of ankle fracture	0043	1.8527	105.57		21.11
27822	T		Treatment of ankle fracture	0046	35.1105	2000.70	535.76	400.14

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27823	T		Treatment of ankle fracture	0046	35.1105	2000.70	535.76	400.14
27824	T		Treat lower leg fracture	0043	1.8527	105.57		21.11
27825	T		Treat lower leg fracture	0043	1.8527	105.57		21.11
27826	T		Treat lower leg fracture	0046	35.1105	2000.70	535.76	400.14
27827	T		Treat lower leg fracture	0046	35.1105	2000.70	535.76	400.14
27828	T		Treat lower leg fracture	0046	35.1105	2000.70	535.76	400.14
27829	T		Treat lower leg joint	0046	35.1105	2000.70	535.76	400.14
27830	T		Treat lower leg dislocation	0043	1.8527	105.57		21.11
27831	T		Treat lower leg dislocation	0043	1.8527	105.57		21.11
27832	T		Treat lower leg dislocation	0046	35.1105	2000.70	535.76	400.14
27840	T		Treat ankle dislocation	0043	1.8527	105.57		21.11
27842	T		Treat ankle dislocation	0045	14.2091	809.68	268.47	161.94
27846	T		Treat ankle dislocation	0046	35.1105	2000.70	535.76	400.14
27848	T		Treat ankle dislocation	0046	35.1105	2000.70	535.76	400.14
27860	T		Fixation of ankle joint	0045	14.2091	809.68	268.47	161.94
27870	T		Fusion of ankle joint, open	0051	35.8607	2043.45		408.69
27871	T		Fusion of tibiofibular joint	0051	35.8607	2043.45		408.69
27880	C		Amputation of lower leg					
27881	C		Amputation of lower leg					
27882	C		Amputation of lower leg					
27884	T		Amputation follow-up surgery	0049	20.2046	1151.32		230.26
27886	C		Amputation follow-up surgery					
27888	C		Amputation of foot at ankle					
27889	T		Amputation of foot at ankle	0050	24.6002	1401.79		280.36
27892	T		Decompression of leg	0049	20.2046	1151.32		230.26
27893	T		Decompression of leg	0049	20.2046	1151.32		230.26
27894	T		Decompression of leg	0049	20.2046	1151.32		230.26
27899	T		Leg/ankle surgery procedure	0043	1.8527	105.57		21.11
28001	T		Drainage of bursa of foot	0007	12.4496	709.42		144.88
28002	T		Treatment of foot infection	0049	20.2046	1151.32		230.26
28003	T		Treatment of foot infection	0049	20.2046	1151.32		230.26
28005	T		Treat foot bone lesion	0055	19.3444	1102.30	355.34	220.46
28008	T		Incision of foot fascia	0055	19.3444	1102.30	355.34	220.46
28010	T		Incision of toe tendon	0055	19.3444	1102.30	355.34	220.46
28011	T		Incision of toe tendons	0055	19.3444	1102.30	355.34	220.46
28020	T		Exploration of foot joint	0055	19.3444	1102.30	355.34	220.46
28022	T		Exploration of foot joint	0055	19.3444	1102.30	355.34	220.46
28024	T		Exploration of toe joint	0055	19.3444	1102.30	355.34	220.46
28030	T		Removal of foot nerve	0220	17.2963	985.60		197.12
28035	T		Decompression of tibia nerve	0220	17.2963	985.60		197.12
28043	T		Excision of foot lesion	0021	14.8872	848.32	219.48	169.66
28045	T		Excision of foot lesion	0055	19.3444	1102.30	355.34	220.46
28046	T		Resection of tumor, foot	0055	19.3444	1102.30	355.34	220.46

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
28050	T		Biopsy of foot joint lining	0055	19.3444	1102.30	355.34	220.46
28052	T		Biopsy of foot joint lining	0055	19.3444	1102.30	355.34	220.46
28054	T		Biopsy of toe joint lining	0055	19.3444	1102.30	355.34	220.46
28060	T		Partial removal, foot fascia	0056	26.5813	1514.68	405.81	302.94
28062	T		Removal of foot fascia	0056	26.5813	1514.68	405.81	302.94
28070	T		Removal of foot joint lining	0056	26.5813	1514.68	405.81	302.94
28072	T		Removal of foot joint lining	0056	26.5813	1514.68	405.81	302.94
28080	T		Removal of foot lesion	0055	19.3444	1102.30	355.34	220.46
28086	T		Excise foot tendon sheath	0055	19.3444	1102.30	355.34	220.46
28088	T		Excise foot tendon sheath	0055	19.3444	1102.30	355.34	220.46
28090	T		Removal of foot lesion	0055	19.3444	1102.30	355.34	220.46
28092	T		Removal of toe lesions	0055	19.3444	1102.30	355.34	220.46
28100	T		Removal of ankle/heel lesion	0055	19.3444	1102.30	355.34	220.46
28102	T		Remove/graft foot lesion	0056	26.5813	1514.68	405.81	302.94
28103	T		Remove/graft foot lesion	0056	26.5813	1514.68	405.81	302.94
28104	T		Removal of foot lesion	0055	19.3444	1102.30	355.34	220.46
28106	T		Remove/graft foot lesion	0056	26.5813	1514.68	405.81	302.94
28107	T		Remove/graft foot lesion	0056	26.5813	1514.68	405.81	302.94
28108	T		Removal of toe lesions	0055	19.3444	1102.30	355.34	220.46
28110	T		Part removal of metatarsal	0056	26.5813	1514.68	405.81	302.94
28111	T		Part removal of metatarsal	0055	19.3444	1102.30	355.34	220.46
28112	T		Part removal of metatarsal	0055	19.3444	1102.30	355.34	220.46
28113	T		Part removal of metatarsal	0055	19.3444	1102.30	355.34	220.46
28114	T		Removal of metatarsal heads	0055	19.3444	1102.30	355.34	220.46
28116	T		Revision of foot	0055	19.3444	1102.30	355.34	220.46
28118	T		Removal of heel bone	0055	19.3444	1102.30	355.34	220.46
28119	T		Removal of heel spur	0055	19.3444	1102.30	355.34	220.46
28120	T		Part removal of ankle/heel	0055	19.3444	1102.30	355.34	220.46
28122	T		Partial removal of foot bone	0055	19.3444	1102.30	355.34	220.46
28124	T		Partial removal of toe	0055	19.3444	1102.30	355.34	220.46
28126	T		Partial removal of toe	0055	19.3444	1102.30	355.34	220.46
28130	T		Removal of ankle bone	0055	19.3444	1102.30	355.34	220.46
28140	T		Removal of metatarsal	0055	19.3444	1102.30	355.34	220.46
28150	T		Removal of toe	0055	19.3444	1102.30	355.34	220.46
28153	T		Partial removal of toe	0055	19.3444	1102.30	355.34	220.46
28160	T		Partial removal of toe	0055	19.3444	1102.30	355.34	220.46
28171	T		Extensive foot surgery	0055	19.3444	1102.30	355.34	220.46
28173	T		Extensive foot surgery	0055	19.3444	1102.30	355.34	220.46
28175	T		Extensive foot surgery	0055	19.3444	1102.30	355.34	220.46
28190	T		Removal of foot foreign body	0019	4.1677	237.49	71.87	47.50
28192	T		Removal of foot foreign body	0021	14.8872	848.32	219.48	169.66
28193	T		Removal of foot foreign body	0020	7.6248	434.48	113.25	86.90
28200	T		Repair of foot tendon	0055	19.3444	1102.30	355.34	220.46

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
28202	T		Repair/graft of foot tendon	0056	26.5813	1514.68	405.81	302.94
28208	T		Repair of foot tendon	0055	19.3444	1102.30	355.34	220.46
28210	T		Repair/graft of foot tendon	0056	26.5813	1514.68	405.81	302.94
28220	T		Release of foot tendon	0055	19.3444	1102.30	355.34	220.46
28222	T		Release of foot tendons	0055	19.3444	1102.30	355.34	220.46
28225	T		Release of foot tendon	0055	19.3444	1102.30	355.34	220.46
28226	T		Release of foot tendons	0055	19.3444	1102.30	355.34	220.46
28230	T		Incision of foot tendon(s)	0055	19.3444	1102.30	355.34	220.46
28232	T		Incision of toe tendon	0055	19.3444	1102.30	355.34	220.46
28234	T		Incision of foot tendon	0055	19.3444	1102.30	355.34	220.46
28238	T		Revision of foot tendon	0056	26.5813	1514.68	405.81	302.94
28240	T		Release of big toe	0055	19.3444	1102.30	355.34	220.46
28250	T		Revision of foot fascia	0056	26.5813	1514.68	405.81	302.94
28260	T		Release of midfoot joint	0056	26.5813	1514.68	405.81	302.94
28261	T		Revision of foot tendon	0056	26.5813	1514.68	405.81	302.94
28262	T		Revision of foot and ankle	0056	26.5813	1514.68	405.81	302.94
28264	T		Release of midfoot joint	0056	26.5813	1514.68	405.81	302.94
28270	T		Release of foot contracture	0055	19.3444	1102.30	355.34	220.46
28272	T		Release of toe joint, each	0055	19.3444	1102.30	355.34	220.46
28280	T		Fusion of toes	0055	19.3444	1102.30	355.34	220.46
28285	T		Repair of hammertoe	0055	19.3444	1102.30	355.34	220.46
28286	T		Repair of hammertoe	0055	19.3444	1102.30	355.34	220.46
28288	T		Partial removal of foot bone	0056	26.5813	1514.68	405.81	302.94
28289	T		Repair hallux rigidus	0056	26.5813	1514.68	405.81	302.94
28290	T		Correction of bunion	0056	26.5813	1514.68	405.81	302.94
28292	T		Correction of bunion	0057	27.0029	1538.71	475.91	307.74
28293	T		Correction of bunion	0057	27.0029	1538.71	475.91	307.74
28294	T		Correction of bunion	0056	26.5813	1514.68	405.81	302.94
28296	T		Correction of bunion	0056	26.5813	1514.68	405.81	302.94
28297	T		Correction of bunion	0057	27.0029	1538.71	475.91	307.74
28298	T		Correction of bunion	0056	26.5813	1514.68	405.81	302.94
28299	T		Correction of bunion	0057	27.0029	1538.71	475.91	307.74
28300	T		Incision of heel bone	0056	26.5813	1514.68	405.81	302.94
28302	T		Incision of ankle bone	0056	26.5813	1514.68	405.81	302.94
28304	T		Incision of midfoot bones	0056	26.5813	1514.68	405.81	302.94
28305	T		Incise/graft midfoot bones	0056	26.5813	1514.68	405.81	302.94
28306	T		Incision of metatarsal	0056	26.5813	1514.68	405.81	302.94
28307	T		Incision of metatarsal	0056	26.5813	1514.68	405.81	302.94
28308	T		Incision of metatarsal	0056	26.5813	1514.68	405.81	302.94
28309	T		Incision of metatarsals	0056	26.5813	1514.68	405.81	302.94
28310	T		Revision of big toe	0055	19.3444	1102.30	355.34	220.46
28312	T		Revision of toe	0055	19.3444	1102.30	355.34	220.46
28313	T		Repair deformity of toe	0055	19.3444	1102.30	355.34	220.46

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
28315	T		Removal of sesamoid bone	0055	19.3444	1102.30	355.34	220.46
28320	T		Repair of foot bones	0056	26.5813	1514.68	405.81	302.94
28322	T		Repair of metatarsals	0056	26.5813	1514.68	405.81	302.94
28340	T		Resect enlarged toe tissue	0055	19.3444	1102.30	355.34	220.46
28341	T		Resect enlarged toe	0055	19.3444	1102.30	355.34	220.46
28344	T		Repair extra toe(s)	0056	26.5813	1514.68	405.81	302.94
28345	T		Repair webbed toe(s)	0056	26.5813	1514.68	405.81	302.94
28360	T		Reconstruct cleft foot	0056	26.5813	1514.68	405.81	302.94
28400	T		Treatment of heel fracture	0043	1.8527	105.57		21.11
28405	T		Treatment of heel fracture	0043	1.8527	105.57		21.11
28406	T		Treatment of heel fracture	0046	35.1105	2000.70	535.76	400.14
28415	T		Treat heel fracture	0046	35.1105	2000.70	535.76	400.14
28420	T		Treat/graft heel fracture	0046	35.1105	2000.70	535.76	400.14
28430	T		Treatment of ankle fracture	0043	1.8527	105.57		21.11
28435	T		Treatment of ankle fracture	0043	1.8527	105.57		21.11
28436	T		Treatment of ankle fracture	0046	35.1105	2000.70	535.76	400.14
28445	T		Treat ankle fracture	0046	35.1105	2000.70	535.76	400.14
28450	T		Treat midfoot fracture, each	0043	1.8527	105.57		21.11
28455	T		Treat midfoot fracture, each	0043	1.8527	105.57		21.11
28456	T		Treat midfoot fracture	0046	35.1105	2000.70	535.76	400.14
28465	T		Treat midfoot fracture, each	0046	35.1105	2000.70	535.76	400.14
28470	T		Treat metatarsal fracture	0043	1.8527	105.57		21.11
28475	T		Treat metatarsal fracture	0043	1.8527	105.57		21.11
28476	T		Treat metatarsal fracture	0046	35.1105	2000.70	535.76	400.14
28485	T		Treat metatarsal fracture	0046	35.1105	2000.70	535.76	400.14
28490	T		Treat big toe fracture	0043	1.8527	105.57		21.11
28495	T		Treat big toe fracture	0043	1.8527	105.57		21.11
28496	T		Treat big toe fracture	0046	35.1105	2000.70	535.76	400.14
28505	T		Treat big toe fracture	0046	35.1105	2000.70	535.76	400.14
28510	T		Treatment of toe fracture	0043	1.8527	105.57		21.11
28515	T		Treatment of toe fracture	0043	1.8527	105.57		21.11
28525	T		Treat toe fracture	0046	35.1105	2000.70	535.76	400.14
28530	T		Treat sesamoid bone fracture	0043	1.8527	105.57		21.11
28531	T		Treat sesamoid bone fracture	0046	35.1105	2000.70	535.76	400.14
28540	T		Treat foot dislocation	0043	1.8527	105.57		21.11
28545	T		Treat foot dislocation	0045	14.2091	809.68	268.47	161.94
28546	T		Treat foot dislocation	0046	35.1105	2000.70	535.76	400.14
28555	T		Repair foot dislocation	0046	35.1105	2000.70	535.76	400.14
28570	T		Treat foot dislocation	0043	1.8527	105.57		21.11
28575	T		Treat foot dislocation	0043	1.8527	105.57		21.11
28576	T		Treat foot dislocation	0046	35.1105	2000.70	535.76	400.14
28585	T		Repair foot dislocation	0046	35.1105	2000.70	535.76	400.14
28600	T		Treat foot dislocation	0043	1.8527	105.57		21.11

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
28605	T		Treat foot dislocation	0043	1.8527	105.57		21.11
28606	T		Treat foot dislocation	0046	35.1105	2000.70	535.76	400.14
28615	T		Repair foot dislocation	0046	35.1105	2000.70	535.76	400.14
28630	T		Treat toe dislocation	0043	1.8527	105.57		21.11
28635	T		Treat toe dislocation	0045	14.2091	809.68	268.47	161.94
28636	T		Treat toe dislocation	0046	35.1105	2000.70	535.76	400.14
28645	T		Repair toe dislocation	0046	35.1105	2000.70	535.76	400.14
28660	T		Treat toe dislocation	0043	1.8527	105.57		21.11
28665	T		Treat toe dislocation	0045	14.2091	809.68	268.47	161.94
28666	T		Treat toe dislocation	0046	35.1105	2000.70	535.76	400.14
28675	T		Repair of toe dislocation	0046	35.1105	2000.70	535.76	400.14
28705	T		Fusion of foot bones	0056	26.5813	1514.68	405.81	302.94
28715	T		Fusion of foot bones	0056	26.5813	1514.68	405.81	302.94
28725	T		Fusion of foot bones	0056	26.5813	1514.68	405.81	302.94
28730	T		Fusion of foot bones	0056	26.5813	1514.68	405.81	302.94
28735	T		Fusion of foot bones	0056	26.5813	1514.68	405.81	302.94
28737	T		Revision of foot bones	0056	26.5813	1514.68	405.81	302.94
28740	T		Fusion of foot bones	0056	26.5813	1514.68	405.81	302.94
28750	T		Fusion of big toe joint	0056	26.5813	1514.68	405.81	302.94
28755	T		Fusion of big toe joint	0055	19.3444	1102.30	355.34	220.46
28760	T		Fusion of big toe joint	0056	26.5813	1514.68	405.81	302.94
28800	C		Amputation of midfoot					
28805	C		Amputation thru metatarsal					
28810	T		Amputation toe & metatarsal	0055	19.3444	1102.30	355.34	220.46
28820	T		Amputation of toe	0055	19.3444	1102.30	355.34	220.46
28825	T		Partial amputation of toe	0055	19.3444	1102.30	355.34	220.46
28899	T		Foot/toes surgery procedure	0043	1.8527	105.57		21.11
29000	S		Application of body cast	0426	1.9972	113.81		22.76
29010	S		Application of body cast	0426	1.9972	113.81		22.76
29015	S		Application of body cast	0426	1.9972	113.81		22.76
29020	S		Application of body cast	0058	1.1091	63.20		12.64
29025	S		Application of body cast	0426	1.9972	113.81		22.76
29035	S		Application of body cast	0426	1.9972	113.81		22.76
29040	S		Application of body cast	0058	1.1091	63.20		12.64
29044	S		Application of body cast	0426	1.9972	113.81		22.76
29046	S		Application of body cast	0426	1.9972	113.81		22.76
29049	S		Application of figure eight	0058	1.1091	63.20		12.64
29055	S		Application of shoulder cast	0426	1.9972	113.81		22.76
29058	S		Application of shoulder cast	0058	1.1091	63.20		12.64
29065	S		Application of long arm cast	0426	1.9972	113.81		22.76
29075	S		Application of forearm cast	0426	1.9972	113.81		22.76
29085	S		Apply hand/wrist cast	0426	1.9972	113.81		22.76
29086	S		Apply finger cast	0426	1.9972	113.81		22.76

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
29105	S		Apply long arm splint	0058	1.1091	63.20		12.64
29125	S		Apply forearm splint	0058	1.1091	63.20		12.64
29126	S		Apply forearm splint	0058	1.1091	63.20		12.64
29130	S		Application of finger splint	0058	1.1091	63.20		12.64
29131	S		Application of finger splint	0058	1.1091	63.20		12.64
29200	S		Strapping of chest	0058	1.1091	63.20		12.64
29220	S		Strapping of low back	0058	1.1091	63.20		12.64
29240	S		Strapping of shoulder	0058	1.1091	63.20		12.64
29260	S		Strapping of elbow or wrist	0058	1.1091	63.20		12.64
29280	S		Strapping of hand or finger	0058	1.1091	63.20		12.64
29305	S		Application of hip cast	0426	1.9972	113.81		22.76
29325	S		Application of hip casts	0426	1.9972	113.81		22.76
29345	S		Application of long leg cast	0426	1.9972	113.81		22.76
29355	S		Application of long leg cast	0426	1.9972	113.81		22.76
29358	S		Apply long leg cast brace	0426	1.9972	113.81		22.76
29365	S		Application of long leg cast	0426	1.9972	113.81		22.76
29405	S		Apply short leg cast	0426	1.9972	113.81		22.76
29425	S		Apply short leg cast	0426	1.9972	113.81		22.76
29435	S		Apply short leg cast	0426	1.9972	113.81		22.76
29440	S		Addition of walker to cast	0426	1.9972	113.81		22.76
29445	S		Apply rigid leg cast	0426	1.9972	113.81		22.76
29450	S		Application of leg cast	0058	1.1091	63.20		12.64
29505	S		Application, long leg splint	0058	1.1091	63.20		12.64
29515	S		Application lower leg splint	0058	1.1091	63.20		12.64
29520	S		Strapping of hip	0058	1.1091	63.20		12.64
29530	S		Strapping of knee	0058	1.1091	63.20		12.64
29540	S		Strapping of ankle and/or ft	0058	1.1091	63.20		12.64
29550	S		Strapping of toes	0058	1.1091	63.20		12.64
29580	S		Application of paste boot	0058	1.1091	63.20		12.64
29590	S		Application of foot splint	0058	1.1091	63.20		12.64
29700	S		Removal/revision of cast	0058	1.1091	63.20		12.64
29705	S		Removal/revision of cast	0058	1.1091	63.20		12.64
29710	S		Removal/revision of cast	0426	1.9972	113.81		22.76
29715	S		Removal/revision of cast	0058	1.1091	63.20		12.64
29720	S		Repair of body cast	0058	1.1091	63.20		12.64
29730	S		Windowing of cast	0058	1.1091	63.20		12.64
29740	S		Wedging of cast	0058	1.1091	63.20		12.64
29750	S		Wedging of clubfoot cast	0058	1.1091	63.20		12.64
29799	S		Casting/strapping procedure	0058	1.1091	63.20		12.64
29800	T		Jaw arthroscopy/surgery	0042	43.5802	2483.33	804.74	496.67
29804	T		Jaw arthroscopy/surgery	0041	28.0254	1596.97		319.39
29805	T		Shoulder arthroscopy, dx	0041	28.0254	1596.97		319.39
29806	T		Shoulder arthroscopy/surgery	0042	43.5802	2483.33	804.74	496.67

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
29807	T		Shoulder arthroscopy/surgery	0042	43.5802	2483.33	804.74	496.67
29819	T		Shoulder arthroscopy/surgery	0041	28.0254	1596.97		319.39
29820	T		Shoulder arthroscopy/surgery	0041	28.0254	1596.97		319.39
29821	T		Shoulder arthroscopy/surgery	0041	28.0254	1596.97		319.39
29822	T		Shoulder arthroscopy/surgery	0041	28.0254	1596.97		319.39
29823	T		Shoulder arthroscopy/surgery	0041	28.0254	1596.97		319.39
29824	T		Shoulder arthroscopy/surgery	0042	43.5802	2483.33	804.74	496.67
29825	T		Shoulder arthroscopy/surgery	0041	28.0254	1596.97		319.39
29826	T		Shoulder arthroscopy/surgery	0042	43.5802	2483.33	804.74	496.67
29827	T		Arthroscop rotator cuff repr	0042	43.5802	2483.33	804.74	496.67
29830	T		Elbow arthroscopy	0041	28.0254	1596.97		319.39
29834	T		Elbow arthroscopy/surgery	0041	28.0254	1596.97		319.39
29835	T		Elbow arthroscopy/surgery	0041	28.0254	1596.97		319.39
29836	T		Elbow arthroscopy/surgery	0041	28.0254	1596.97		319.39
29837	T		Elbow arthroscopy/surgery	0041	28.0254	1596.97		319.39
29838	T		Elbow arthroscopy/surgery	0041	28.0254	1596.97		319.39
29840	T		Wrist arthroscopy	0041	28.0254	1596.97		319.39
29843	T		Wrist arthroscopy/surgery	0041	28.0254	1596.97		319.39
29844	T		Wrist arthroscopy/surgery	0041	28.0254	1596.97		319.39
29845	T		Wrist arthroscopy/surgery	0041	28.0254	1596.97		319.39
29846	T		Wrist arthroscopy/surgery	0041	28.0254	1596.97		319.39
29847	T		Wrist arthroscopy/surgery	0042	43.5802	2483.33	804.74	496.67
29848	T		Wrist endoscopy/surgery	0041	28.0254	1596.97		319.39
29850	T		Knee arthroscopy/surgery	0041	28.0254	1596.97		319.39
29851	T		Knee arthroscopy/surgery	0042	43.5802	2483.33	804.74	496.67
29855	T		Tibial arthroscopy/surgery	0042	43.5802	2483.33	804.74	496.67
29856	T		Tibial arthroscopy/surgery	0042	43.5802	2483.33	804.74	496.67
29860	T		Hip arthroscopy, dx	0041	28.0254	1596.97		319.39
29861	T		Hip arthroscopy/surgery	0042	43.5802	2483.33	804.74	496.67
29862	T		Hip arthroscopy/surgery	0042	43.5802	2483.33	804.74	496.67
29863	T		Hip arthroscopy/surgery	0042	43.5802	2483.33	804.74	496.67
29866	T	NI	Autgrft implnt, knee w/scope	0042	43.5802	2483.33	804.74	496.67
29867	T	NI	Allgrft implnt, knee w/scope	0042	43.5802	2483.33	804.74	496.67
29868	T	NI	Meniscal trnspl, knee w/scpe	0042	43.5802	2483.33	804.74	496.67
29870	T		Knee arthroscopy, dx	0041	28.0254	1596.97		319.39
29871	T		Knee arthroscopy/drainage	0041	28.0254	1596.97		319.39
29873	T		Knee arthroscopy/surgery	0041	28.0254	1596.97		319.39
29874	T		Knee arthroscopy/surgery	0041	28.0254	1596.97		319.39
29875	T		Knee arthroscopy/surgery	0041	28.0254	1596.97		319.39
29876	T		Knee arthroscopy/surgery	0041	28.0254	1596.97		319.39
29877	T		Knee arthroscopy/surgery	0041	28.0254	1596.97		319.39
29879	T		Knee arthroscopy/surgery	0041	28.0254	1596.97		319.39
29880	T		Knee arthroscopy/surgery	0041	28.0254	1596.97		319.39

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
29881	T		Knee arthroscopy/surgery	0041	28.0254	1596.97		319.39
29882	T		Knee arthroscopy/surgery	0041	28.0254	1596.97		319.39
29883	T		Knee arthroscopy/surgery	0041	28.0254	1596.97		319.39
29884	T		Knee arthroscopy/surgery	0041	28.0254	1596.97		319.39
29885	T		Knee arthroscopy/surgery	0042	43.5802	2483.33	804.74	496.67
29886	T		Knee arthroscopy/surgery	0041	28.0254	1596.97		319.39
29887	T		Knee arthroscopy/surgery	0041	28.0254	1596.97		319.39
29888	T		Knee arthroscopy/surgery	0042	43.5802	2483.33	804.74	496.67
29889	T		Knee arthroscopy/surgery	0042	43.5802	2483.33	804.74	496.67
29891	T		Ankle arthroscopy/surgery	0041	28.0254	1596.97		319.39
29892	T		Ankle arthroscopy/surgery	0041	28.0254	1596.97		319.39
29893	T		Scope, plantar fasciotomy	0055	19.3444	1102.30	355.34	220.46
29894	T		Ankle arthroscopy/surgery	0041	28.0254	1596.97		319.39
29895	T		Ankle arthroscopy/surgery	0041	28.0254	1596.97		319.39
29897	T		Ankle arthroscopy/surgery	0041	28.0254	1596.97		319.39
29898	T		Ankle arthroscopy/surgery	0041	28.0254	1596.97		319.39
29899	T		Ankle arthroscopy/surgery	0042	43.5802	2483.33	804.74	496.67
29900	T		Mcp joint arthroscopy, dx	0053	15.5097	883.79	253.49	176.76
29901	T		Mcp joint arthroscopy, surg	0053	15.5097	883.79	253.49	176.76
29902	T		Mcp joint arthroscopy, surg	0053	15.5097	883.79	253.49	176.76
29999	T		Arthroscopy of joint	0041	28.0254	1596.97		319.39
30000	T		Drainage of nose lesion	0251	1.9352	110.27		22.05
30020	T		Drainage of nose lesion	0251	1.9352	110.27		22.05
30100	T		Intranasal biopsy	0252	6.5183	371.43	113.41	74.29
30110	T		Removal of nose polyp(s)	0253	15.9877	911.03	282.29	182.21
30115	T		Removal of nose polyp(s)	0253	15.9877	911.03	282.29	182.21
30117	T		Removal of intranasal lesion	0253	15.9877	911.03	282.29	182.21
30118	T		Removal of intranasal lesion	0254	23.3442	1330.22	321.35	266.04
30120	T		Revision of nose	0253	15.9877	911.03	282.29	182.21
30124	T		Removal of nose lesion	0252	6.5183	371.43	113.41	74.29
30125	T		Removal of nose lesion	0256	36.9298	2104.37		420.87
30130	T		Removal of turbinate bones	0253	15.9877	911.03	282.29	182.21
30140	T		Removal of turbinate bones	0254	23.3442	1330.22	321.35	266.04
30150	T		Partial removal of nose	0256	36.9298	2104.37		420.87
30160	T		Removal of nose	0256	36.9298	2104.37		420.87
30200	T		Injection treatment of nose	0252	6.5183	371.43	113.41	74.29
30210	T		Nasal sinus therapy	0252	6.5183	371.43	113.41	74.29
30220	T		Insert nasal septal button	0252	6.5183	371.43	113.41	74.29
30300	X		Remove nasal foreign body	0340	0.6328	36.06		7.21
30310	T		Remove nasal foreign body	0253	15.9877	911.03	282.29	182.21
30320	T		Remove nasal foreign body	0253	15.9877	911.03	282.29	182.21
30400	T		Reconstruction of nose	0256	36.9298	2104.37		420.87
30410	T		Reconstruction of nose	0256	36.9298	2104.37		420.87

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
30420	T		Reconstruction of nose	0256	36.9298	2104.37		420.87
30430	T		Revision of nose	0254	23.3442	1330.22	321.35	266.04
30435	T		Revision of nose	0256	36.9298	2104.37		420.87
30450	T		Revision of nose	0256	36.9298	2104.37		420.87
30460	T		Revision of nose	0256	36.9298	2104.37		420.87
30462	T		Revision of nose	0256	36.9298	2104.37		420.87
30465	T		Repair nasal stenosis	0256	36.9298	2104.37		420.87
30520	T		Repair of nasal septum	0254	23.3442	1330.22	321.35	266.04
30540	T		Repair nasal defect	0256	36.9298	2104.37		420.87
30545	T		Repair nasal defect	0256	36.9298	2104.37		420.87
30560	T		Release of nasal adhesions	0251	1.9352	110.27		22.05
30580	T		Repair upper jaw fistula	0256	36.9298	2104.37		420.87
30600	T		Repair mouth/nose fistula	0256	36.9298	2104.37		420.87
30620	T		Intranasal reconstruction	0256	36.9298	2104.37		420.87
30630	T		Repair nasal septum defect	0254	23.3442	1330.22	321.35	266.04
30801	T		Cauterization, inner nose	0252	6.5183	371.43	113.41	74.29
30802	T		Cauterization, inner nose	0252	6.5183	371.43	113.41	74.29
30901	T		Control of nosebleed	0250	1.3781	78.53	27.49	15.71
30903	T		Control of nosebleed	0250	1.3781	78.53	27.49	15.71
30905	T		Control of nosebleed	0250	1.3781	78.53	27.49	15.71
30906	T		Repeat control of nosebleed	0250	1.3781	78.53	27.49	15.71
30915	T		Ligation, nasal sinus artery	0091	29.6620	1690.23	348.23	338.05
30920	T		Ligation, upper jaw artery	0092	26.9952	1538.27	505.37	307.65
30930	T		Therapy, fracture of nose	0253	15.9877	911.03	282.29	182.21
30999	T		Nasal surgery procedure	0251	1.9352	110.27		22.05
31000	T		Irrigation, maxillary sinus	0251	1.9352	110.27		22.05
31002	T		Irrigation, sphenoid sinus	0252	6.5183	371.43	113.41	74.29
31020	T		Exploration, maxillary sinus	0254	23.3442	1330.22	321.35	266.04
31030	T		Exploration, maxillary sinus	0256	36.9298	2104.37		420.87
31032	T		Explore sinus, remove polyps	0256	36.9298	2104.37		420.87
31040	T		Exploration behind upper jaw	0254	23.3442	1330.22	321.35	266.04
31050	T		Exploration, sphenoid sinus	0256	36.9298	2104.37		420.87
31051	T		Sphenoid sinus surgery	0256	36.9298	2104.37		420.87
31070	T		Exploration of frontal sinus	0254	23.3442	1330.22	321.35	266.04
31075	T		Exploration of frontal sinus	0256	36.9298	2104.37		420.87
31080	T		Removal of frontal sinus	0256	36.9298	2104.37		420.87
31081	T		Removal of frontal sinus	0256	36.9298	2104.37		420.87
31084	T		Removal of frontal sinus	0256	36.9298	2104.37		420.87
31085	T		Removal of frontal sinus	0256	36.9298	2104.37		420.87
31086	T		Removal of frontal sinus	0256	36.9298	2104.37		420.87
31087	T		Removal of frontal sinus	0256	36.9298	2104.37		420.87
31090	T		Exploration of sinuses	0256	36.9298	2104.37		420.87
31200	T		Removal of ethmoid sinus	0256	36.9298	2104.37		420.87

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
31201	T		Removal of ethmoid sinus	0256	36.9298	2104.37		420.87
31205	T		Removal of ethmoid sinus	0256	36.9298	2104.37		420.87
31225	C		Removal of upper jaw					
31230	C		Removal of upper jaw					
31231	T		Nasal endoscopy, dx	0072	1.3903	79.22	21.27	15.84
31233	T		Nasal/sinus endoscopy, dx	0072	1.3903	79.22	21.27	15.84
31235	T		Nasal/sinus endoscopy, dx	0074	16.1205	918.59	295.70	183.72
31237	T		Nasal/sinus endoscopy, surg	0075	20.9362	1193.01	445.92	238.60
31238	T		Nasal/sinus endoscopy, surg	0074	16.1205	918.59	295.70	183.72
31239	T		Nasal/sinus endoscopy, surg	0075	20.9362	1193.01	445.92	238.60
31240	T		Nasal/sinus endoscopy, surg	0074	16.1205	918.59	295.70	183.72
31254	T		Revision of ethmoid sinus	0075	20.9362	1193.01	445.92	238.60
31255	T		Removal of ethmoid sinus	0075	20.9362	1193.01	445.92	238.60
31256	T		Exploration maxillary sinus	0075	20.9362	1193.01	445.92	238.60
31267	T		Endoscopy, maxillary sinus	0075	20.9362	1193.01	445.92	238.60
31276	T		Sinus endoscopy, surgical	0075	20.9362	1193.01	445.92	238.60
31287	T		Nasal/sinus endoscopy, surg	0075	20.9362	1193.01	445.92	238.60
31288	T		Nasal/sinus endoscopy, surg	0075	20.9362	1193.01	445.92	238.60
31290	C		Nasal/sinus endoscopy, surg					
31291	C		Nasal/sinus endoscopy, surg					
31292	T		Nasal/sinus endoscopy, surg	0075	20.9362	1193.01	445.92	238.60
31293	C		Nasal/sinus endoscopy, surg					
31294	C		Nasal/sinus endoscopy, surg					
31299	T		Sinus surgery procedure	0251	1.9352	110.27		22.05
31300	T		Removal of larynx lesion	0254	23.3442	1330.22	321.35	266.04
31320	T		Diagnostic incision, larynx	0256	36.9298	2104.37		420.87
31360	C		Removal of larynx					
31365	C		Removal of larynx					
31367	C		Partial removal of larynx					
31368	C		Partial removal of larynx					
31370	C		Partial removal of larynx					
31375	C		Partial removal of larynx					
31380	C		Partial removal of larynx					
31382	C		Partial removal of larynx					
31390	C		Removal of larynx & pharynx					
31395	C		Reconstruct larynx & pharynx					
31400	T		Revision of larynx	0256	36.9298	2104.37		420.87
31420	T		Removal of epiglottis	0256	36.9298	2104.37		420.87
31500	S		Insert emergency airway	0094	2.6945	153.54	48.58	30.71
31502	T		Change of windpipe airway	0121	2.2909	130.54	43.80	26.11
31505	T		Diagnostic laryngoscopy	0071	0.7396	42.14	11.31	8.43
31510	T		Laryngoscopy with biopsy	0074	16.1205	918.59	295.70	183.72
31511	T		Remove foreign body, larynx	0072	1.3903	79.22	21.27	15.84

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
31512	T		Removal of larynx lesion	0074	16.1205	918.59	295.70	183.72
31513	T		Injection into vocal cord	0072	1.3903	79.22	21.27	15.84
31515	T		Laryngoscopy for aspiration	0074	16.1205	918.59	295.70	183.72
31520	T		Diagnostic laryngoscopy	0072	1.3903	79.22	21.27	15.84
31525	T		Diagnostic laryngoscopy	0074	16.1205	918.59	295.70	183.72
31526	T		Diagnostic laryngoscopy	0075	20.9362	1193.01	445.92	238.60
31527	T		Laryngoscopy for treatment	0075	20.9362	1193.01	445.92	238.60
31528	T		Laryngoscopy and dilation	0074	16.1205	918.59	295.70	183.72
31529	T		Laryngoscopy and dilation	0074	16.1205	918.59	295.70	183.72
31530	T		Operative laryngoscopy	0075	20.9362	1193.01	445.92	238.60
31531	T		Operative laryngoscopy	0075	20.9362	1193.01	445.92	238.60
31535	T		Operative laryngoscopy	0075	20.9362	1193.01	445.92	238.60
31536	T		Operative laryngoscopy	0075	20.9362	1193.01	445.92	238.60
31540	T		Operative laryngoscopy	0075	20.9362	1193.01	445.92	238.60
31541	T		Operative laryngoscopy	0075	20.9362	1193.01	445.92	238.60
31545	T	NI	Remove vc lesion w/scope	0075	20.9362	1193.01	445.92	238.60
31546	T	NI	Remove vc lesion scope/graft	0075	20.9362	1193.01	445.92	238.60
31560	T		Operative laryngoscopy	0075	20.9362	1193.01	445.92	238.60
31561	T		Operative laryngoscopy	0075	20.9362	1193.01	445.92	238.60
31570	T		Laryngoscopy with injection	0074	16.1205	918.59	295.70	183.72
31571	T		Laryngoscopy with injection	0075	20.9362	1193.01	445.92	238.60
31575	T		Diagnostic laryngoscopy	0072	1.3903	79.22	21.27	15.84
31576	T		Laryngoscopy with biopsy	0075	20.9362	1193.01	445.92	238.60
31577	T		Remove foreign body, larynx	0073	4.1373	235.76	73.38	47.15
31578	T		Removal of larynx lesion	0075	20.9362	1193.01	445.92	238.60
31579	T		Diagnostic laryngoscopy	0073	4.1373	235.76	73.38	47.15
31580	T		Revision of larynx	0256	36.9298	2104.37		420.87
31582	T		Revision of larynx	0256	36.9298	2104.37		420.87
31584	C		Treat larynx fracture					
31585	T		Treat larynx fracture	0253	15.9877	911.03	282.29	182.21
31586	T		Treat larynx fracture	0256	36.9298	2104.37		420.87
31587	C		Revision of larynx					
31588	T		Revision of larynx	0256	36.9298	2104.37		420.87
31590	T		Reinnervate larynx	0256	36.9298	2104.37		420.87
31595	T		Larynx nerve surgery	0256	36.9298	2104.37		420.87
31599	T		Larynx surgery procedure	0251	1.9352	110.27		22.05
31600	T		Incision of windpipe	0254	23.3442	1330.22	321.35	266.04
31601	T		Incision of windpipe	0254	23.3442	1330.22	321.35	266.04
31603	T		Incision of windpipe	0252	6.5183	371.43	113.41	74.29
31605	T		Incision of windpipe	0252	6.5183	371.43	113.41	74.29
31610	T		Incision of windpipe	0254	23.3442	1330.22	321.35	266.04
31611	T		Surgery/speech prosthesis	0254	23.3442	1330.22	321.35	266.04
31612	T		Puncture/clear windpipe	0254	23.3442	1330.22	321.35	266.04

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
31613	T		Repair windpipe opening	0254	23.3442	1330.22	321.35	266.04
31614	T		Repair windpipe opening	0256	36.9298	2104.37		420.87
31615	T		Visualization of windpipe	0076	9.4372	537.76	189.82	107.55
31620	S	NI	Endobronchial us add-on	0670	30.3817	1731.24	542.37	346.25
31622	T		Dx bronchoscope/wash	0076	9.4372	537.76	189.82	107.55
31623	T		Dx bronchoscope/brush	0076	9.4372	537.76	189.82	107.55
31624	T		Dx bronchoscope/lavage	0076	9.4372	537.76	189.82	107.55
31625	T		Bronchoscopy w/biopsy(s)	0076	9.4372	537.76	189.82	107.55
31628	T		Bronchoscopy/lung bx, each	0076	9.4372	537.76	189.82	107.55
31629	T		Bronchoscopy/needle bx, each	0076	9.4372	537.76	189.82	107.55
31630	T		Bronchoscopy dilate/fx repr	0415	21.9912	1253.12	459.92	250.62
31631	T		Bronchoscopy, dilate w/stent	0415	21.9912	1253.12	459.92	250.62
31632	T		Bronchoscopy/lung bx, add'l	0076	9.4372	537.76	189.82	107.55
31633	T		Bronchoscopy/needle bx add'l	0076	9.4372	537.76	189.82	107.55
31635	T		Bronchoscopy w/fb removal	0076	9.4372	537.76	189.82	107.55
31636	T	NI	Bronchoscopy, bronch stents	0415	21.9912	1253.12	459.92	250.62
31637	T	NI	Bronchoscopy, stent add-on	0076	9.4372	537.76	189.82	107.55
31638	T	NI	Bronchoscopy, revise stent	0415	21.9912	1253.12	459.92	250.62
31640	T		Bronchoscopy w/tumor excise	0415	21.9912	1253.12	459.92	250.62
31641	T		Bronchoscopy, treat blockage	0415	21.9912	1253.12	459.92	250.62
31643	T		Diag bronchoscope/catheter	0076	9.4372	537.76	189.82	107.55
31645	T		Bronchoscopy, clear airways	0076	9.4372	537.76	189.82	107.55
31646	T		Bronchoscopy, reclear airway	0076	9.4372	537.76	189.82	107.55
31656	T		Bronchoscopy, inj for x-ray	0076	9.4372	537.76	189.82	107.55
31700	T		Insertion of airway catheter	0072	1.3903	79.22	21.27	15.84
31708	N		Instill airway contrast dye					
31710	N		Insertion of airway catheter					
31715	N		Injection for bronchus x-ray					
31717	T		Bronchial brush biopsy	0073	4.1373	235.76	73.38	47.15
31720	T		Clearance of airways	0071	0.7396	42.14	11.31	8.43
31725	C		Clearance of airways					
31730	T		Intro, windpipe wire/tube	0073	4.1373	235.76	73.38	47.15
31750	T		Repair of windpipe	0256	36.9298	2104.37		420.87
31755	T		Repair of windpipe	0256	36.9298	2104.37		420.87
31760	C		Repair of windpipe					
31766	C		Reconstruction of windpipe					
31770	C		Repair/graft of bronchus					
31775	C		Reconstruct bronchus					
31780	C		Reconstruct windpipe					
31781	C		Reconstruct windpipe					
31785	T		Remove windpipe lesion	0254	23.3442	1330.22	321.35	266.04
31786	C		Remove windpipe lesion					
31800	C		Repair of windpipe injury					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
31805	C		Repair of windpipe injury					
31820	T		Closure of windpipe lesion	0253	15.9877	911.03	282.29	182.21
31825	T		Repair of windpipe defect	0254	23.3442	1330.22	321.35	266.04
31830	T		Revise windpipe scar	0254	23.3442	1330.22	321.35	266.04
31899	T		Airways surgical procedure	0076	9.4372	537.76	189.82	107.55
32000	T		Drainage of chest	0070	3.3166	188.99		37.80
32002	T		Treatment of collapsed lung	0070	3.3166	188.99		37.80
32005	T		Treat lung lining chemically	0070	3.3166	188.99		37.80
32019	T	NI	Insert pleural catheter	0070	3.3166	188.99		37.80
32020	T		Insertion of chest tube	0070	3.3166	188.99		37.80
32035	C		Exploration of chest					
32036	C		Exploration of chest					
32095	C		Biopsy through chest wall					
32100	C		Exploration/biopsy of chest					
32110	C		Explore/repair chest					
32120	C		Re-exploration of chest					
32124	C		Explore chest free adhesions					
32140	C		Removal of lung lesion(s)					
32141	C		Remove/treat lung lesions					
32150	C		Removal of lung lesion(s)					
32151	C		Remove lung foreign body					
32160	C		Open chest heart massage					
32200	C		Drain, open, lung lesion					
32201	T		Drain, percut, lung lesion	0070	3.3166	188.99		37.80
32215	C		Treat chest lining					
32220	C		Release of lung					
32225	C		Partial release of lung					
32310	C		Removal of chest lining					
32320	C		Free/remove chest lining					
32400	T		Needle biopsy chest lining	0685	5.8806	335.09	115.47	67.02
32402	C		Open biopsy chest lining					
32405	T		Biopsy, lung or mediastinum	0685	5.8806	335.09	115.47	67.02
32420	T		Puncture/clear lung	0070	3.3166	188.99		37.80
32440	C		Removal of lung					
32442	C		Sleeve pneumonectomy					
32445	C		Removal of lung					
32480	C		Partial removal of lung					
32482	C		Bilobectomy					
32484	C		Segmentectomy					
32486	C		Sleeve lobectomy					
32488	C		Completion pneumonectomy					
32491	C		Lung volume reduction					
32500	C		Partial removal of lung					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
32501	C		Repair bronchus add-on		.	.	.	.
32520	C		Remove lung & revise chest		.	.	.	.
32522	C		Remove lung & revise chest		.	.	.	.
32525	C		Remove lung & revise chest		.	.	.	.
32540	C		Removal of lung lesion		.	.	.	.
32601	T		Thoracoscopy, diagnostic	0069	29.9158	1704.69	591.64	340.94
32602	T		Thoracoscopy, diagnostic	0069	29.9158	1704.69	591.64	340.94
32603	T		Thoracoscopy, diagnostic	0069	29.9158	1704.69	591.64	340.94
32604	T		Thoracoscopy, diagnostic	0069	29.9158	1704.69	591.64	340.94
32605	T		Thoracoscopy, diagnostic	0069	29.9158	1704.69	591.64	340.94
32606	T		Thoracoscopy, diagnostic	0069	29.9158	1704.69	591.64	340.94
32650	C		Thoracoscopy, surgical		.	.	.	.
32651	C		Thoracoscopy, surgical		.	.	.	.
32652	C		Thoracoscopy, surgical		.	.	.	.
32653	C		Thoracoscopy, surgical		.	.	.	.
32654	C		Thoracoscopy, surgical		.	.	.	.
32655	C		Thoracoscopy, surgical		.	.	.	.
32656	C		Thoracoscopy, surgical		.	.	.	.
32657	C		Thoracoscopy, surgical		.	.	.	.
32658	C		Thoracoscopy, surgical		.	.	.	.
32659	C		Thoracoscopy, surgical		.	.	.	.
32660	C		Thoracoscopy, surgical		.	.	.	.
32661	C		Thoracoscopy, surgical		.	.	.	.
32662	C		Thoracoscopy, surgical		.	.	.	.
32663	C		Thoracoscopy, surgical		.	.	.	.
32664	C		Thoracoscopy, surgical		.	.	.	.
32665	C		Thoracoscopy, surgical		.	.	.	.
32800	C		Repair lung hernia		.	.	.	.
32810	C		Close chest after drainage		.	.	.	.
32815	C		Close bronchial fistula		.	.	.	.
32820	C		Reconstruct injured chest		.	.	.	.
32850	C		Donor pneumonectomy		.	.	.	.
32851	C		Lung transplant, single		.	.	.	.
32852	C		Lung transplant with bypass		.	.	.	.
32853	C		Lung transplant, double		.	.	.	.
32854	C		Lung transplant with bypass		.	.	.	.
32855	C	NI	Prepare donor lung, single		.	.	.	.
32856	C	NI	Prepare donor lung, double		.	.	.	.
32900	C		Removal of rib(s)		.	.	.	.
32905	C		Revise & repair chest wall		.	.	.	.
32906	C		Revise & repair chest wall		.	.	.	.
32940	C		Revision of lung		.	.	.	.
32960	T		Therapeutic pneumothorax	0070	3.3166	188.99	.	37.80

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
32997	C		Total lung lavage					
32999	T		Chest surgery procedure	0070	3.3166	188.99		37.80
33010	T		Drainage of heart sac	0070	3.3166	188.99		37.80
33011	T		Repeat drainage of heart sac	0070	3.3166	188.99		37.80
33015	C		Incision of heart sac					
33020	C		Incision of heart sac					
33025	C		Incision of heart sac					
33030	C		Partial removal of heart sac					
33031	C		Partial removal of heart sac					
33050	C		Removal of heart sac lesion					
33120	C		Removal of heart lesion					
33130	C		Removal of heart lesion					
33140	C		Heart revascularize (tmr)					
33141	C		Heart tmr w/other procedure					
33200	C		Insertion of heart pacemaker					
33201	C		Insertion of heart pacemaker					
33206	T		Insertion of heart pacemaker	0089	109.5827	6244.35	1682.28	1248.87
33207	T		Insertion of heart pacemaker	0089	109.5827	6244.35	1682.28	1248.87
33208	T		Insertion of heart pacemaker	0655	135.1464	7701.05		1540.21
33210	T		Insertion of heart electrode	0106	55.1440	3142.27		628.45
33211	T		Insertion of heart electrode	0106	55.1440	3142.27		628.45
33212	T		Insertion of pulse generator	0090	90.5432	5159.42	1612.80	1031.88
33213	T		Insertion of pulse generator	0654	105.3805	6004.90		1200.98
33214	T		Upgrade of pacemaker system	0655	135.1464	7701.05		1540.21
33215	T		Reposition pacing-defib lead	0105	21.5449	1227.69	370.40	245.54
33216	T		Insert lead pace-defib, one	0106	55.1440	3142.27		628.45
33217	T		Insert lead pace-defib, dual	0106	55.1440	3142.27		628.45
33218	T		Repair lead pace-defib, one	0106	55.1440	3142.27		628.45
33220	T		Repair lead pace-defib, dual	0106	55.1440	3142.27		628.45
33222	T		Revise pocket, pacemaker	0027	16.8355	959.34	329.72	191.87
33223	T		Revise pocket, pacing-defib	0027	16.8355	959.34	329.72	191.87
33224	T		Insert pacing lead & connect	0418	74.5141	4246.04		849.21
33225	S		L ventric pacing lead add-on	1525		3750.00		750.00
33226	T		Reposition l ventric lead	0105	21.5449	1227.69	370.40	245.54
33233	T		Removal of pacemaker system	0105	21.5449	1227.69	370.40	245.54
33234	T		Removal of pacemaker system	0105	21.5449	1227.69	370.40	245.54
33235	T		Removal pacemaker electrode	0105	21.5449	1227.69	370.40	245.54
33236	C		Remove electrode/thoracotomy					
33237	C		Remove electrode/thoracotomy					
33238	C		Remove electrode/thoracotomy					
33240	B		Insert pulse generator					
33241	T		Remove pulse generator	0105	21.5449	1227.69	370.40	245.54
33243	C		Remove eltrd/thoracotomy					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
33244	T		Remove eltrd, transven	0105	21.5449	1227.69	370.40	245.54
33245	C		Insert epic eltrd pace-defib		.	.	.	.
33246	C		Insert epic eltrd/generator		.	.	.	.
33249	B		Eltrd/insert pace-defib		.	.	.	.
33250	C		Ablate heart dysrhythm focus		.	.	.	.
33251	C		Ablate heart dysrhythm focus		.	.	.	.
33253	C		Reconstruct atria		.	.	.	.
33261	C		Ablate heart dysrhythm focus		.	.	.	.
33282	S		Implant pat-active ht record	0680	63.9488	3643.99	.	728.80
33284	T		Remove pat-active ht record	0109	7.5181	428.40	131.49	85.68
33300	C		Repair of heart wound		.	.	.	.
33305	C		Repair of heart wound		.	.	.	.
33310	C		Exploratory heart surgery		.	.	.	.
33315	C		Exploratory heart surgery		.	.	.	.
33320	C		Repair major blood vessel(s)		.	.	.	.
33321	C		Repair major vessel		.	.	.	.
33322	C		Repair major blood vessel(s)		.	.	.	.
33330	C		Insert major vessel graft		.	.	.	.
33332	C		Insert major vessel graft		.	.	.	.
33335	C		Insert major vessel graft		.	.	.	.
33400	C		Repair of aortic valve		.	.	.	.
33401	C		Valvuloplasty, open		.	.	.	.
33403	C		Valvuloplasty, w/cp bypass		.	.	.	.
33404	C		Prepare heart-aorta conduit		.	.	.	.
33405	C		Replacement of aortic valve		.	.	.	.
33406	C		Replacement of aortic valve		.	.	.	.
33410	C		Replacement of aortic valve		.	.	.	.
33411	C		Replacement of aortic valve		.	.	.	.
33412	C		Replacement of aortic valve		.	.	.	.
33413	C		Replacement of aortic valve		.	.	.	.
33414	C		Repair of aortic valve		.	.	.	.
33415	C		Revision, subvalvular tissue		.	.	.	.
33416	C		Revise ventricle muscle		.	.	.	.
33417	C		Repair of aortic valve		.	.	.	.
33420	C		Revision of mitral valve		.	.	.	.
33422	C		Revision of mitral valve		.	.	.	.
33425	C		Repair of mitral valve		.	.	.	.
33426	C		Repair of mitral valve		.	.	.	.
33427	C		Repair of mitral valve		.	.	.	.
33430	C		Replacement of mitral valve		.	.	.	.
33460	C		Revision of tricuspid valve		.	.	.	.
33463	C		Valvuloplasty, tricuspid		.	.	.	.
33464	C		Valvuloplasty, tricuspid		.	.	.	.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
33465	C		Replace tricuspid valve					
33468	C		Revision of tricuspid valve					
33470	C		Revision of pulmonary valve					
33471	C		Valvotomy, pulmonary valve					
33472	C		Revision of pulmonary valve					
33474	C		Revision of pulmonary valve					
33475	C		Replacement, pulmonary valve					
33476	C		Revision of heart chamber					
33478	C		Revision of heart chamber					
33496	C		Repair, prosth valve clot					
33500	C		Repair heart vessel fistula					
33501	C		Repair heart vessel fistula					
33502	C		Coronary artery correction					
33503	C		Coronary artery graft					
33504	C		Coronary artery graft					
33505	C		Repair artery w/tunnel					
33506	C		Repair artery, translocation					
33508	N		Endoscopic vein harvest					
33510	C		CABG, vein, single					
33511	C		CABG, vein, two					
33512	C		CABG, vein, three					
33513	C		CABG, vein, four					
33514	C		CABG, vein, five					
33516	C		Cabg, vein, six or more					
33517	C		CABG, artery-vein, single					
33518	C		CABG, artery-vein, two					
33519	C		CABG, artery-vein, three					
33521	C		CABG, artery-vein, four					
33522	C		CABG, artery-vein, five					
33523	C		Cabg, art-vein, six or more					
33530	C		Coronary artery, bypass/reop					
33533	C		CABG, arterial, single					
33534	C		CABG, arterial, two					
33535	C		CABG, arterial, three					
33536	C		Cabg, arterial, four or more					
33542	C		Removal of heart lesion					
33545	C		Repair of heart damage					
33572	C		Open coronary endarterectomy					
33600	C		Closure of valve					
33602	C		Closure of valve					
33606	C		Anastomosis/artery-aorta					
33608	C		Repair anomaly w/conduit					
33610	C		Repair by enlargement					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
33611	C		Repair double ventricle					
33612	C		Repair double ventricle					
33615	C		Repair, modified fontan					
33617	C		Repair single ventricle					
33619	C		Repair single ventricle					
33641	C		Repair heart septum defect					
33645	C		Revision of heart veins					
33647	C		Repair heart septum defects					
33660	C		Repair of heart defects					
33665	C		Repair of heart defects					
33670	C		Repair of heart chambers					
33681	C		Repair heart septum defect					
33684	C		Repair heart septum defect					
33688	C		Repair heart septum defect					
33690	C		Reinforce pulmonary artery					
33692	C		Repair of heart defects					
33694	C		Repair of heart defects					
33697	C		Repair of heart defects					
33702	C		Repair of heart defects					
33710	C		Repair of heart defects					
33720	C		Repair of heart defect					
33722	C		Repair of heart defect					
33730	C		Repair heart-vein defect(s)					
33732	C		Repair heart-vein defect					
33735	C		Revision of heart chamber					
33736	C		Revision of heart chamber					
33737	C		Revision of heart chamber					
33750	C		Major vessel shunt					
33755	C		Major vessel shunt					
33762	C		Major vessel shunt					
33764	C		Major vessel shunt & graft					
33766	C		Major vessel shunt					
33767	C		Major vessel shunt					
33770	C		Repair great vessels defect					
33771	C		Repair great vessels defect					
33774	C		Repair great vessels defect					
33775	C		Repair great vessels defect					
33776	C		Repair great vessels defect					
33777	C		Repair great vessels defect					
33778	C		Repair great vessels defect					
33779	C		Repair great vessels defect					
33780	C		Repair great vessels defect					
33781	C		Repair great vessels defect					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
33786	C		Repair arterial trunk					
33788	C		Revision of pulmonary artery					
33800	C		Aortic suspension					
33802	C		Repair vessel defect					
33803	C		Repair vessel defect					
33813	C		Repair septal defect					
33814	C		Repair septal defect					
33820	C		Revise major vessel					
33822	C		Revise major vessel					
33824	C		Revise major vessel					
33840	C		Remove aorta constriction					
33845	C		Remove aorta constriction					
33851	C		Remove aorta constriction					
33852	C		Repair septal defect					
33853	C		Repair septal defect					
33860	C		Ascending aortic graft					
33861	C		Ascending aortic graft					
33863	C		Ascending aortic graft					
33870	C		Transverse aortic arch graft					
33875	C		Thoracic aortic graft					
33877	C		Thoracoabdominal graft					
33910	C		Remove lung artery emboli					
33915	C		Remove lung artery emboli					
33916	C		Surgery of great vessel					
33917	C		Repair pulmonary artery					
33918	C		Repair pulmonary atresia					
33919	C		Repair pulmonary atresia					
33920	C		Repair pulmonary atresia					
33922	C		Transect pulmonary artery					
33924	C		Remove pulmonary shunt					
33930	C		Removal of donor heart/lung					
33933	C	NI	Prepare donor heart/lung					
33935	C		Transplantation, heart/lung					
33940	C		Removal of donor heart					
33944	C	NI	Prepare donor heart					
33945	C		Transplantation of heart					
33960	C		External circulation assist					
33961	C		External circulation assist					
33967	C		Insert ia percut device					
33968	C		Remove aortic assist device					
33970	C		Aortic circulation assist					
33971	C		Aortic circulation assist					
33973	C		Insert balloon device					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
33974	C		Remove intra-aortic balloon					
33975	C		Implant ventricular device					
33976	C		Implant ventricular device					
33977	C		Remove ventricular device					
33978	C		Remove ventricular device					
33979	C		Insert intracorporeal device					
33980	C		Remove intracorporeal device					
33999	T		Cardiac surgery procedure	0070	3.3166	188.99		37.80
34001	C		Removal of artery clot					
34051	C		Removal of artery clot					
34101	T		Removal of artery clot	0088	36.0282	2052.99	655.22	410.60
34111	T		Removal of arm artery clot	0088	36.0282	2052.99	655.22	410.60
34151	C		Removal of artery clot					
34201	T		Removal of artery clot	0088	36.0282	2052.99	655.22	410.60
34203	T		Removal of leg artery clot	0088	36.0282	2052.99	655.22	410.60
34401	C		Removal of vein clot					
34421	T		Removal of vein clot	0088	36.0282	2052.99	655.22	410.60
34451	C		Removal of vein clot					
34471	T		Removal of vein clot	0088	36.0282	2052.99	655.22	410.60
34490	T		Removal of vein clot	0088	36.0282	2052.99	655.22	410.60
34501	T		Repair valve, femoral vein	0088	36.0282	2052.99	655.22	410.60
34502	C		Reconstruct vena cava					
34510	T		Transposition of vein valve	0088	36.0282	2052.99	655.22	410.60
34520	T		Cross-over vein graft	0088	36.0282	2052.99	655.22	410.60
34530	T		Leg vein fusion	0088	36.0282	2052.99	655.22	410.60
34800	C		Endovas aaa repr w/sm tube					
34802	C		Endovas aaa repr w/2-p part					
34803	C	NI	Endovas aaa repr w/3-p part					
34804	C		Endovas aaa repr w/1-p part					
34805	C		Endovas aaa repr w/long tube					
34808	C		Endovas iliac a device addon					
34812	C		Xpose for endoprosth, femorl					
34813	C		Femoral endovas graft add-on					
34820	C		Xpose for endoprosth, iliac					
34825	C		Endovasc extend prosth, init					
34826	C		Endovasc exten prosth, add'l					
34830	C		Open aortic tube prosth repr					
34831	C		Open aortoiliac prosth repr					
34832	C		Open aortofemor prosth repr					
34833	C		Xpose for endoprosth, iliac					
34834	C		Xpose, endoprosth, brachial					
34900	C		Endovasc iliac repr w/graft					
35001	C		Repair defect of artery					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
35002	C		Repair artery rupture, neck		.	.	.	.
35005	C		Repair defect of artery		.	.	.	.
35011	T		Repair defect of artery	0653	28.0840	1600.31	.	320.06
35013	C		Repair artery rupture, arm		.	.	.	.
35021	C		Repair defect of artery		.	.	.	.
35022	C		Repair artery rupture, chest		.	.	.	.
35045	C		Repair defect of arm artery		.	.	.	.
35081	C		Repair defect of artery		.	.	.	.
35082	C		Repair artery rupture, aorta		.	.	.	.
35091	C		Repair defect of artery		.	.	.	.
35092	C		Repair artery rupture, aorta		.	.	.	.
35102	C		Repair defect of artery		.	.	.	.
35103	C		Repair artery rupture, groin		.	.	.	.
35111	C		Repair defect of artery		.	.	.	.
35112	C		Repair artery rupture,spleen		.	.	.	.
35121	C		Repair defect of artery		.	.	.	.
35122	C		Repair artery rupture, belly		.	.	.	.
35131	C		Repair defect of artery		.	.	.	.
35132	C		Repair artery rupture, groin		.	.	.	.
35141	C		Repair defect of artery		.	.	.	.
35142	C		Repair artery rupture, thigh		.	.	.	.
35151	C		Repair defect of artery		.	.	.	.
35152	C		Repair artery rupture, knee		.	.	.	.
35161	D		Repair defect of artery		.	.	.	.
35162	D		Repair artery rupture		.	.	.	.
35180	T		Repair blood vessel lesion	0093	24.0351	1369.59	277.34	273.92
35182	C		Repair blood vessel lesion		.	.	.	.
35184	T		Repair blood vessel lesion	0093	24.0351	1369.59	277.34	273.92
35188	T		Repair blood vessel lesion	0088	36.0282	2052.99	655.22	410.60
35189	C		Repair blood vessel lesion		.	.	.	.
35190	T		Repair blood vessel lesion	0093	24.0351	1369.59	277.34	273.92
35201	T		Repair blood vessel lesion	0093	24.0351	1369.59	277.34	273.92
35206	T		Repair blood vessel lesion	0093	24.0351	1369.59	277.34	273.92
35207	T		Repair blood vessel lesion	0088	36.0282	2052.99	655.22	410.60
35211	C		Repair blood vessel lesion		.	.	.	.
35216	C		Repair blood vessel lesion		.	.	.	.
35221	C		Repair blood vessel lesion		.	.	.	.
35226	T		Repair blood vessel lesion	0093	24.0351	1369.59	277.34	273.92
35231	T		Repair blood vessel lesion	0093	24.0351	1369.59	277.34	273.92
35236	T		Repair blood vessel lesion	0093	24.0351	1369.59	277.34	273.92
35241	C		Repair blood vessel lesion		.	.	.	.
35246	C		Repair blood vessel lesion		.	.	.	.
35251	C		Repair blood vessel lesion		.	.	.	.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
35256	T		Repair blood vessel lesion	0093	24.0351	1369.59	277.34	273.92
35261	T		Repair blood vessel lesion	0653	28.0840	1600.31		320.06
35266	T		Repair blood vessel lesion	0653	28.0840	1600.31		320.06
35271	C		Repair blood vessel lesion					
35276	C		Repair blood vessel lesion					
35281	C		Repair blood vessel lesion					
35286	T		Repair blood vessel lesion	0653	28.0840	1600.31		320.06
35301	C		Rechanneling of artery					
35311	C		Rechanneling of artery					
35321	T		Rechanneling of artery	0093	24.0351	1369.59	277.34	273.92
35331	C		Rechanneling of artery					
35341	C		Rechanneling of artery					
35351	C		Rechanneling of artery					
35355	C		Rechanneling of artery					
35361	C		Rechanneling of artery					
35363	C		Rechanneling of artery					
35371	C		Rechanneling of artery					
35372	C		Rechanneling of artery					
35381	C		Rechanneling of artery					
35390	C		Reoperation, carotid add-on					
35400	C		Angioscopy					
35450	C		Repair arterial blockage					
35452	C		Repair arterial blockage					
35454	C		Repair arterial blockage					
35456	C		Repair arterial blockage					
35458	T		Repair arterial blockage	0081	32.7548	1866.47		373.29
35459	T		Repair arterial blockage	0081	32.7548	1866.47		373.29
35460	T		Repair venous blockage	0081	32.7548	1866.47		373.29
35470	T		Repair arterial blockage	0081	32.7548	1866.47		373.29
35471	T		Repair arterial blockage	0081	32.7548	1866.47		373.29
35472	T		Repair arterial blockage	0081	32.7548	1866.47		373.29
35473	T		Repair arterial blockage	0081	32.7548	1866.47		373.29
35474	T		Repair arterial blockage	0081	32.7548	1866.47		373.29
35475	T		Repair arterial blockage	0081	32.7548	1866.47		373.29
35476	T		Repair venous blockage	0081	32.7548	1866.47		373.29
35480	C		Atherectomy, open					
35481	C		Atherectomy, open					
35482	C		Atherectomy, open					
35483	C		Atherectomy, open					
35484	T		Atherectomy, open	0081	32.7548	1866.47		373.29
35485	T		Atherectomy, open	0081	32.7548	1866.47		373.29
35490	T		Atherectomy, percutaneous	0081	32.7548	1866.47		373.29
35491	T		Atherectomy, percutaneous	0081	32.7548	1866.47		373.29

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
35492	T		Atherectomy, percutaneous	0081	32.7548	1866.47		373.29
35493	T		Atherectomy, percutaneous	0081	32.7548	1866.47		373.29
35494	T		Atherectomy, percutaneous	0081	32.7548	1866.47		373.29
35495	T		Atherectomy, percutaneous	0081	32.7548	1866.47		373.29
35500	N		Harvest vein for bypass					
35501	C		Artery bypass graft					
35506	C		Artery bypass graft					
35507	C		Artery bypass graft					
35508	C		Artery bypass graft					
35509	C		Artery bypass graft					
35510	C		Artery bypass graft					
35511	C		Artery bypass graft					
35512	C		Artery bypass graft					
35515	C		Artery bypass graft					
35516	C		Artery bypass graft					
35518	C		Artery bypass graft					
35521	C		Artery bypass graft					
35522	C		Artery bypass graft					
35525	C		Artery bypass graft					
35526	C		Artery bypass graft					
35531	C		Artery bypass graft					
35533	C		Artery bypass graft					
35536	C		Artery bypass graft					
35541	C		Artery bypass graft					
35546	C		Artery bypass graft					
35548	C		Artery bypass graft					
35549	C		Artery bypass graft					
35551	C		Artery bypass graft					
35556	C		Artery bypass graft					
35558	C		Artery bypass graft					
35560	C		Artery bypass graft					
35563	C		Artery bypass graft					
35565	C		Artery bypass graft					
35566	C		Artery bypass graft					
35571	C		Artery bypass graft					
35572	N		Harvest femoropopliteal vein					
35582	D		Vein bypass graft					
35583	C		Vein bypass graft					
35585	C		Vein bypass graft					
35587	C		Vein bypass graft					
35600	C		Harvest artery for cabg					
35601	C		Artery bypass graft					
35606	C		Artery bypass graft					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
35612	C		Artery bypass graft		.	.	.	.
35616	C		Artery bypass graft		.	.	.	.
35621	C		Artery bypass graft		.	.	.	.
35623	C		Bypass graft, not vein		.	.	.	.
35626	C		Artery bypass graft		.	.	.	.
35631	C		Artery bypass graft		.	.	.	.
35636	C		Artery bypass graft		.	.	.	.
35641	C		Artery bypass graft		.	.	.	.
35642	C		Artery bypass graft		.	.	.	.
35645	C		Artery bypass graft		.	.	.	.
35646	C		Artery bypass graft		.	.	.	.
35647	C		Artery bypass graft		.	.	.	.
35650	C		Artery bypass graft		.	.	.	.
35651	C		Artery bypass graft		.	.	.	.
35654	C		Artery bypass graft		.	.	.	.
35656	C		Artery bypass graft		.	.	.	.
35661	C		Artery bypass graft		.	.	.	.
35663	C		Artery bypass graft		.	.	.	.
35665	C		Artery bypass graft		.	.	.	.
35666	C		Artery bypass graft		.	.	.	.
35671	C		Artery bypass graft		.	.	.	.
35681	C		Composite bypass graft		.	.	.	.
35682	C		Composite bypass graft		.	.	.	.
35683	C		Composite bypass graft		.	.	.	.
35685	T		Bypass graft patency/patch	0093	24.0351	1369.59	277.34	273.92
35686	T		Bypass graft/av fist patency	0093	24.0351	1369.59	277.34	273.92
35691	C		Arterial transposition		.	.	.	.
35693	C		Arterial transposition		.	.	.	.
35694	C		Arterial transposition		.	.	.	.
35695	C		Arterial transposition		.	.	.	.
35697	C		Reimplant artery each		.	.	.	.
35700	C		Reoperation, bypass graft		.	.	.	.
35701	C		Exploration, carotid artery		.	.	.	.
35721	C		Exploration, femoral artery		.	.	.	.
35741	C		Exploration popliteal artery		.	.	.	.
35761	T		Exploration of artery/vein	0115	25.6621	1462.30	459.35	292.46
35800	C		Explore neck vessels		.	.	.	.
35820	C		Explore chest vessels		.	.	.	.
35840	C		Explore abdominal vessels		.	.	.	.
35860	T		Explore limb vessels	0093	24.0351	1369.59	277.34	273.92
35870	C		Repair vessel graft defect		.	.	.	.
35875	T		Removal of clot in graft	0088	36.0282	2052.99	655.22	410.60
35876	T		Removal of clot in graft	0088	36.0282	2052.99	655.22	410.60

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
35879	T		Revise graft w/vein	0088	36.0282	2052.99	655.22	410.60
35881	T		Revise graft w/vein	0088	36.0282	2052.99	655.22	410.60
35901	C		Excision, graft, neck					
35903	T		Excision, graft, extremity	0115	25.6621	1462.30	459.35	292.46
35905	C		Excision, graft, thorax					
35907	C		Excision, graft, abdomen					
36000	N		Place needle in vein					
36002	S		Pseudoaneurysm injection trt	0267	2.4250	138.18	62.18	27.64
36005	N		Injection ext venography					
36010	N		Place catheter in vein					
36011	N		Place catheter in vein					
36012	N		Place catheter in vein					
36013	N		Place catheter in artery					
36014	N		Place catheter in artery					
36015	N		Place catheter in artery					
36100	N		Establish access to artery					
36120	N		Establish access to artery					
36140	N		Establish access to artery					
36145	N		Artery to vein shunt					
36160	N		Establish access to aorta					
36200	N		Place catheter in aorta					
36215	N		Place catheter in artery					
36216	N		Place catheter in artery					
36217	N		Place catheter in artery					
36218	N		Place catheter in artery					
36245	N		Place catheter in artery					
36246	N		Place catheter in artery					
36247	N		Place catheter in artery					
36248	N		Place catheter in artery					
36260	T		Insertion of infusion pump	0119	125.9746	7178.41		1435.68
36261	T		Revision of infusion pump	0124	19.9665	1137.75		227.55
36262	T		Removal of infusion pump	0124	19.9665	1137.75		227.55
36299	N		Vessel injection procedure					
36400	N		Bl draw < 3 yrs fem/jugular					
36405	N		Bl draw < 3 yrs scalp vein					
36406	N		Bl draw < 3 yrs other vein					
36410	N		Non-routine bl draw > 3 yrs					
36415	E		Routine venipuncture					
36416	E		Capillary blood draw					
36420	T		Vein access cutdown < 1 yr	0035	0.2889	16.46		3.29
36425	T		Vein access cutdown > 1 yr	0035	0.2889	16.46		3.29
36430	S		Blood transfusion service	0110	3.7809	215.45		43.09
36440	S		Bl push transfuse, 2 yr or <	0110	3.7809	215.45		43.09

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
36450	S		Bl exchange/transfuse, nb	0110	3.7809	215.45		43.09
36455	S		Bl exchange/transfuse non-nb	0110	3.7809	215.45		43.09
36460	S		Transfusion service, fetal	0110	3.7809	215.45		43.09
36468	T		Injection(s), spider veins	0098	1.3424	76.49		15.30
36469	T		Injection(s), spider veins	0098	1.3424	76.49		15.30
36470	T		Injection therapy of vein	0098	1.3424	76.49		15.30
36471	T		Injection therapy of veins	0098	1.3424	76.49		15.30
36475	T	NI	Endovenous rf, 1st vein	0092	26.9952	1538.27	505.37	307.65
36476	T	NI	Endovenous rf, vein add-on	0092	26.9952	1538.27	505.37	307.65
36478	T	NI	Endovenous laser, 1st vein	0092	26.9952	1538.27	505.37	307.65
36479	T	NI	Endovenous laser vein addon	0092	26.9952	1538.27	505.37	307.65
36481	N		Insertion of catheter, vein					
36500	N		Insertion of catheter, vein					
36510	C		Insertion of catheter, vein					
36511	S		Apheresis wbc	0111	12.7259	725.16	200.18	145.03
36512	S		Apheresis rbc	0111	12.7259	725.16	200.18	145.03
36513	S		Apheresis platelets	0111	12.7259	725.16	200.18	145.03
36514	S		Apheresis plasma	0111	12.7259	725.16	200.18	145.03
36515	S		Apheresis, adsorp/reinfuse	0111	12.7259	725.16	200.18	145.03
36516	S		Apheresis, selective	0112	37.3315	2127.26	612.47	425.45
36522	S		Photopheresis	0112	37.3315	2127.26	612.47	425.45
36540	N		Collect blood venous device					
36550	T		Declot vascular device	0677	2.5535	145.51		29.10
36555	T		Insert non-tunnel cv cath	0187	3.8526	219.53		43.91
36556	T		Insert non-tunnel cv cath	0187	3.8526	219.53		43.91
36557	T		Insert tunneled cv cath	0032	10.7448	612.27		122.45
36558	T		Insert tunneled cv cath	0032	10.7448	612.27		122.45
36560	T		Insert tunneled cv cath	0115	25.6621	1462.30	459.35	292.46
36561	T		Insert tunneled cv cath	0115	25.6621	1462.30	459.35	292.46
36563	T		Insert tunneled cv cath	0119	125.9746	7178.41		1435.68
36565	T		Insert tunneled cv cath	0115	25.6621	1462.30	459.35	292.46
36566	T		Insert tunneled cv cath	1564		4750.00		950.00
36568	T		Insert picc cath	0187	3.8526	219.53		43.91
36569	T		Insert picc cath	0187	3.8526	219.53		43.91
36570	T		Insert picvad cath	0032	10.7448	612.27		122.45
36571	T		Insert picvad cath	0032	10.7448	612.27		122.45
36575	T		Repair tunneled cv cath	0187	3.8526	219.53		43.91
36576	T		Repair tunneled cv cath	0187	3.8526	219.53		43.91
36578	T		Replace tunneled cv cath	0187	3.8526	219.53		43.91
36580	T		Replace cvad cath	0187	3.8526	219.53		43.91
36581	T		Replace tunneled cv cath	0032	10.7448	612.27		122.45
36582	T		Replace tunneled cv cath	0115	25.6621	1462.30	459.35	292.46
36583	T		Replace tunneled cv cath	0119	125.9746	7178.41		1435.68

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
36584	T		Replace picc cath	0187	3.8526	219.53		43.91
36585	T		Replace picvad cath	0032	10.7448	612.27		122.45
36589	T		Removal tunneled cv cath	0109	7.5181	428.40	131.49	85.68
36590	T		Removal tunneled cv cath	0187	3.8526	219.53		43.91
36595	T		Mech remov tunneled cv cath	0187	3.8526	219.53		43.91
36596	T		Mech remov tunneled cv cath	0187	3.8526	219.53		43.91
36597	T		Reposition venous catheter	0187	3.8526	219.53		43.91
36600	N		Withdrawal of arterial blood					
36620	N		Insertion catheter, artery					
36625	N		Insertion catheter, artery					
36640	T		Insertion catheter, artery	0032	10.7448	612.27		122.45
36660	C		Insertion catheter, artery					
36680	T		Insert needle, bone cavity	0120	1.9620	111.80	28.21	22.36
36800	T		Insertion of cannula	0115	25.6621	1462.30	459.35	292.46
36810	T		Insertion of cannula	0115	25.6621	1462.30	459.35	292.46
36815	T		Insertion of cannula	0115	25.6621	1462.30	459.35	292.46
36818	T	NI	Av fuse, uppr arm, cephalic	0088	36.0282	2052.99	655.22	410.60
36819	T		Av fuse, uppr arm, basilic	0088	36.0282	2052.99	655.22	410.60
36820	T		Av fusion/forearm vein	0088	36.0282	2052.99	655.22	410.60
36821	T		Av fusion direct any site	0088	36.0282	2052.99	655.22	410.60
36822	C		Insertion of cannula(s)					
36823	C		Insertion of cannula(s)					
36825	T		Artery-vein autograft	0088	36.0282	2052.99	655.22	410.60
36830	T		Artery-vein nonautograft	0088	36.0282	2052.99	655.22	410.60
36831	T		Open thrombect av fistula	0088	36.0282	2052.99	655.22	410.60
36832	T		Av fistula revision, open	0088	36.0282	2052.99	655.22	410.60
36833	T		Av fistula revision	0088	36.0282	2052.99	655.22	410.60
36834	T		Repair A-V aneurysm	0088	36.0282	2052.99	655.22	410.60
36835	T		Artery to vein shunt	0115	25.6621	1462.30	459.35	292.46
36838	T		Dist revas ligation, hemo	0088	36.0282	2052.99	655.22	410.60
36860	T		External cannula declotting	0677	2.5535	145.51		29.10
36861	T		Cannula declotting	0115	25.6621	1462.30	459.35	292.46
36870	T		Percut thrombect av fistula	0653	28.0840	1600.31		320.06
37140	C		Revision of circulation					
37145	C		Revision of circulation					
37160	C		Revision of circulation					
37180	C		Revision of circulation					
37181	C		Splice spleen/kidney veins					
37182	C		Insert hepatic shunt (tips)					
37183	C		Remove hepatic shunt (tips)					
37195	C		Thrombolytic therapy, stroke					
37200	T		Transcatheter biopsy	0685	5.8806	335.09	115.47	67.02
37201	T		Transcatheter therapy infuse	0676	4.2729	243.48		48.70

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
37202	T		Transcatheter therapy infuse	0677	2.5535	145.51		29.10
37203	T		Transcatheter retrieval	0103	13.1337	748.40	223.63	149.68
37204	T		Transcatheter occlusion	0115	25.6621	1462.30	459.35	292.46
37205	T		Transcath iv stent, percut	0229	62.1357	3540.68	771.23	708.14
37206	T		Transcath iv stent/perc addl	0229	62.1357	3540.68	771.23	708.14
37207	T		Transcath iv stent, open	0229	62.1357	3540.68	771.23	708.14
37208	T		Transcath iv stent/open addl	0229	62.1357	3540.68	771.23	708.14
37209	T		Exchange arterial catheter	0103	13.1337	748.40	223.63	149.68
37215	C	NI	Transcath stent, cca w/eps					
37216	C	NI	Transcath stent, cca w/o eps					
37250	S		Iv us first vessel add-on	0416	4.8182	274.56	99.43	54.91
37251	S		Iv us each add vessel add-on	0416	4.8182	274.56	99.43	54.91
37500	T		Endoscopy ligate perf veins	0092	26.9952	1538.27	505.37	307.65
37501	T		Vascular endoscopy procedure	0092	26.9952	1538.27	505.37	307.65
37565	T		Ligation of neck vein	0093	24.0351	1369.59	277.34	273.92
37600	T		Ligation of neck artery	0093	24.0351	1369.59	277.34	273.92
37605	T		Ligation of neck artery	0091	29.6620	1690.23	348.23	338.05
37606	T		Ligation of neck artery	0091	29.6620	1690.23	348.23	338.05
37607	T		Ligation of a-v fistula	0092	26.9952	1538.27	505.37	307.65
37609	T		Temporal artery procedure	0021	14.8872	848.32	219.48	169.66
37615	T		Ligation of neck artery	0091	29.6620	1690.23	348.23	338.05
37616	C		Ligation of chest artery					
37617	C		Ligation of abdomen artery					
37618	C		Ligation of extremity artery					
37620	T		Revision of major vein	0091	29.6620	1690.23	348.23	338.05
37650	T		Revision of major vein	0091	29.6620	1690.23	348.23	338.05
37660	C		Revision of major vein					
37700	T		Revise leg vein	0091	29.6620	1690.23	348.23	338.05
37720	T		Removal of leg vein	0092	26.9952	1538.27	505.37	307.65
37730	T		Removal of leg veins	0092	26.9952	1538.27	505.37	307.65
37735	T		Removal of leg veins/lesion	0092	26.9952	1538.27	505.37	307.65
37760	T		Ligation, leg veins, open	0091	29.6620	1690.23	348.23	338.05
37765	T		Phleb veins - extrem - to 20	0091	29.6620	1690.23	348.23	338.05
37766	T		Phleb veins - extrem 20+	0091	29.6620	1690.23	348.23	338.05
37780	T		Revision of leg vein	0091	29.6620	1690.23	348.23	338.05
37785	T		Ligate/divide/excise vein	0091	29.6620	1690.23	348.23	338.05
37788	C		Revascularization, penis					
37790	T		Penile venous occlusion	0181	31.6828	1805.38	621.82	361.08
37799	T		Vascular surgery procedure	0035	0.2889	16.46		3.29
38100	C		Removal of spleen, total					
38101	C		Removal of spleen, partial					
38102	C		Removal of spleen, total					
38115	C		Repair of ruptured spleen					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
38120	T		Laparoscopy, splenectomy	0131	42.7526	2436.17	1001.89	487.23
38129	T		Laparoscope proc, spleen	0130	31.6832	1805.40	659.53	361.08
38200	N		Injection for spleen x-ray					
38204	E		BI donor search management					
38205	S		Harvest allogenic stem cells	0111	12.7259	725.16	200.18	145.03
38206	S		Harvest auto stem cells	0111	12.7259	725.16	200.18	145.03
38207	E		Cryopreserve stem cells					
38208	E		Thaw preserved stem cells					
38209	E		Wash harvest stem cells					
38210	E		T-cell depletion of harvest					
38211	E		Tumor cell deplete of harvst					
38212	E		Rbc depletion of harvest					
38213	E		Platelet deplete of harvest					
38214	E		Volume deplete of harvest					
38215	E		Harvest stem cell concentrte					
38220	T		Bone marrow aspiration	0003	2.4779	141.20		28.24
38221	T		Bone marrow biopsy	0003	2.4779	141.20		28.24
38230	S		Bone marrow collection	0111	12.7259	725.16	200.18	145.03
38240	S		Bone marrow/stem transplant	0123	10.6755	608.32		121.66
38241	S		Bone marrow/stem transplant	0123	10.6755	608.32		121.66
38242	S		Lymphocyte infuse transplant	0111	12.7259	725.16	200.18	145.03
38300	T		Drainage, lymph node lesion	0008	19.3572	1103.03		220.61
38305	T		Drainage, lymph node lesion	0008	19.3572	1103.03		220.61
38308	T		Incision of lymph channels	0113	21.0044	1196.89		239.38
38380	C		Thoracic duct procedure					
38381	C		Thoracic duct procedure					
38382	C		Thoracic duct procedure					
38500	T		Biopsy/removal, lymph nodes	0113	21.0044	1196.89		239.38
38505	T		Needle biopsy, lymph nodes	0005	3.7391	213.07	71.59	42.61
38510	T		Biopsy/removal, lymph nodes	0113	21.0044	1196.89		239.38
38520	T		Biopsy/removal, lymph nodes	0113	21.0044	1196.89		239.38
38525	T		Biopsy/removal, lymph nodes	0113	21.0044	1196.89		239.38
38530	T		Biopsy/removal, lymph nodes	0113	21.0044	1196.89		239.38
38542	T		Explore deep node(s), neck	0114	39.6713	2260.59	485.91	452.12
38550	T		Removal, neck/armpit lesion	0113	21.0044	1196.89		239.38
38555	T		Removal, neck/armpit lesion	0113	21.0044	1196.89		239.38
38562	C		Removal, pelvic lymph nodes					
38564	C		Removal, abdomen lymph nodes					
38570	T		Laparoscopy, lymph node biop	0131	42.7526	2436.17	1001.89	487.23
38571	T		Laparoscopy, lymphadenectomy	0132	61.3208	3494.24	1239.22	698.85
38572	T		Laparoscopy, lymphadenectomy	0131	42.7526	2436.17	1001.89	487.23
38589	T		Laparoscope proc, lymphatic	0130	31.6832	1805.40	659.53	361.08
38700	T		Removal of lymph nodes, neck	0113	21.0044	1196.89		239.38

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
38720	T		Removal of lymph nodes, neck	0113	21.0044	1196.89		239.38
38724	C		Removal of lymph nodes, neck					
38740	T		Remove armpit lymph nodes	0114	39.6713	2260.59	485.91	452.12
38745	T		Remove armpit lymph nodes	0114	39.6713	2260.59	485.91	452.12
38746	C		Remove thoracic lymph nodes					
38747	C		Remove abdominal lymph nodes					
38760	T		Remove groin lymph nodes	0113	21.0044	1196.89		239.38
38765	C		Remove groin lymph nodes					
38770	C		Remove pelvis lymph nodes					
38780	C		Remove abdomen lymph nodes					
38790	N		Inject for lymphatic x-ray					
38792	N		Identify sentinel node					
38794	N		Access thoracic lymph duct					
38999	S		Blood/lymph system procedure	0110	3.7809	215.45		43.09
39000	C		Exploration of chest					
39010	C		Exploration of chest					
39200	C		Removal chest lesion					
39220	C		Removal chest lesion					
39400	T		Visualization of chest	0069	29.9158	1704.69	591.64	340.94
39499	C		Chest procedure					
39501	C		Repair diaphragm laceration					
39502	C		Repair paraesophageal hernia					
39503	C		Repair of diaphragm hernia					
39520	C		Repair of diaphragm hernia					
39530	C		Repair of diaphragm hernia					
39531	C		Repair of diaphragm hernia					
39540	C		Repair of diaphragm hernia					
39541	C		Repair of diaphragm hernia					
39545	C		Revision of diaphragm					
39560	C		Resect diaphragm, simple					
39561	C		Resect diaphragm, complex					
39599	C		Diaphragm surgery procedure					
4000F	E	NI	Tobacco use txmnt counseling					
4001F	E	NI	Tobacco use txmnt, pharmacol					
4002F	E	NI	Statin therapy, rx					
4006F	E	NI	Beta-blocker therapy, rx					
4009F	E	NI	Ace inhibitor therapy, rx					
4011F	E	NI	Oral antiplatelet tx, rx					
40490	T		Biopsy of lip	0251	1.9352	110.27		22.05
40500	T		Partial excision of lip	0253	15.9877	911.03	282.29	182.21
40510	T		Partial excision of lip	0254	23.3442	1330.22	321.35	266.04
40520	T		Partial excision of lip	0253	15.9877	911.03	282.29	182.21
40525	T		Reconstruct lip with flap	0254	23.3442	1330.22	321.35	266.04

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
40527	T		Reconstruct lip with flap	0254	23.3442	1330.22	321.35	266.04
40530	T		Partial removal of lip	0254	23.3442	1330.22	321.35	266.04
40650	T		Repair lip	0252	6.5183	371.43	113.41	74.29
40652	T		Repair lip	0252	6.5183	371.43	113.41	74.29
40654	T		Repair lip	0252	6.5183	371.43	113.41	74.29
40700	T		Repair cleft lip/nasal	0256	36.9298	2104.37		420.87
40701	T		Repair cleft lip/nasal	0256	36.9298	2104.37		420.87
40702	T		Repair cleft lip/nasal	0256	36.9298	2104.37		420.87
40720	T		Repair cleft lip/nasal	0256	36.9298	2104.37		420.87
40761	T		Repair cleft lip/nasal	0256	36.9298	2104.37		420.87
40799	T		Lip surgery procedure	0251	1.9352	110.27		22.05
40800	T		Drainage of mouth lesion	0251	1.9352	110.27		22.05
40801	T		Drainage of mouth lesion	0252	6.5183	371.43	113.41	74.29
40804	X		Removal, foreign body, mouth	0340	0.6328	36.06		7.21
40805	T		Removal, foreign body, mouth	0252	6.5183	371.43	113.41	74.29
40806	T		Incision of lip fold	0251	1.9352	110.27		22.05
40808	T		Biopsy of mouth lesion	0251	1.9352	110.27		22.05
40810	T		Excision of mouth lesion	0253	15.9877	911.03	282.29	182.21
40812	T		Excise/repair mouth lesion	0253	15.9877	911.03	282.29	182.21
40814	T		Excise/repair mouth lesion	0253	15.9877	911.03	282.29	182.21
40816	T		Excision of mouth lesion	0254	23.3442	1330.22	321.35	266.04
40818	T		Excise oral mucosa for graft	0251	1.9352	110.27		22.05
40819	T		Excise lip or cheek fold	0252	6.5183	371.43	113.41	74.29
40820	T		Treatment of mouth lesion	0253	15.9877	911.03	282.29	182.21
40830	T		Repair mouth laceration	0251	1.9352	110.27		22.05
40831	T		Repair mouth laceration	0252	6.5183	371.43	113.41	74.29
40840	T		Reconstruction of mouth	0254	23.3442	1330.22	321.35	266.04
40842	T		Reconstruction of mouth	0254	23.3442	1330.22	321.35	266.04
40843	T		Reconstruction of mouth	0254	23.3442	1330.22	321.35	266.04
40844	T		Reconstruction of mouth	0256	36.9298	2104.37		420.87
40845	T		Reconstruction of mouth	0256	36.9298	2104.37		420.87
40899	T		Mouth surgery procedure	0251	1.9352	110.27		22.05
41000	T		Drainage of mouth lesion	0253	15.9877	911.03	282.29	182.21
41005	T		Drainage of mouth lesion	0251	1.9352	110.27		22.05
41006	T		Drainage of mouth lesion	0254	23.3442	1330.22	321.35	266.04
41007	T		Drainage of mouth lesion	0253	15.9877	911.03	282.29	182.21
41008	T		Drainage of mouth lesion	0253	15.9877	911.03	282.29	182.21
41009	T		Drainage of mouth lesion	0251	1.9352	110.27		22.05
41010	T		Incision of tongue fold	0252	6.5183	371.43	113.41	74.29
41015	T		Drainage of mouth lesion	0251	1.9352	110.27		22.05
41016	T		Drainage of mouth lesion	0252	6.5183	371.43	113.41	74.29
41017	T		Drainage of mouth lesion	0252	6.5183	371.43	113.41	74.29
41018	T		Drainage of mouth lesion	0252	6.5183	371.43	113.41	74.29

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
41100	T		Biopsy of tongue	0252	6.5183	371.43	113.41	74.29
41105	T		Biopsy of tongue	0253	15.9877	911.03	282.29	182.21
41108	T		Biopsy of floor of mouth	0252	6.5183	371.43	113.41	74.29
41110	T		Excision of tongue lesion	0253	15.9877	911.03	282.29	182.21
41112	T		Excision of tongue lesion	0253	15.9877	911.03	282.29	182.21
41113	T		Excision of tongue lesion	0253	15.9877	911.03	282.29	182.21
41114	T		Excision of tongue lesion	0254	23.3442	1330.22	321.35	266.04
41115	T		Excision of tongue fold	0252	6.5183	371.43	113.41	74.29
41116	T		Excision of mouth lesion	0253	15.9877	911.03	282.29	182.21
41120	T		Partial removal of tongue	0254	23.3442	1330.22	321.35	266.04
41130	C		Partial removal of tongue					
41135	C		Tongue and neck surgery					
41140	C		Removal of tongue					
41145	C		Tongue removal, neck surgery					
41150	C		Tongue, mouth, jaw surgery					
41153	C		Tongue, mouth, neck surgery					
41155	C		Tongue, jaw, & neck surgery					
41250	T		Repair tongue laceration	0251	1.9352	110.27		22.05
41251	T		Repair tongue laceration	0251	1.9352	110.27		22.05
41252	T		Repair tongue laceration	0252	6.5183	371.43	113.41	74.29
41500	T		Fixation of tongue	0254	23.3442	1330.22	321.35	266.04
41510	T		Tongue to lip surgery	0253	15.9877	911.03	282.29	182.21
41520	T		Reconstruction, tongue fold	0252	6.5183	371.43	113.41	74.29
41599	T		Tongue and mouth surgery	0251	1.9352	110.27		22.05
41800	T		Drainage of gum lesion	0251	1.9352	110.27		22.05
41805	T		Removal foreign body, gum	0254	23.3442	1330.22	321.35	266.04
41806	T		Removal foreign body,jawbone	0253	15.9877	911.03	282.29	182.21
41820	T		Excision, gum, each quadrant	0252	6.5183	371.43	113.41	74.29
41821	T		Excision of gum flap	0252	6.5183	371.43	113.41	74.29
41822	T		Excision of gum lesion	0253	15.9877	911.03	282.29	182.21
41823	T		Excision of gum lesion	0254	23.3442	1330.22	321.35	266.04
41825	T		Excision of gum lesion	0253	15.9877	911.03	282.29	182.21
41826	T		Excision of gum lesion	0253	15.9877	911.03	282.29	182.21
41827	T		Excision of gum lesion	0254	23.3442	1330.22	321.35	266.04
41828	T		Excision of gum lesion	0253	15.9877	911.03	282.29	182.21
41830	T		Removal of gum tissue	0253	15.9877	911.03	282.29	182.21
41850	T		Treatment of gum lesion	0253	15.9877	911.03	282.29	182.21
41870	T		Gum graft	0254	23.3442	1330.22	321.35	266.04
41872	T		Repair gum	0253	15.9877	911.03	282.29	182.21
41874	T		Repair tooth socket	0254	23.3442	1330.22	321.35	266.04
41899	T		Dental surgery procedure	0251	1.9352	110.27		22.05
42000	T		Drainage mouth roof lesion	0251	1.9352	110.27		22.05
42100	T		Biopsy roof of mouth	0252	6.5183	371.43	113.41	74.29

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
42104	T		Excision lesion, mouth roof	0253	15.9877	911.03	282.29	182.21
42106	T		Excision lesion, mouth roof	0253	15.9877	911.03	282.29	182.21
42107	T		Excision lesion, mouth roof	0254	23.3442	1330.22	321.35	266.04
42120	T		Remove palate/lesion	0256	36.9298	2104.37		420.87
42140	T		Excision of uvula	0252	6.5183	371.43	113.41	74.29
42145	T		Repair palate, pharynx/uvula	0254	23.3442	1330.22	321.35	266.04
42160	T		Treatment mouth roof lesion	0253	15.9877	911.03	282.29	182.21
42180	T		Repair palate	0251	1.9352	110.27		22.05
42182	T		Repair palate	0256	36.9298	2104.37		420.87
42200	T		Reconstruct cleft palate	0256	36.9298	2104.37		420.87
42205	T		Reconstruct cleft palate	0256	36.9298	2104.37		420.87
42210	T		Reconstruct cleft palate	0256	36.9298	2104.37		420.87
42215	T		Reconstruct cleft palate	0256	36.9298	2104.37		420.87
42220	T		Reconstruct cleft palate	0256	36.9298	2104.37		420.87
42225	T		Reconstruct cleft palate	0256	36.9298	2104.37		420.87
42226	T		Lengthening of palate	0256	36.9298	2104.37		420.87
42227	T		Lengthening of palate	0256	36.9298	2104.37		420.87
42235	T		Repair palate	0253	15.9877	911.03	282.29	182.21
42260	T		Repair nose to lip fistula	0254	23.3442	1330.22	321.35	266.04
42280	T		Preparation, palate mold	0251	1.9352	110.27		22.05
42281	T		Insertion, palate prosthesis	0253	15.9877	911.03	282.29	182.21
42299	T		Palate/uvula surgery	0251	1.9352	110.27		22.05
42300	T		Drainage of salivary gland	0253	15.9877	911.03	282.29	182.21
42305	T		Drainage of salivary gland	0253	15.9877	911.03	282.29	182.21
42310	T		Drainage of salivary gland	0251	1.9352	110.27		22.05
42320	T		Drainage of salivary gland	0251	1.9352	110.27		22.05
42325	T		Create salivary cyst drain	0251	1.9352	110.27		22.05
42326	T		Create salivary cyst drain	0252	6.5183	371.43	113.41	74.29
42330	T		Removal of salivary stone	0253	15.9877	911.03	282.29	182.21
42335	T		Removal of salivary stone	0253	15.9877	911.03	282.29	182.21
42340	T		Removal of salivary stone	0253	15.9877	911.03	282.29	182.21
42400	T		Biopsy of salivary gland	0005	3.7391	213.07	71.59	42.61
42405	T		Biopsy of salivary gland	0253	15.9877	911.03	282.29	182.21
42408	T		Excision of salivary cyst	0253	15.9877	911.03	282.29	182.21
42409	T		Drainage of salivary cyst	0253	15.9877	911.03	282.29	182.21
42410	T		Excise parotid gland/lesion	0256	36.9298	2104.37		420.87
42415	T		Excise parotid gland/lesion	0256	36.9298	2104.37		420.87
42420	T		Excise parotid gland/lesion	0256	36.9298	2104.37		420.87
42425	T		Excise parotid gland/lesion	0256	36.9298	2104.37		420.87
42426	C		Excise parotid gland/lesion					
42440	T		Excise submaxillary gland	0256	36.9298	2104.37		420.87
42450	T		Excise sublingual gland	0254	23.3442	1330.22	321.35	266.04
42500	T		Repair salivary duct	0254	23.3442	1330.22	321.35	266.04

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
42505	T		Repair salivary duct	0256	36.9298	2104.37		420.87
42507	T		Parotid duct diversion	0256	36.9298	2104.37		420.87
42508	T		Parotid duct diversion	0256	36.9298	2104.37		420.87
42509	T		Parotid duct diversion	0256	36.9298	2104.37		420.87
42510	T		Parotid duct diversion	0256	36.9298	2104.37		420.87
42550	N		Injection for salivary x-ray					
42600	T		Closure of salivary fistula	0253	15.9877	911.03	282.29	182.21
42650	T		Dilation of salivary duct	0252	6.5183	371.43	113.41	74.29
42660	T		Dilation of salivary duct	0251	1.9352	110.27		22.05
42665	T		Ligation of salivary duct	0254	23.3442	1330.22	321.35	266.04
42699	T		Salivary surgery procedure	0251	1.9352	110.27		22.05
42700	T		Drainage of tonsil abscess	0251	1.9352	110.27		22.05
42720	T		Drainage of throat abscess	0253	15.9877	911.03	282.29	182.21
42725	T		Drainage of throat abscess	0256	36.9298	2104.37		420.87
42800	T		Biopsy of throat	0253	15.9877	911.03	282.29	182.21
42802	T		Biopsy of throat	0253	15.9877	911.03	282.29	182.21
42804	T		Biopsy of upper nose/throat	0253	15.9877	911.03	282.29	182.21
42806	T		Biopsy of upper nose/throat	0254	23.3442	1330.22	321.35	266.04
42808	T		Excise pharynx lesion	0253	15.9877	911.03	282.29	182.21
42809	X		Remove pharynx foreign body	0340	0.6328	36.06		7.21
42810	T		Excision of neck cyst	0254	23.3442	1330.22	321.35	266.04
42815	T		Excision of neck cyst	0256	36.9298	2104.37		420.87
42820	T		Remove tonsils and adenoids	0258	21.7774	1240.94	437.25	248.19
42821	T		Remove tonsils and adenoids	0258	21.7774	1240.94	437.25	248.19
42825	T		Removal of tonsils	0258	21.7774	1240.94	437.25	248.19
42826	T		Removal of tonsils	0258	21.7774	1240.94	437.25	248.19
42830	T		Removal of adenoids	0258	21.7774	1240.94	437.25	248.19
42831	T		Removal of adenoids	0258	21.7774	1240.94	437.25	248.19
42835	T		Removal of adenoids	0258	21.7774	1240.94	437.25	248.19
42836	T		Removal of adenoids	0258	21.7774	1240.94	437.25	248.19
42842	T		Extensive surgery of throat	0254	23.3442	1330.22	321.35	266.04
42844	T		Extensive surgery of throat	0256	36.9298	2104.37		420.87
42845	C		Extensive surgery of throat					
42860	T		Excision of tonsil tags	0258	21.7774	1240.94	437.25	248.19
42870	T		Excision of lingual tonsil	0258	21.7774	1240.94	437.25	248.19
42890	T		Partial removal of pharynx	0256	36.9298	2104.37		420.87
42892	T		Revision of pharyngeal walls	0256	36.9298	2104.37		420.87
42894	C		Revision of pharyngeal walls					
42900	T		Repair throat wound	0252	6.5183	371.43	113.41	74.29
42950	T		Reconstruction of throat	0254	23.3442	1330.22	321.35	266.04
42953	C		Repair throat, esophagus					
42955	T		Surgical opening of throat	0254	23.3442	1330.22	321.35	266.04
42960	T		Control throat bleeding	0250	1.3781	78.53	27.49	15.71

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
42961	C		Control throat bleeding		.	.	.	.
42962	T		Control throat bleeding	0256	36.9298	2104.37	.	420.87
42970	T		Control nose/throat bleeding	0250	1.3781	78.53	27.49	15.71
42971	C		Control nose/throat bleeding		.	.	.	.
42972	T		Control nose/throat bleeding	0253	15.9877	911.03	282.29	182.21
42999	T		Throat surgery procedure	0251	1.9352	110.27	.	22.05
43020	T		Incision of esophagus	0252	6.5183	371.43	113.41	74.29
43030	T		Throat muscle surgery	0253	15.9877	911.03	282.29	182.21
43045	C		Incision of esophagus		.	.	.	.
43100	C		Excision of esophagus lesion		.	.	.	.
43101	C		Excision of esophagus lesion		.	.	.	.
43107	C		Removal of esophagus		.	.	.	.
43108	C		Removal of esophagus		.	.	.	.
43112	C		Removal of esophagus		.	.	.	.
43113	C		Removal of esophagus		.	.	.	.
43116	C		Partial removal of esophagus		.	.	.	.
43117	C		Partial removal of esophagus		.	.	.	.
43118	C		Partial removal of esophagus		.	.	.	.
43121	C		Partial removal of esophagus		.	.	.	.
43122	C		Partial removal of esophagus		.	.	.	.
43123	C		Partial removal of esophagus		.	.	.	.
43124	C		Removal of esophagus		.	.	.	.
43130	T		Removal of esophagus pouch	0254	23.3442	1330.22	321.35	266.04
43135	C		Removal of esophagus pouch		.	.	.	.
43200	T		Esophagus endoscopy	0141	8.0725	460.00	143.38	92.00
43201	T		Esoph scope w/submucous inj	0141	8.0725	460.00	143.38	92.00
43202	T		Esophagus endoscopy, biopsy	0141	8.0725	460.00	143.38	92.00
43204	T		Esoph scope w/sclerosis inj	0141	8.0725	460.00	143.38	92.00
43205	T		Esophagus endoscopy/ligation	0141	8.0725	460.00	143.38	92.00
43215	T		Esophagus endoscopy	0141	8.0725	460.00	143.38	92.00
43216	T		Esophagus endoscopy/lesion	0141	8.0725	460.00	143.38	92.00
43217	T		Esophagus endoscopy	0141	8.0725	460.00	143.38	92.00
43219	T		Esophagus endoscopy	0384	27.0831	1543.28	335.19	308.66
43220	T		Esoph endoscopy, dilation	0141	8.0725	460.00	143.38	92.00
43226	T		Esoph endoscopy, dilation	0141	8.0725	460.00	143.38	92.00
43227	T		Esoph endoscopy, repair	0141	8.0725	460.00	143.38	92.00
43228	T		Esoph endoscopy, ablation	0422	22.1959	1264.79	425.00	252.96
43231	T		Esoph endoscopy w/us exam	0141	8.0725	460.00	143.38	92.00
43232	T		Esoph endoscopy w/us fn bx	0141	8.0725	460.00	143.38	92.00
43234	T		Upper GI endoscopy, exam	0141	8.0725	460.00	143.38	92.00
43235	T		Uppr gi endoscopy, diagnosis	0141	8.0725	460.00	143.38	92.00
43236	T		Uppr gi scope w/submuc inj	0141	8.0725	460.00	143.38	92.00
43237	T		Endoscopic us exam, esoph	0141	8.0725	460.00	143.38	92.00

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
43238	T		Uppr gi endoscopy w/us fn bx	0141	8.0725	460.00	143.38	92.00
43239	T		Upper GI endoscopy, biopsy	0141	8.0725	460.00	143.38	92.00
43240	T		Esoph endoscope w/drain cyst	0141	8.0725	460.00	143.38	92.00
43241	T		Upper GI endoscopy with tube	0141	8.0725	460.00	143.38	92.00
43242	T		Uppr gi endoscopy w/us fn bx	0141	8.0725	460.00	143.38	92.00
43243	T		Upper gi endoscopy & inject	0141	8.0725	460.00	143.38	92.00
43244	T		Upper GI endoscopy/ligation	0141	8.0725	460.00	143.38	92.00
43245	T		Uppr gi scope dilate strictr	0141	8.0725	460.00	143.38	92.00
43246	T		Place gastrostomy tube	0141	8.0725	460.00	143.38	92.00
43247	T		Operative upper GI endoscopy	0141	8.0725	460.00	143.38	92.00
43248	T		Uppr gi endoscopy/guide wire	0141	8.0725	460.00	143.38	92.00
43249	T		Esoph endoscopy, dilation	0141	8.0725	460.00	143.38	92.00
43250	T		Upper GI endoscopy/tumor	0141	8.0725	460.00	143.38	92.00
43251	T		Operative upper GI endoscopy	0141	8.0725	460.00	143.38	92.00
43255	T		Operative upper GI endoscopy	0141	8.0725	460.00	143.38	92.00
43256	T		Uppr gi endoscopy w/stent	0384	27.0831	1543.28	335.19	308.66
43257	T	NI	Uppr gi scope w/thrml txmnt	0422	22.1959	1264.79	425.00	252.96
43258	T		Operative upper GI endoscopy	0141	8.0725	460.00	143.38	92.00
43259	T		Endoscopic ultrasound exam	0141	8.0725	460.00	143.38	92.00
43260	T		Endo cholangiopancreatograph	0151	18.7294	1067.26	245.46	213.45
43261	T		Endo cholangiopancreatograph	0151	18.7294	1067.26	245.46	213.45
43262	T		Endo cholangiopancreatograph	0151	18.7294	1067.26	245.46	213.45
43263	T		Endo cholangiopancreatograph	0151	18.7294	1067.26	245.46	213.45
43264	T		Endo cholangiopancreatograph	0151	18.7294	1067.26	245.46	213.45
43265	T		Endo cholangiopancreatograph	0151	18.7294	1067.26	245.46	213.45
43267	T		Endo cholangiopancreatograph	0151	18.7294	1067.26	245.46	213.45
43268	T		Endo cholangiopancreatograph	0384	27.0831	1543.28	335.19	308.66
43269	T		Endo cholangiopancreatograph	0384	27.0831	1543.28	335.19	308.66
43271	T		Endo cholangiopancreatograph	0151	18.7294	1067.26	245.46	213.45
43272	T		Endo cholangiopancreatograph	0151	18.7294	1067.26	245.46	213.45
43280	T		Laparoscopy, fundoplasty	0132	61.3208	3494.24	1239.22	698.85
43289	T		Laparoscope proc, esoph	0130	31.6832	1805.40	659.53	361.08
43300	C		Repair of esophagus					
43305	C		Repair esophagus and fistula					
43310	C		Repair of esophagus					
43312	C		Repair esophagus and fistula					
43313	C		Esophagoplasty congenital					
43314	C		Tracheo-esophagoplasty cong					
43320	C		Fuse esophagus & stomach					
43324	C		Revise esophagus & stomach					
43325	C		Revise esophagus & stomach					
43326	C		Revise esophagus & stomach					
43330	C		Repair of esophagus					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
43331	C		Repair of esophagus		.	.	.	.
43340	C		Fuse esophagus & intestine		.	.	.	.
43341	C		Fuse esophagus & intestine		.	.	.	.
43350	C		Surgical opening, esophagus		.	.	.	.
43351	C		Surgical opening, esophagus		.	.	.	.
43352	C		Surgical opening, esophagus		.	.	.	.
43360	C		Gastrointestinal repair		.	.	.	.
43361	C		Gastrointestinal repair		.	.	.	.
43400	C		Ligate esophagus veins		.	.	.	.
43401	C		Esophagus surgery for veins		.	.	.	.
43405	C		Ligate/staple esophagus		.	.	.	.
43410	C		Repair esophagus wound		.	.	.	.
43415	C		Repair esophagus wound		.	.	.	.
43420	C		Repair esophagus opening		.	.	.	.
43425	C		Repair esophagus opening		.	.	.	.
43450	T		Dilate esophagus	0140	6.4907	369.86	107.24	73.97
43453	T		Dilate esophagus	0140	6.4907	369.86	107.24	73.97
43456	T		Dilate esophagus	0140	6.4907	369.86	107.24	73.97
43458	T		Dilate esophagus	0140	6.4907	369.86	107.24	73.97
43460	C		Pressure treatment esophagus		.	.	.	.
43496	C		Free jejunum flap, microvasc		.	.	.	.
43499	T		Esophagus surgery procedure	0141	8.0725	460.00	143.38	92.00
43500	C		Surgical opening of stomach		.	.	.	.
43501	C		Surgical repair of stomach		.	.	.	.
43502	C		Surgical repair of stomach		.	.	.	.
43510	T		Surgical opening of stomach	0141	8.0725	460.00	143.38	92.00
43520	C		Incision of pyloric muscle		.	.	.	.
43600	T		Biopsy of stomach	0141	8.0725	460.00	143.38	92.00
43605	C		Biopsy of stomach		.	.	.	.
43610	C		Excision of stomach lesion		.	.	.	.
43611	C		Excision of stomach lesion		.	.	.	.
43620	C		Removal of stomach		.	.	.	.
43621	C		Removal of stomach		.	.	.	.
43622	C		Removal of stomach		.	.	.	.
43631	C		Removal of stomach, partial		.	.	.	.
43632	C		Removal of stomach, partial		.	.	.	.
43633	C		Removal of stomach, partial		.	.	.	.
43634	C		Removal of stomach, partial		.	.	.	.
43635	C		Removal of stomach, partial		.	.	.	.
43638	C		Removal of stomach, partial		.	.	.	.
43639	C		Removal of stomach, partial		.	.	.	.
43640	C		Vagotomy & pylorus repair		.	.	.	.
43641	C		Vagotomy & pylorus repair		.	.	.	.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
43644	C	NI	Lap gastric bypass/roux-en-y		.	.	.	.
43645	C	NI	Lap gastr bypass incl smll i		.	.	.	.
43651	T		Laparoscopy, vagus nerve	0132	61.3208	3494.24	1239.22	698.85
43652	T		Laparoscopy, vagus nerve	0132	61.3208	3494.24	1239.22	698.85
43653	T		Laparoscopy, gastrostomy	0131	42.7526	2436.17	1001.89	487.23
43659	T		Laparoscope proc, stom	0130	31.6832	1805.40	659.53	361.08
43750	T		Place gastrostomy tube	0141	8.0725	460.00	143.38	92.00
43752	X		Nasal/orogastric w/stent	0272	1.3880	79.09	35.59	15.82
43760	T		Change gastrostomy tube	0121	2.2909	130.54	43.80	26.11
43761	T		Reposition gastrostomy tube	0121	2.2909	130.54	43.80	26.11
43800	C		Reconstruction of pylorus		.	.	.	.
43810	C		Fusion of stomach and bowel		.	.	.	.
43820	C		Fusion of stomach and bowel		.	.	.	.
43825	C		Fusion of stomach and bowel		.	.	.	.
43830	T		Place gastrostomy tube	0422	22.1959	1264.79	425.00	252.96
43831	T		Place gastrostomy tube	0141	8.0725	460.00	143.38	92.00
43832	C		Place gastrostomy tube		.	.	.	.
43840	C		Repair of stomach lesion		.	.	.	.
43842	C		V-band gastroplasty		.	.	.	.
43843	C		Gastroplasty w/o v-band		.	.	.	.
43845	C	NI	Gastroplasty duodenal switch		.	.	.	.
43846	C		Gastric bypass for obesity		.	.	.	.
43847	C		Gastric bypass incl small i		.	.	.	.
43848	C		Revision gastroplasty		.	.	.	.
43850	C		Revise stomach-bowel fusion		.	.	.	.
43855	C		Revise stomach-bowel fusion		.	.	.	.
43860	C		Revise stomach-bowel fusion		.	.	.	.
43865	C		Revise stomach-bowel fusion		.	.	.	.
43870	T		Repair stomach opening	0141	8.0725	460.00	143.38	92.00
43880	C		Repair stomach-bowel fistula		.	.	.	.
43999	T		Stomach surgery procedure	0141	8.0725	460.00	143.38	92.00
44005	C		Freeing of bowel adhesion		.	.	.	.
44010	C		Incision of small bowel		.	.	.	.
44015	C		Insert needle cath bowel		.	.	.	.
44020	C		Explore small intestine		.	.	.	.
44021	C		Decompress small bowel		.	.	.	.
44025	C		Incision of large bowel		.	.	.	.
44050	C		Reduce bowel obstruction		.	.	.	.
44055	C		Correct malrotation of bowel		.	.	.	.
44100	T		Biopsy of bowel	0141	8.0725	460.00	143.38	92.00
44110	C		Excise intestine lesion(s)		.	.	.	.
44111	C		Excision of bowel lesion(s)		.	.	.	.
44120	C		Removal of small intestine		.	.	.	.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
44121	C		Removal of small intestine		.	.	.	.
44125	C		Removal of small intestine		.	.	.	.
44126	C		Enterectomy w/o taper, cong		.	.	.	.
44127	C		Enterectomy w/taper, cong		.	.	.	.
44128	C		Enterectomy cong, add-on		.	.	.	.
44130	C		Bowel to bowel fusion		.	.	.	.
44132	C		Enterectomy, cadaver donor		.	.	.	.
44133	C		Enterectomy, live donor		.	.	.	.
44135	C		Intestine transplnt, cadaver		.	.	.	.
44136	C		Intestine transplant, live		.	.	.	.
44137	C	NI	Remove intestinal allograft		.	.	.	.
44139	C		Mobilization of colon		.	.	.	.
44140	C		Partial removal of colon		.	.	.	.
44141	C		Partial removal of colon		.	.	.	.
44143	C		Partial removal of colon		.	.	.	.
44144	C		Partial removal of colon		.	.	.	.
44145	C		Partial removal of colon		.	.	.	.
44146	C		Partial removal of colon		.	.	.	.
44147	C		Partial removal of colon		.	.	.	.
44150	C		Removal of colon		.	.	.	.
44151	C		Removal of colon/ileostomy		.	.	.	.
44152	C		Removal of colon/ileostomy		.	.	.	.
44153	C		Removal of colon/ileostomy		.	.	.	.
44155	C		Removal of colon/ileostomy		.	.	.	.
44156	C		Removal of colon/ileostomy		.	.	.	.
44160	C		Removal of colon		.	.	.	.
44200	T		Laparoscopy, enterolysis	0131	42.7526	2436.17	1001.89	487.23
44201	T		Laparoscopy, jejunostomy	0131	42.7526	2436.17	1001.89	487.23
44202	C		Lap resect s/intestine singl		.	.	.	.
44203	C		Lap resect s/intestine, addl		.	.	.	.
44204	C		Laparo partial colectomy		.	.	.	.
44205	C		Lap colectomy part w/ileum		.	.	.	.
44206	T		Lap part colectomy w/stoma	0132	61.3208	3494.24	1239.22	698.85
44207	T		L colectomy/coloproctostomy	0132	61.3208	3494.24	1239.22	698.85
44208	T		L colectomy/coloproctostomy	0132	61.3208	3494.24	1239.22	698.85
44210	C		Laparo total proctocolectomy		.	.	.	.
44211	C		Laparo total proctocolectomy		.	.	.	.
44212	C		Laparo total proctocolectomy		.	.	.	.
44238	T		Laparoscope proc, intestine	0130	31.6832	1805.40	659.53	361.08
44239	T		Laparoscope proc, rectum	0130	31.6832	1805.40	659.53	361.08
44300	C		Open bowel to skin		.	.	.	.
44310	C		Ileostomy/jejunostomy		.	.	.	.
44312	T		Revision of ileostomy	0027	16.8355	959.34	329.72	191.87

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
44314	C		Revision of ileostomy		.	.	.	.
44316	C		Devise bowel pouch		.	.	.	.
44320	C		Colostomy		.	.	.	.
44322	C		Colostomy with biopsies		.	.	.	.
44340	T		Revision of colostomy	0027	16.8355	959.34	329.72	191.87
44345	C		Revision of colostomy		.	.	.	.
44346	C		Revision of colostomy		.	.	.	.
44360	T		Small bowel endoscopy	0142	8.7069	496.15	152.78	99.23
44361	T		Small bowel endoscopy/biopsy	0142	8.7069	496.15	152.78	99.23
44363	T		Small bowel endoscopy	0142	8.7069	496.15	152.78	99.23
44364	T		Small bowel endoscopy	0142	8.7069	496.15	152.78	99.23
44365	T		Small bowel endoscopy	0142	8.7069	496.15	152.78	99.23
44366	T		Small bowel endoscopy	0142	8.7069	496.15	152.78	99.23
44369	T		Small bowel endoscopy	0142	8.7069	496.15	152.78	99.23
44370	T		Small bowel endoscopy/stent	0384	27.0831	1543.28	335.19	308.66
44372	T		Small bowel endoscopy	0142	8.7069	496.15	152.78	99.23
44373	T		Small bowel endoscopy	0142	8.7069	496.15	152.78	99.23
44376	T		Small bowel endoscopy	0142	8.7069	496.15	152.78	99.23
44377	T		Small bowel endoscopy/biopsy	0142	8.7069	496.15	152.78	99.23
44378	T		Small bowel endoscopy	0142	8.7069	496.15	152.78	99.23
44379	T		S bowel endoscope w/stent	0384	27.0831	1543.28	335.19	308.66
44380	T		Small bowel endoscopy	0142	8.7069	496.15	152.78	99.23
44382	T		Small bowel endoscopy	0142	8.7069	496.15	152.78	99.23
44383	T		Ileoscopy w/stent	0384	27.0831	1543.28	335.19	308.66
44385	T		Endoscopy of bowel pouch	0143	8.5992	490.01	186.06	98.00
44386	T		Endoscopy, bowel pouch/biop	0143	8.5992	490.01	186.06	98.00
44388	T		Colonoscopy	0143	8.5992	490.01	186.06	98.00
44389	T		Colonoscopy with biopsy	0143	8.5992	490.01	186.06	98.00
44390	T		Colonoscopy for foreign body	0143	8.5992	490.01	186.06	98.00
44391	T		Colonoscopy for bleeding	0143	8.5992	490.01	186.06	98.00
44392	T		Colonoscopy & polypectomy	0143	8.5992	490.01	186.06	98.00
44393	T		Colonoscopy, lesion removal	0143	8.5992	490.01	186.06	98.00
44394	T		Colonoscopy w/snare	0143	8.5992	490.01	186.06	98.00
44397	T		Colonoscopy w/stent	0384	27.0831	1543.28	335.19	308.66
44500	T		Intro, gastrointestinal tube	0121	2.2909	130.54	43.80	26.11
44602	C		Suture, small intestine		.	.	.	.
44603	C		Suture, small intestine		.	.	.	.
44604	C		Suture, large intestine		.	.	.	.
44605	C		Repair of bowel lesion		.	.	.	.
44615	C		Intestinal stricturoplasty		.	.	.	.
44620	C		Repair bowel opening		.	.	.	.
44625	C		Repair bowel opening		.	.	.	.
44626	C		Repair bowel opening		.	.	.	.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
44640	C		Repair bowel-skin fistula					
44650	C		Repair bowel fistula					
44660	C		Repair bowel-bladder fistula					
44661	C		Repair bowel-bladder fistula					
44680	C		Surgical revision, intestine					
44700	C		Suspend bowel w/prosthesis					
44701	N		Intraop colon lavage add-on					
44715	C	NI	Prepare donor intestine					
44720	C	NI	Prep donor intestine/venous					
44721	C	NI	Prep donor intestine/artery					
44799	T		Unlisted procedure intestine	0142	8.7069	496.15	152.78	99.23
44800	C		Excision of bowel pouch					
44820	C		Excision of mesentery lesion					
44850	C		Repair of mesentery					
44899	C		Bowel surgery procedure					
44900	C		Drain app abscess, open					
44901	T		Drain app abscess, percut	0037	9.3421	532.34	234.20	106.47
44950	C		Appendectomy					
44955	C		Appendectomy add-on					
44960	C		Appendectomy					
44970	T		Laparoscopy, appendectomy	0131	42.7526	2436.17	1001.89	487.23
44979	T		Laparoscope proc, app	0130	31.6832	1805.40	659.53	361.08
45000	T		Drainage of pelvic abscess	0148	4.3129	245.76	63.38	49.15
45005	T		Drainage of rectal abscess	0155	13.1091	747.00	188.89	149.40
45020	T		Drainage of rectal abscess	0155	13.1091	747.00	188.89	149.40
45100	T		Biopsy of rectum	0149	17.7572	1011.86	293.06	202.37
45108	T		Removal of anorectal lesion	0150	23.1856	1321.19	437.12	264.24
45110	C		Removal of rectum					
45111	C		Partial removal of rectum					
45112	C		Removal of rectum					
45113	C		Partial proctectomy					
45114	C		Partial removal of rectum					
45116	C		Partial removal of rectum					
45119	C		Remove rectum w/reservoir					
45120	C		Removal of rectum					
45121	C		Removal of rectum and colon					
45123	C		Partial proctectomy					
45126	C		Pelvic exenteration					
45130	C		Excision of rectal prolapse					
45135	C		Excision of rectal prolapse					
45136	C		Excise ileoanal reservior					
45150	T		Excision of rectal stricture	0149	17.7572	1011.86	293.06	202.37
45160	T		Excision of rectal lesion	0150	23.1856	1321.19	437.12	264.24

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
45170	T		Excision of rectal lesion	0150	23.1856	1321.19	437.12	264.24
45190	T		Destruction, rectal tumor	0150	23.1856	1321.19	437.12	264.24
45300	T		Proctosigmoidoscopy dx	0146	4.3484	247.78	64.40	49.56
45303	T		Proctosigmoidoscopy dilate	0146	4.3484	247.78	64.40	49.56
45305	T		Proctosigmoidoscopy w/bx	0146	4.3484	247.78	64.40	49.56
45307	T		Proctosigmoidoscopy fb	0146	4.3484	247.78	64.40	49.56
45308	T		Proctosigmoidoscopy removal	0147	8.0251	457.29		91.46
45309	T		Proctosigmoidoscopy removal	0147	8.0251	457.29		91.46
45315	T		Proctosigmoidoscopy removal	0147	8.0251	457.29		91.46
45317	T		Proctosigmoidoscopy bleed	0147	8.0251	457.29		91.46
45320	T		Proctosigmoidoscopy ablate	0147	8.0251	457.29		91.46
45321	T		Proctosigmoidoscopy volvul	0147	8.0251	457.29		91.46
45327	T		Proctosigmoidoscopy w/stent	0384	27.0831	1543.28	335.19	308.66
45330	T		Diagnostic sigmoidoscopy	0146	4.3484	247.78	64.40	49.56
45331	T		Sigmoidoscopy and biopsy	0146	4.3484	247.78	64.40	49.56
45332	T		Sigmoidoscopy w/fb removal	0146	4.3484	247.78	64.40	49.56
45333	T		Sigmoidoscopy & polypectomy	0147	8.0251	457.29		91.46
45334	T		Sigmoidoscopy for bleeding	0147	8.0251	457.29		91.46
45335	T		Sigmoidoscopy w/submuc inj	0147	8.0251	457.29		91.46
45337	T		Sigmoidoscopy & decompress	0147	8.0251	457.29		91.46
45338	T		Sigmoidoscopy w/tumr remove	0147	8.0251	457.29		91.46
45339	T		Sigmoidoscopy w/ablate tumr	0147	8.0251	457.29		91.46
45340	T		Sig w/balloon dilation	0147	8.0251	457.29		91.46
45341	T		Sigmoidoscopy w/ultrasound	0147	8.0251	457.29		91.46
45342	T		Sigmoidoscopy w/us guide bx	0147	8.0251	457.29		91.46
45345	T		Sigmoidoscopy w/stent	0384	27.0831	1543.28	335.19	308.66
45355	T		Surgical colonoscopy	0143	8.5992	490.01	186.06	98.00
45378	T		Diagnostic colonoscopy	0143	8.5992	490.01	186.06	98.00
45379	T		Colonoscopy w/fb removal	0143	8.5992	490.01	186.06	98.00
45380	T		Colonoscopy and biopsy	0143	8.5992	490.01	186.06	98.00
45381	T		Colonoscopy, submucous inj	0143	8.5992	490.01	186.06	98.00
45382	T		Colonoscopy/control bleeding	0143	8.5992	490.01	186.06	98.00
45383	T		Lesion removal colonoscopy	0143	8.5992	490.01	186.06	98.00
45384	T		Lesion remove colonoscopy	0143	8.5992	490.01	186.06	98.00
45385	T		Lesion removal colonoscopy	0143	8.5992	490.01	186.06	98.00
45386	T		Colonoscopy dilate stricture	0143	8.5992	490.01	186.06	98.00
45387	T		Colonoscopy w/stent	0384	27.0831	1543.28	335.19	308.66
45391	T	NI	Colonoscopy w/endoscope us	0143	8.5992	490.01	186.06	98.00
45392	T	NI	Colonoscopy w/endoscopic fnb	0143	8.5992	490.01	186.06	98.00
45500	T		Repair of rectum	0149	17.7572	1011.86	293.06	202.37
45505	T		Repair of rectum	0150	23.1856	1321.19	437.12	264.24
45520	T		Treatment of rectal prolapse	0098	1.3424	76.49		15.30
45540	C		Correct rectal prolapse					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
45541	T		Correct rectal prolapse	0150	23.1856	1321.19	437.12	264.24
45550	C		Repair rectum/remove sigmoid		.	.	.	.
45560	T		Repair of rectocele	0150	23.1856	1321.19	437.12	264.24
45562	C		Exploration/repair of rectum		.	.	.	.
45563	C		Exploration/repair of rectum		.	.	.	.
45800	C		Repair rect/bladder fistula		.	.	.	.
45805	C		Repair fistula w/colostomy		.	.	.	.
45820	C		Repair rectourethral fistula		.	.	.	.
45825	C		Repair fistula w/colostomy		.	.	.	.
45900	T		Reduction of rectal prolapse	0148	4.3129	245.76	63.38	49.15
45905	T		Dilation of anal sphincter	0149	17.7572	1011.86	293.06	202.37
45910	T		Dilation of rectal narrowing	0149	17.7572	1011.86	293.06	202.37
45915	T		Remove rectal obstruction	0148	4.3129	245.76	63.38	49.15
45999	T		Rectum surgery procedure	0148	4.3129	245.76	63.38	49.15
46020	T		Placement of seton	0150	23.1856	1321.19	437.12	264.24
46030	T		Removal of rectal marker	0148	4.3129	245.76	63.38	49.15
46040	T		Incision of rectal abscess	0149	17.7572	1011.86	293.06	202.37
46045	T		Incision of rectal abscess	0150	23.1856	1321.19	437.12	264.24
46050	T		Incision of anal abscess	0148	4.3129	245.76	63.38	49.15
46060	T		Incision of rectal abscess	0150	23.1856	1321.19	437.12	264.24
46070	T		Incision of anal septum	0155	13.1091	747.00	188.89	149.40
46080	T		Incision of anal sphincter	0149	17.7572	1011.86	293.06	202.37
46083	T		Incise external hemorrhoid	0148	4.3129	245.76	63.38	49.15
46200	T		Removal of anal fissure	0150	23.1856	1321.19	437.12	264.24
46210	T		Removal of anal crypt	0149	17.7572	1011.86	293.06	202.37
46211	T		Removal of anal crypts	0150	23.1856	1321.19	437.12	264.24
46220	T		Removal of anal tag	0149	17.7572	1011.86	293.06	202.37
46221	T		Ligation of hemorrhoid(s)	0148	4.3129	245.76	63.38	49.15
46230	T		Removal of anal tags	0149	17.7572	1011.86	293.06	202.37
46250	T		Hemorrhoidectomy	0150	23.1856	1321.19	437.12	264.24
46255	T		Hemorrhoidectomy	0150	23.1856	1321.19	437.12	264.24
46257	T		Remove hemorrhoids & fissure	0150	23.1856	1321.19	437.12	264.24
46258	T		Remove hemorrhoids & fistula	0150	23.1856	1321.19	437.12	264.24
46260	T		Hemorrhoidectomy	0150	23.1856	1321.19	437.12	264.24
46261	T		Remove hemorrhoids & fissure	0150	23.1856	1321.19	437.12	264.24
46262	T		Remove hemorrhoids & fistula	0150	23.1856	1321.19	437.12	264.24
46270	T		Removal of anal fistula	0150	23.1856	1321.19	437.12	264.24
46275	T		Removal of anal fistula	0150	23.1856	1321.19	437.12	264.24
46280	T		Removal of anal fistula	0150	23.1856	1321.19	437.12	264.24
46285	T		Removal of anal fistula	0150	23.1856	1321.19	437.12	264.24
46288	T		Repair anal fistula	0150	23.1856	1321.19	437.12	264.24
46320	T		Removal of hemorrhoid clot	0148	4.3129	245.76	63.38	49.15
46500	T		Injection into hemorrhoid(s)	0155	13.1091	747.00	188.89	149.40

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
46600	X		Diagnostic anoscopy	0340	0.6328	36.06		7.21
46604	T		Anoscopy and dilation	0147	8.0251	457.29		91.46
46606	T		Anoscopy and biopsy	0147	8.0251	457.29		91.46
46608	T		Anoscopy, remove for body	0147	8.0251	457.29		91.46
46610	T		Anoscopy, remove lesion	0147	8.0251	457.29		91.46
46611	T		Anoscopy	0147	8.0251	457.29		91.46
46612	T		Anoscopy, remove lesions	0147	8.0251	457.29		91.46
46614	T		Anoscopy, control bleeding	0147	8.0251	457.29		91.46
46615	T		Anoscopy	0147	8.0251	457.29		91.46
46700	T		Repair of anal stricture	0150	23.1856	1321.19	437.12	264.24
46705	C		Repair of anal stricture					
46706	T		Repr of anal fistula w/glue	0150	23.1856	1321.19	437.12	264.24
46715	C		Rep perf anoper fistu					
46716	C		Rep perf anoper/vestib fistu					
46730	C		Construction of absent anus					
46735	C		Construction of absent anus					
46740	C		Construction of absent anus					
46742	C		Repair of imperforated anus					
46744	C		Repair of cloacal anomaly					
46746	C		Repair of cloacal anomaly					
46748	C		Repair of cloacal anomaly					
46750	T		Repair of anal sphincter	0150	23.1856	1321.19	437.12	264.24
46751	C		Repair of anal sphincter					
46753	T		Reconstruction of anus	0150	23.1856	1321.19	437.12	264.24
46754	T		Removal of suture from anus	0149	17.7572	1011.86	293.06	202.37
46760	T		Repair of anal sphincter	0150	23.1856	1321.19	437.12	264.24
46761	T		Repair of anal sphincter	0150	23.1856	1321.19	437.12	264.24
46762	T		Implant artificial sphincter	0150	23.1856	1321.19	437.12	264.24
46900	T		Destruction, anal lesion(s)	0016	2.8321	161.38	57.31	32.28
46910	T		Destruction, anal lesion(s)	0017	17.3894	990.90	227.84	198.18
46916	T		Cryosurgery, anal lesion(s)	0013	1.1380	64.85	14.20	12.97
46917	T		Laser surgery, anal lesions	0695	20.5193	1169.25	266.59	233.85
46922	T		Excision of anal lesion(s)	0695	20.5193	1169.25	266.59	233.85
46924	T		Destruction, anal lesion(s)	0695	20.5193	1169.25	266.59	233.85
46934	T		Destruction of hemorrhoids	0155	13.1091	747.00	188.89	149.40
46935	T		Destruction of hemorrhoids	0155	13.1091	747.00	188.89	149.40
46936	T		Destruction of hemorrhoids	0149	17.7572	1011.86	293.06	202.37
46937	T		Cryotherapy of rectal lesion	0149	17.7572	1011.86	293.06	202.37
46938	T		Cryotherapy of rectal lesion	0150	23.1856	1321.19	437.12	264.24
46940	T		Treatment of anal fissure	0149	17.7572	1011.86	293.06	202.37
46942	T		Treatment of anal fissure	0148	4.3129	245.76	63.38	49.15
46945	T		Ligation of hemorrhoids	0155	13.1091	747.00	188.89	149.40
46946	T		Ligation of hemorrhoids	0155	13.1091	747.00	188.89	149.40

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
46947	T	NI	Hemorrhoidopexy by stapling	0150	23.1856	1321.19	437.12	264.24
46999	T		Anus surgery procedure	0148	4.3129	245.76	63.38	49.15
47000	T		Needle biopsy of liver	0685	5.8806	335.09	115.47	67.02
47001	N		Needle biopsy, liver add-on					
47010	C		Open drainage, liver lesion					
47011	T		Percut drain, liver lesion	0037	9.3421	532.34	234.20	106.47
47015	C		Inject/aspirate liver cyst					
47100	C		Wedge biopsy of liver					
47120	C		Partial removal of liver					
47122	C		Extensive removal of liver					
47125	C		Partial removal of liver					
47130	C		Partial removal of liver					
47133	C		Removal of donor liver					
47135	C		Transplantation of liver					
47136	C		Transplantation of liver					
47140	C		Partial removal, donor liver					
47141	C		Partial removal, donor liver					
47142	C		Partial removal, donor liver					
47143	C	NI	Prep donor liver, whole					
47144	C	NI	Prep donor liver, 3-segment					
47145	C	NI	Prep donor liver, lobe split					
47146	C	NI	Prep donor liver/venous					
47147	C	NI	Prep donor liver/arterial					
47300	C		Surgery for liver lesion					
47350	C		Repair liver wound					
47360	C		Repair liver wound					
47361	C		Repair liver wound					
47362	C		Repair liver wound					
47370	T		Laparo ablate liver tumor rf	0131	42.7526	2436.17	1001.89	487.23
47371	T		Laparo ablate liver cryosurg	0131	42.7526	2436.17	1001.89	487.23
47379	T		Laparoscope procedure, liver	0130	31.6832	1805.40	659.53	361.08
47380	C		Open ablate liver tumor rf					
47381	C		Open ablate liver tumor cryo					
47382	T		Percut ablate liver rf	0423	30.7704	1753.39		350.68
47399	T		Liver surgery procedure	0002	0.9553	54.44		10.89
47400	C		Incision of liver duct					
47420	C		Incision of bile duct					
47425	C		Incision of bile duct					
47460	C		Incise bile duct sphincter					
47480	C		Incision of gallbladder					
47490	T		Incision of gallbladder	0152	12.4585	709.92		141.98
47500	N		Injection for liver x-rays					
47505	N		Injection for liver x-rays					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
47510	T		Insert catheter, bile duct	0152	12.4585	709.92		141.98
47511	T		Insert bile duct drain	0152	12.4585	709.92		141.98
47525	T		Change bile duct catheter	0122	8.2869	472.21	96.84	94.44
47530	T		Revise/reinsert bile tube	0122	8.2869	472.21	96.84	94.44
47550	C		Bile duct endoscopy add-on					
47552	T		Biliary endoscopy thru skin	0152	12.4585	709.92		141.98
47553	T		Biliary endoscopy thru skin	0152	12.4585	709.92		141.98
47554	T		Biliary endoscopy thru skin	0152	12.4585	709.92		141.98
47555	T		Biliary endoscopy thru skin	0152	12.4585	709.92		141.98
47556	T		Biliary endoscopy thru skin	0152	12.4585	709.92		141.98
47560	T		Laparoscopy w/cholangio	0130	31.6832	1805.40	659.53	361.08
47561	T		Laparo w/cholangio/biopsy	0130	31.6832	1805.40	659.53	361.08
47562	T		Laparoscopic cholecystectomy	0131	42.7526	2436.17	1001.89	487.23
47563	T		Laparo cholecystectomy/graph	0131	42.7526	2436.17	1001.89	487.23
47564	T		Laparo cholecystectomy/explr	0131	42.7526	2436.17	1001.89	487.23
47570	C		Laparo cholecystoenterostomy					
47579	T		Laparoscope proc, biliary	0130	31.6832	1805.40	659.53	361.08
47600	C		Removal of gallbladder					
47605	C		Removal of gallbladder					
47610	C		Removal of gallbladder					
47612	C		Removal of gallbladder					
47620	C		Removal of gallbladder					
47630	T		Remove bile duct stone	0152	12.4585	709.92		141.98
47700	C		Exploration of bile ducts					
47701	C		Bile duct revision					
47711	C		Excision of bile duct tumor					
47712	C		Excision of bile duct tumor					
47715	C		Excision of bile duct cyst					
47716	C		Fusion of bile duct cyst					
47720	C		Fuse gallbladder & bowel					
47721	C		Fuse upper gi structures					
47740	C		Fuse gallbladder & bowel					
47741	C		Fuse gallbladder & bowel					
47760	C		Fuse bile ducts and bowel					
47765	C		Fuse liver ducts & bowel					
47780	C		Fuse bile ducts and bowel					
47785	C		Fuse bile ducts and bowel					
47800	C		Reconstruction of bile ducts					
47801	C		Placement, bile duct support					
47802	C		Fuse liver duct & intestine					
47900	C		Suture bile duct injury					
47999	T		Bile tract surgery procedure	0152	12.4585	709.92		141.98
48000	C		Drainage of abdomen					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
48001	C		Placement of drain, pancreas					
48005	C		Resect/debride pancreas					
48020	C		Removal of pancreatic stone					
48100	C		Biopsy of pancreas, open					
48102	T		Needle biopsy, pancreas	0685	5.8806	335.09	115.47	67.02
48120	C		Removal of pancreas lesion					
48140	C		Partial removal of pancreas					
48145	C		Partial removal of pancreas					
48146	C		Pancreatectomy					
48148	C		Removal of pancreatic duct					
48150	C		Partial removal of pancreas					
48152	C		Pancreatectomy					
48153	C		Pancreatectomy					
48154	C		Pancreatectomy					
48155	C		Removal of pancreas					
48160	E		Pancreas removal/transplant					
48180	C		Fuse pancreas and bowel					
48400	C		Injection, intraop add-on					
48500	C		Surgery of pancreatic cyst					
48510	C		Drain pancreatic pseudocyst					
48511	T		Drain pancreatic pseudocyst	0037	9.3421	532.34	234.20	106.47
48520	C		Fuse pancreas cyst and bowel					
48540	C		Fuse pancreas cyst and bowel					
48545	C		Pancreatorrhaphy					
48547	C		Duodenal exclusion					
48550	E		Donor pancreatectomy					
48551	C	NI	Prep donor pancreas					
48552	C	NI	Prep donor pancreas/venous					
48554	E		Transpl allograft pancreas					
48556	C		Removal, allograft pancreas					
48999	T		Pancreas surgery procedure	0004	1.7081	97.33	22.36	19.47
49000	C		Exploration of abdomen					
49002	C		Reopening of abdomen					
49010	C		Exploration behind abdomen					
49020	C		Drain abdominal abscess					
49021	T		Drain abdominal abscess	0037	9.3421	532.34	234.20	106.47
49040	C		Drain, open, abdom abscess					
49041	T		Drain, percut, abdom abscess	0037	9.3421	532.34	234.20	106.47
49060	C		Drain, open, retrop abscess					
49061	T		Drain, percut, retroper absc	0037	9.3421	532.34	234.20	106.47
49062	C		Drain to peritoneal cavity					
49080	T		Puncture, peritoneal cavity	0070	3.3166	188.99		37.80
49081	T		Removal of abdominal fluid	0070	3.3166	188.99		37.80

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
49085	T		Remove abdomen foreign body	0153	24.2544	1382.09	410.87	276.42
49180	T		Biopsy, abdominal mass	0685	5.8806	335.09	115.47	67.02
49200	T		Removal of abdominal lesion	0130	31.6832	1805.40	659.53	361.08
49201	C		Remove abdom lesion, complex					
49215	C		Excise sacral spine tumor					
49220	C		Multiple surgery, abdomen					
49250	T		Excision of umbilicus	0153	24.2544	1382.09	410.87	276.42
49255	C		Removal of omentum					
49320	T		Diag laparo separate proc	0130	31.6832	1805.40	659.53	361.08
49321	T		Laparoscopy, biopsy	0130	31.6832	1805.40	659.53	361.08
49322	T		Laparoscopy, aspiration	0130	31.6832	1805.40	659.53	361.08
49323	T		Laparo drain lymphocele	0130	31.6832	1805.40	659.53	361.08
49329	T		Laparo proc, abdm/per/oment	0130	31.6832	1805.40	659.53	361.08
49400	N		Air injection into abdomen					
49419	T		Insrt abdom cath for chemotx	0115	25.6621	1462.30	459.35	292.46
49420	T		Insert abdom drain, temp	0652	27.7725	1582.56		316.51
49421	T		Insert abdom drain, perm	0652	27.7725	1582.56		316.51
49422	T		Remove perm cannula/catheter	0105	21.5449	1227.69	370.40	245.54
49423	T		Exchange drainage catheter	0152	12.4585	709.92		141.98
49424	N		Assess cyst, contrast inject					
49425	C		Insert abdomen-venous drain					
49426	T		Revise abdomen-venous shunt	0153	24.2544	1382.09	410.87	276.42
49427	N		Injection, abdominal shunt					
49428	C		Ligation of shunt					
49429	T		Removal of shunt	0105	21.5449	1227.69	370.40	245.54
49491	T		Rpr hern preemie reduc	0154	28.0759	1599.85	464.85	319.97
49492	T		Rpr ing hern premie, blocked	0154	28.0759	1599.85	464.85	319.97
49495	T		Rpr ing hernia baby, reduc	0154	28.0759	1599.85	464.85	319.97
49496	T		Rpr ing hernia baby, blocked	0154	28.0759	1599.85	464.85	319.97
49500	T		Rpr ing hernia, init, reduce	0154	28.0759	1599.85	464.85	319.97
49501	T		Rpr ing hernia, init blocked	0154	28.0759	1599.85	464.85	319.97
49505	T		Prp i/hern init reduc >5 yr	0154	28.0759	1599.85	464.85	319.97
49507	T		Prp i/hern init block >5 yr	0154	28.0759	1599.85	464.85	319.97
49520	T		Rerepair ing hernia, reduce	0154	28.0759	1599.85	464.85	319.97
49521	T		Rerepair ing hernia, blocked	0154	28.0759	1599.85	464.85	319.97
49525	T		Repair ing hernia, sliding	0154	28.0759	1599.85	464.85	319.97
49540	T		Repair lumbar hernia	0154	28.0759	1599.85	464.85	319.97
49550	T		Rpr rem hernia, init, reduce	0154	28.0759	1599.85	464.85	319.97
49553	T		Rpr fem hernia, init blocked	0154	28.0759	1599.85	464.85	319.97
49555	T		Rerepair fem hernia, reduce	0154	28.0759	1599.85	464.85	319.97
49557	T		Rerepair fem hernia, blocked	0154	28.0759	1599.85	464.85	319.97
49560	T		Rpr ventral hern init, reduc	0154	28.0759	1599.85	464.85	319.97
49561	T		Rpr ventral hern init, block	0154	28.0759	1599.85	464.85	319.97

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
49565	T		Rerepair ventrl hern, reduce	0154	28.0759	1599.85	464.85	319.97
49566	T		Rerepair ventrl hern, block	0154	28.0759	1599.85	464.85	319.97
49568	T		Hernia repair w/mesh	0154	28.0759	1599.85	464.85	319.97
49570	T		Rpr epigastric hern, reduce	0154	28.0759	1599.85	464.85	319.97
49572	T		Rpr epigastric hern, blocked	0154	28.0759	1599.85	464.85	319.97
49580	T		Rpr umbil hern, reduc < 5 yr	0154	28.0759	1599.85	464.85	319.97
49582	T		Rpr umbil hern, block < 5 yr	0154	28.0759	1599.85	464.85	319.97
49585	T		Rpr umbil hern, reduc > 5 yr	0154	28.0759	1599.85	464.85	319.97
49587	T		Rpr umbil hern, block > 5 yr	0154	28.0759	1599.85	464.85	319.97
49590	T		Repair spigelian hernia	0154	28.0759	1599.85	464.85	319.97
49600	T		Repair umbilical lesion	0154	28.0759	1599.85	464.85	319.97
49605	C		Repair umbilical lesion					
49606	C		Repair umbilical lesion					
49610	C		Repair umbilical lesion					
49611	C		Repair umbilical lesion					
49650	T		Laparo hernia repair initial	0131	42.7526	2436.17	1001.89	487.23
49651	T		Laparo hernia repair recur	0131	42.7526	2436.17	1001.89	487.23
49659	T		Laparo proc, hernia repair	0130	31.6832	1805.40	659.53	361.08
49900	C		Repair of abdominal wall					
49904	C		Omental flap, extra-abdom					
49905	C		Omental flap, intra-abdom					
49906	C		Free omental flap, microvasc					
49999	T		Abdomen surgery procedure	0153	24.2544	1382.09	410.87	276.42
50010	C		Exploration of kidney					
50020	T		Renal abscess, open drain	0162	23.0182	1311.65		262.33
50021	T		Renal abscess, percut drain	0037	9.3421	532.34	234.20	106.47
50040	C		Drainage of kidney					
50045	C		Exploration of kidney					
50060	C		Removal of kidney stone					
50065	C		Incision of kidney					
50070	C		Incision of kidney					
50075	C		Removal of kidney stone					
50080	T		Removal of kidney stone	0163	36.0744	2055.63		411.13
50081	T		Removal of kidney stone	0163	36.0744	2055.63		411.13
50100	C		Revise kidney blood vessels					
50120	C		Exploration of kidney					
50125	C		Explore and drain kidney					
50130	C		Removal of kidney stone					
50135	C		Exploration of kidney					
50200	T		Biopsy of kidney	0685	5.8806	335.09	115.47	67.02
50205	C		Biopsy of kidney					
50220	C		Remove kidney, open					
50225	C		Removal kidney open, complex					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
50230	C		Removal kidney open, radical					
50234	C		Removal of kidney & ureter					
50236	C		Removal of kidney & ureter					
50240	C		Partial removal of kidney					
50280	C		Removal of kidney lesion					
50290	C		Removal of kidney lesion					
50300	C		Remove cadaver donor kidney					
50320	C		Remove kidney, living donor					
50323	C	NI	Prep cadaver renal allograft					
50325	C	NI	Prep donor renal graft					
50327	C	NI	Prep renal graft/venous					
50328	C	NI	Prep renal graft/arterial					
50329	C	NI	Prep renal graft/ureteral					
50340	C		Removal of kidney					
50360	C		Transplantation of kidney					
50365	C		Transplantation of kidney					
50370	C		Remove transplanted kidney					
50380	C		Reimplantation of kidney					
50390	T		Drainage of kidney lesion	0685	5.8806	335.09	115.47	67.02
50391	T	NI	Instll rx agnt into rnal tub	0156	2.4782	141.22	40.52	28.24
50392	T		Insert kidney drain	0161	17.8851	1019.15	249.36	203.83
50393	T		Insert ureteral tube	0161	17.8851	1019.15	249.36	203.83
50394	N		Injection for kidney x-ray					
50395	T		Create passage to kidney	0161	17.8851	1019.15	249.36	203.83
50396	T		Measure kidney pressure	0164	1.2563	71.59	17.59	14.32
50398	T		Change kidney tube	0122	8.2869	472.21	96.84	94.44
50400	C		Revision of kidney/ureter					
50405	C		Revision of kidney/ureter					
50500	C		Repair of kidney wound					
50520	C		Close kidney-skin fistula					
50525	C		Repair renal-abdomen fistula					
50526	C		Repair renal-abdomen fistula					
50540	C		Revision of horseshoe kidney					
50541	T		Laparo ablate renal cyst	0130	31.6832	1805.40	659.53	361.08
50542	T		Laparo ablate renal mass	0131	42.7526	2436.17	1001.89	487.23
50543	T		Laparo partial nephrectomy	0131	42.7526	2436.17	1001.89	487.23
50544	T		Laparoscopy, pyeloplasty	0130	31.6832	1805.40	659.53	361.08
50545	C		Laparo radical nephrectomy					
50546	C		Laparoscopic nephrectomy					
50547	C		Laparo removal donor kidney					
50548	C		Laparo remove w/ureter					
50549	T		Laparoscope proc, renal	0130	31.6832	1805.40	659.53	361.08
50551	T		Kidney endoscopy	0160	6.7674	385.63	105.06	77.13

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
50553	T		Kidney endoscopy	0161	17.8851	1019.15	249.36	203.83
50555	T		Kidney endoscopy & biopsy	0160	6.7674	385.63	105.06	77.13
50557	T		Kidney endoscopy & treatment	0162	23.0182	1311.65		262.33
50559	D		Renal endoscopy/radiotracer					
50561	T		Kidney endoscopy & treatment	0161	17.8851	1019.15	249.36	203.83
50562	T		Renal scope w/tumor resect	0160	6.7674	385.63	105.06	77.13
50570	T		Kidney endoscopy	0160	6.7674	385.63	105.06	77.13
50572	T		Kidney endoscopy	0160	6.7674	385.63	105.06	77.13
50574	T		Kidney endoscopy & biopsy	0160	6.7674	385.63	105.06	77.13
50575	T		Kidney endoscopy	0163	36.0744	2055.63		411.13
50576	T		Kidney endoscopy & treatment	0161	17.8851	1019.15	249.36	203.83
50578	D		Renal endoscopy/radiotracer					
50580	C		Kidney endoscopy & treatment					
50590	T		Fragmenting of kidney stone	0169	44.6235	2542.78	1115.69	508.56
50600	C		Exploration of ureter					
50605	C		Insert ureteral support					
50610	C		Removal of ureter stone					
50620	C		Removal of ureter stone					
50630	C		Removal of ureter stone					
50650	C		Removal of ureter					
50660	C		Removal of ureter					
50684	N		Injection for ureter x-ray					
50686	T		Measure ureter pressure	0164	1.2563	71.59	17.59	14.32
50688	T		Change of ureter tube	0122	8.2869	472.21	96.84	94.44
50690	N		Injection for ureter x-ray					
50700	C		Revision of ureter					
50715	C		Release of ureter					
50722	C		Release of ureter					
50725	C		Release/revise ureter					
50727	C		Revise ureter					
50728	C		Revise ureter					
50740	C		Fusion of ureter & kidney					
50750	C		Fusion of ureter & kidney					
50760	C		Fusion of ureters					
50770	C		Splicing of ureters					
50780	C		Reimplant ureter in bladder					
50782	C		Reimplant ureter in bladder					
50783	C		Reimplant ureter in bladder					
50785	C		Reimplant ureter in bladder					
50800	C		Implant ureter in bowel					
50810	C		Fusion of ureter & bowel					
50815	C		Urine shunt to intestine					
50820	C		Construct bowel bladder					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
50825	C		Construct bowel bladder					
50830	C		Revise urine flow					
50840	C		Replace ureter by bowel					
50845	C		Appendico-vesicostomy					
50860	C		Transplant ureter to skin					
50900	C		Repair of ureter					
50920	C		Closure ureter/skin fistula					
50930	C		Closure ureter/bowel fistula					
50940	C		Release of ureter					
50945	T		Laparoscopy ureterolithotomy	0131	42.7526	2436.17	1001.89	487.23
50947	T		Laparo new ureter/bladder	0131	42.7526	2436.17	1001.89	487.23
50948	T		Laparo new ureter/bladder	0131	42.7526	2436.17	1001.89	487.23
50949	T		Laparoscope proc, ureter	0130	31.6832	1805.40	659.53	361.08
50951	T		Endoscopy of ureter	0160	6.7674	385.63	105.06	77.13
50953	T		Endoscopy of ureter	0160	6.7674	385.63	105.06	77.13
50955	T		Ureter endoscopy & biopsy	0161	17.8851	1019.15	249.36	203.83
50957	T		Ureter endoscopy & treatment	0161	17.8851	1019.15	249.36	203.83
50959	D		Ureter endoscopy & tracer					
50961	T		Ureter endoscopy & treatment	0161	17.8851	1019.15	249.36	203.83
50970	T		Ureter endoscopy	0160	6.7674	385.63	105.06	77.13
50972	T		Ureter endoscopy & catheter	0160	6.7674	385.63	105.06	77.13
50974	T		Ureter endoscopy & biopsy	0161	17.8851	1019.15	249.36	203.83
50976	T		Ureter endoscopy & treatment	0161	17.8851	1019.15	249.36	203.83
50978	D		Ureter endoscopy & tracer					
50980	T		Ureter endoscopy & treatment	0161	17.8851	1019.15	249.36	203.83
51000	T		Drainage of bladder	0164	1.2563	71.59	17.59	14.32
51005	T		Drainage of bladder	0164	1.2563	71.59	17.59	14.32
51010	T		Drainage of bladder	0165	16.0415	914.09		182.82
51020	T		Incise & treat bladder	0162	23.0182	1311.65		262.33
51030	T		Incise & treat bladder	0162	23.0182	1311.65		262.33
51040	T		Incise & drain bladder	0162	23.0182	1311.65		262.33
51045	T		Incise bladder/drain ureter	0160	6.7674	385.63	105.06	77.13
51050	T		Removal of bladder stone	0162	23.0182	1311.65		262.33
51060	C		Removal of ureter stone					
51065	T		Remove ureter calculus	0162	23.0182	1311.65		262.33
51080	T		Drainage of bladder abscess	0007	12.4496	709.42		141.88
51500	T		Removal of bladder cyst	0154	28.0759	1599.85	464.85	319.97
51520	T		Removal of bladder lesion	0162	23.0182	1311.65		262.33
51525	C		Removal of bladder lesion					
51530	C		Removal of bladder lesion					
51535	C		Repair of ureter lesion					
51550	C		Partial removal of bladder					
51555	C		Partial removal of bladder					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
51565	C		Revise bladder & ureter(s)					
51570	C		Removal of bladder					
51575	C		Removal of bladder & nodes					
51580	C		Remove bladder/revise tract					
51585	C		Removal of bladder & nodes					
51590	C		Remove bladder/revise tract					
51595	C		Remove bladder/revise tract					
51596	C		Remove bladder/create pouch					
51597	C		Removal of pelvic structures					
51600	N		Injection for bladder x-ray					
51605	N		Preparation for bladder xray					
51610	N		Injection for bladder x-ray					
51700	T		Irrigation of bladder	0164	1.2563	71.59	17.59	14.32
51701	N		Insert bladder catheter					
51702	N		Insert temp bladder cath					
51703	N		Insert bladder cath, complex					
51705	T		Change of bladder tube	0121	2.2909	130.54	43.80	26.11
51710	T		Change of bladder tube	0122	8.2869	472.21	96.84	94.44
51715	T		Endoscopic injection/implant	0167	28.4301	1620.03	549.80	324.01
51720	T		Treatment of bladder lesion	0156	2.4782	141.22	40.52	28.24
51725	T		Simple cystometrogram	0156	2.4782	141.22	40.52	28.24
51726	T		Complex cystometrogram	0156	2.4782	141.22	40.52	28.24
51736	T		Urine flow measurement	0164	1.2563	71.59	17.59	14.32
51741	T		Electro-uroflowmetry, first	0164	1.2563	71.59	17.59	14.32
51772	T		Urethra pressure profile	0164	1.2563	71.59	17.59	14.32
51784	T		Anal/urinary muscle study	0164	1.2563	71.59	17.59	14.32
51785	T		Anal/urinary muscle study	0164	1.2563	71.59	17.59	14.32
51792	T		Urinary reflex study	0164	1.2563	71.59	17.59	14.32
51795	T		Urine voiding pressure study	0164	1.2563	71.59	17.59	14.32
51797	T		Intraabdominal pressure test	0164	1.2563	71.59	17.59	14.32
51798	X		Us urine capacity measure	0340	0.6328	36.06		7.21
51800	C		Revision of bladder/urethra					
51820	C		Revision of urinary tract					
51840	C		Attach bladder/urethra					
51841	C		Attach bladder/urethra					
51845	C		Repair bladder neck					
51860	C		Repair of bladder wound					
51865	C		Repair of bladder wound					
51880	T		Repair of bladder opening	0162	23.0182	1311.65		262.33
51900	C		Repair bladder/vagina lesion					
51920	C		Close bladder-uterus fistula					
51925	C		Hysterectomy/bladder repair					
51940	C		Correction of bladder defect					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
51960	C		Revision of bladder & bowel					
51980	C		Construct bladder opening					
51990	T		Laparo urethral suspension	0131	42.7526	2436.17	1001.89	487.23
51992	T		Laparo sling operation	0132	61.3208	3494.24	1239.22	698.85
52000	T		Cystoscopy	0160	6.7674	385.63	105.06	77.13
52001	T		Cystoscopy, removal of clots	0160	6.7674	385.63	105.06	77.13
52005	T		Cystoscopy & ureter catheter	0161	17.8851	1019.15	249.36	203.83
52007	T		Cystoscopy and biopsy	0161	17.8851	1019.15	249.36	203.83
52010	T		Cystoscopy & duct catheter	0160	6.7674	385.63	105.06	77.13
52204	T		Cystoscopy	0161	17.8851	1019.15	249.36	203.83
52214	T		Cystoscopy and treatment	0162	23.0182	1311.65		262.33
52224	T		Cystoscopy and treatment	0162	23.0182	1311.65		262.33
52234	T		Cystoscopy and treatment	0162	23.0182	1311.65		262.33
52235	T		Cystoscopy and treatment	0162	23.0182	1311.65		262.33
52240	T		Cystoscopy and treatment	0162	23.0182	1311.65		262.33
52250	T		Cystoscopy and radiotracer	0162	23.0182	1311.65		262.33
52260	T		Cystoscopy and treatment	0161	17.8851	1019.15	249.36	203.83
52265	T		Cystoscopy and treatment	0160	6.7674	385.63	105.06	77.13
52270	T		Cystoscopy & revise urethra	0161	17.8851	1019.15	249.36	203.83
52275	T		Cystoscopy & revise urethra	0161	17.8851	1019.15	249.36	203.83
52276	T		Cystoscopy and treatment	0161	17.8851	1019.15	249.36	203.83
52277	T		Cystoscopy and treatment	0162	23.0182	1311.65		262.33
52281	T		Cystoscopy and treatment	0161	17.8851	1019.15	249.36	203.83
52282	T		Cystoscopy, implant stent	0163	36.0744	2055.63		411.13
52283	T		Cystoscopy and treatment	0161	17.8851	1019.15	249.36	203.83
52285	T		Cystoscopy and treatment	0161	17.8851	1019.15	249.36	203.83
52290	T		Cystoscopy and treatment	0161	17.8851	1019.15	249.36	203.83
52300	T		Cystoscopy and treatment	0161	17.8851	1019.15	249.36	203.83
52301	T		Cystoscopy and treatment	0161	17.8851	1019.15	249.36	203.83
52305	T		Cystoscopy and treatment	0161	17.8851	1019.15	249.36	203.83
52310	T		Cystoscopy and treatment	0160	6.7674	385.63	105.06	77.13
52315	T		Cystoscopy and treatment	0161	17.8851	1019.15	249.36	203.83
52317	T		Remove bladder stone	0162	23.0182	1311.65		262.33
52318	T		Remove bladder stone	0162	23.0182	1311.65		262.33
52320	T		Cystoscopy and treatment	0162	23.0182	1311.65		262.33
52325	T		Cystoscopy, stone removal	0162	23.0182	1311.65		262.33
52327	T		Cystoscopy, inject material	0162	23.0182	1311.65		262.33
52330	T		Cystoscopy and treatment	0162	23.0182	1311.65		262.33
52332	T		Cystoscopy and treatment	0162	23.0182	1311.65		262.33
52334	T		Create passage to kidney	0162	23.0182	1311.65		262.33
52341	T		Cysto w/ureter stricture tx	0162	23.0182	1311.65		262.33
52342	T		Cysto w/up stricture tx	0162	23.0182	1311.65		262.33
52343	T		Cysto w/renal stricture tx	0162	23.0182	1311.65		262.33

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
52344	T		Cysto/uretero, stricture tx	0162	23.0182	1311.65		262.33
52345	T		Cysto/uretero w/up stricture	0162	23.0182	1311.65		262.33
52346	T		Cystouretero w/renal strict	0162	23.0182	1311.65		262.33
52347	D		Cystoscopy, resect ducts					
52351	T		Cystouretero & or pyeloscope	0161	17.8851	1019.15	249.36	203.83
52352	T		Cystouretero w/stone remove	0162	23.0182	1311.65		262.33
52353	T		Cystouretero w/lithotripsy	0163	36.0744	2055.63		411.13
52354	T		Cystouretero w/biopsy	0162	23.0182	1311.65		262.33
52355	T		Cystouretero w/excise tumor	0162	23.0182	1311.65		262.33
52400	T		Cystouretero w/congen repr	0162	23.0182	1311.65		262.33
52402	T	NI	Cystourethro cut ejacul duct	0162	23.0182	1311.65		262.33
52450	T		Incision of prostate	0162	23.0182	1311.65		262.33
52500	T		Revision of bladder neck	0162	23.0182	1311.65		262.33
52510	T		Dilation prostatic urethra	0161	17.8851	1019.15	249.36	203.83
52601	T		Prostatectomy (TURP)	0163	36.0744	2055.63		411.13
52606	T		Control postop bleeding	0162	23.0182	1311.65		262.33
52612	T		Prostatectomy, first stage	0163	36.0744	2055.63		411.13
52614	T		Prostatectomy, second stage	0163	36.0744	2055.63		411.13
52620	T		Remove residual prostate	0163	36.0744	2055.63		411.13
52630	T		Remove prostate regrowth	0163	36.0744	2055.63		411.13
52640	T		Relieve bladder contracture	0162	23.0182	1311.65		262.33
52647	T		Laser surgery of prostate	0163	36.0744	2055.63		411.13
52648	T		Laser surgery of prostate	0163	36.0744	2055.63		411.13
52700	T		Drainage of prostate abscess	0162	23.0182	1311.65		262.33
53000	T		Incision of urethra	0166	17.7694	1012.55	218.73	202.51
53010	T		Incision of urethra	0166	17.7694	1012.55	218.73	202.51
53020	T		Incision of urethra	0166	17.7694	1012.55	218.73	202.51
53025	T		Incision of urethra	0166	17.7694	1012.55	218.73	202.51
53040	T		Drainage of urethra abscess	0167	28.4301	1620.03	549.80	324.01
53060	T		Drainage of urethra abscess	0166	17.7694	1012.55	218.73	202.51
53080	T		Drainage of urinary leakage	0166	17.7694	1012.55	218.73	202.51
53085	T		Drainage of urinary leakage	0166	17.7694	1012.55	218.73	202.51
53200	T		Biopsy of urethra	0166	17.7694	1012.55	218.73	202.51
53210	T		Removal of urethra	0168	30.7725	1753.51	405.60	350.70
53215	T		Removal of urethra	0166	17.7694	1012.55	218.73	202.51
53220	T		Treatment of urethra lesion	0168	30.7725	1753.51	405.60	350.70
53230	T		Removal of urethra lesion	0168	30.7725	1753.51	405.60	350.70
53235	T		Removal of urethra lesion	0166	17.7694	1012.55	218.73	202.51
53240	T		Surgery for urethra pouch	0168	30.7725	1753.51	405.60	350.70
53250	T		Removal of urethra gland	0166	17.7694	1012.55	218.73	202.51
53260	T		Treatment of urethra lesion	0166	17.7694	1012.55	218.73	202.51
53265	T		Treatment of urethra lesion	0166	17.7694	1012.55	218.73	202.51
53270	T		Removal of urethra gland	0167	28.4301	1620.03	549.80	324.01

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
53275	T		Repair of urethra defect	0166	17.7694	1012.55	218.73	202.51
53400	T		Revise urethra, stage 1	0168	30.7725	1753.51	405.60	350.70
53405	T		Revise urethra, stage 2	0168	30.7725	1753.51	405.60	350.70
53410	T		Reconstruction of urethra	0168	30.7725	1753.51	405.60	350.70
53415	C		Reconstruction of urethra					
53420	T		Reconstruct urethra, stage 1	0168	30.7725	1753.51	405.60	350.70
53425	T		Reconstruct urethra, stage 2	0168	30.7725	1753.51	405.60	350.70
53430	T		Reconstruction of urethra	0168	30.7725	1753.51	405.60	350.70
53431	T		Reconstruct urethra/bladder	0168	30.7725	1753.51	405.60	350.70
53440	S		Male sling procedure	0385	69.6845	3970.83		794.17
53442	T		Remove/revise male sling	0167	28.4301	1620.03	549.80	324.01
53444	S		Insert tandem cuff	0385	69.6845	3970.83		794.17
53445	S		Insert uro/ves nck sphincter	0386	113.9823	6495.05		1299.01
53446	T		Remove uro sphincter	0168	30.7725	1753.51	405.60	350.70
53447	S		Remove/replace ur sphincter	0386	113.9823	6495.05		1299.01
53448	C		Remov/replc ur sphinctr comp					
53449	T		Repair uro sphincter	0168	30.7725	1753.51	405.60	350.70
53450	T		Revision of urethra	0168	30.7725	1753.51	405.60	350.70
53460	T		Revision of urethra	0166	17.7694	1012.55	218.73	202.51
53500	T		Urethrlys, transvag w/ scope	0168	30.7725	1753.51	405.60	350.70
53502	T		Repair of urethra injury	0166	17.7694	1012.55	218.73	202.51
53505	T		Repair of urethra injury	0167	28.4301	1620.03	549.80	324.01
53510	T		Repair of urethra injury	0166	17.7694	1012.55	218.73	202.51
53515	T		Repair of urethra injury	0168	30.7725	1753.51	405.60	350.70
53520	T		Repair of urethra defect	0168	30.7725	1753.51	405.60	350.70
53600	T		Dilate urethra stricture	0156	2.4782	141.22	40.52	28.24
53601	T		Dilate urethra stricture	0164	1.2563	71.59	17.59	14.32
53605	T		Dilate urethra stricture	0161	17.8851	1019.15	249.36	203.83
53620	T		Dilate urethra stricture	0165	16.0415	914.09		182.82
53621	T		Dilate urethra stricture	0164	1.2563	71.59	17.59	14.32
53660	T		Dilation of urethra	0164	1.2563	71.59	17.59	14.32
53661	T		Dilation of urethra	0164	1.2563	71.59	17.59	14.32
53665	T		Dilation of urethra	0166	17.7694	1012.55	218.73	202.51
53850	T		Prostatic microwave thermotx	0675	46.1821	2631.59		526.32
53852	T		Prostatic rf thermotx	0675	46.1821	2631.59		526.32
53853	T		Prostatic water thermother	0162	23.0182	1311.65		262.33
53899	T		Urology surgery procedure	0164	1.2563	71.59	17.59	14.32
54000	T		Slitting of prepuce	0166	17.7694	1012.55	218.73	202.51
54001	T		Slitting of prepuce	0166	17.7694	1012.55	218.73	202.51
54015	T		Drain penis lesion	0007	12.4496	709.42		141.88
54050	T		Destruction, penis lesion(s)	0013	1.1380	64.85	14.20	12.97
54055	T		Destruction, penis lesion(s)	0017	17.3894	990.90	227.84	198.18
54056	T		Cryosurgery, penis lesion(s)	0012	0.7477	42.61	11.18	8.52

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
54057	T		Laser surg, penis lesion(s)	0017	17.3894	990.90	227.84	198.18
54060	T		Excision of penis lesion(s)	0017	17.3894	990.90	227.84	198.18
54065	T		Destruction, penis lesion(s)	0695	20.5193	1169.25	266.59	233.85
54100	T		Biopsy of penis	0021	14.8872	848.32	219.48	169.66
54105	T		Biopsy of penis	0022	19.3700	1103.76	354.45	220.75
54110	T		Treatment of penis lesion	0181	31.6828	1805.38	621.82	361.08
54111	T		Treat penis lesion, graft	0181	31.6828	1805.38	621.82	361.08
54112	T		Treat penis lesion, graft	0181	31.6828	1805.38	621.82	361.08
54115	T		Treatment of penis lesion	0008	19.3572	1103.03		220.61
54120	T		Partial removal of penis	0181	31.6828	1805.38	621.82	361.08
54125	C		Removal of penis					
54130	C		Remove penis & nodes					
54135	C		Remove penis & nodes					
54150	T		Circumcision	0180	19.7320	1124.39	304.87	224.88
54152	T		Circumcision	0180	19.7320	1124.39	304.87	224.88
54160	T		Circumcision	0180	19.7320	1124.39	304.87	224.88
54161	T		Circumcision	0180	19.7320	1124.39	304.87	224.88
54162	T		Lysis penil circumic lesion	0180	19.7320	1124.39	304.87	224.88
54163	T		Repair of circumcision	0180	19.7320	1124.39	304.87	224.88
54164	T		Frenulotomy of penis	0180	19.7320	1124.39	304.87	224.88
54200	T		Treatment of penis lesion	0156	2.4782	141.22	40.52	28.24
54205	T		Treatment of penis lesion	0181	31.6828	1805.38	621.82	361.08
54220	T		Treatment of penis lesion	0156	2.4782	141.22	40.52	28.24
54230	N		Prepare penis study					
54231	T		Dynamic cavernosometry	0165	16.0415	914.09		182.82
54235	T		Penile injection	0164	1.2563	71.59	17.59	14.32
54240	T		Penis study	0164	1.2563	71.59	17.59	14.32
54250	T		Penis study	0164	1.2563	71.59	17.59	14.32
54300	T		Revision of penis	0181	31.6828	1805.38	621.82	361.08
54304	T		Revision of penis	0181	31.6828	1805.38	621.82	361.08
54308	T		Reconstruction of urethra	0181	31.6828	1805.38	621.82	361.08
54312	T		Reconstruction of urethra	0181	31.6828	1805.38	621.82	361.08
54316	T		Reconstruction of urethra	0181	31.6828	1805.38	621.82	361.08
54318	T		Reconstruction of urethra	0181	31.6828	1805.38	621.82	361.08
54322	T		Reconstruction of urethra	0181	31.6828	1805.38	621.82	361.08
54324	T		Reconstruction of urethra	0181	31.6828	1805.38	621.82	361.08
54326	T		Reconstruction of urethra	0181	31.6828	1805.38	621.82	361.08
54328	T		Revise penis/urethra	0181	31.6828	1805.38	621.82	361.08
54332	C		Revise penis/urethra					
54336	C		Revise penis/urethra					
54340	T		Secondary urethral surgery	0181	31.6828	1805.38	621.82	361.08
54344	T		Secondary urethral surgery	0181	31.6828	1805.38	621.82	361.08
54348	T		Secondary urethral surgery	0181	31.6828	1805.38	621.82	361.08

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
54352	T		Reconstruct urethra/penis	0181	31.6828	1805.38	621.82	361.08
54360	T		Penis plastic surgery	0181	31.6828	1805.38	621.82	361.08
54380	T		Repair penis	0181	31.6828	1805.38	621.82	361.08
54385	T		Repair penis	0181	31.6828	1805.38	621.82	361.08
54390	C		Repair penis and bladder					
54400	S		Insert semi-rigid prosthesis	0385	69.6845	3970.83		794.17
54401	S		Insert self-contd prosthesis	0386	113.9823	6495.05		1299.01
54405	S		Insert multi-comp penis pros	0386	113.9823	6495.05		1299.01
54406	T		Remove muti-comp penis pros	0181	31.6828	1805.38	621.82	361.08
54408	T		Repair multi-comp penis pros	0181	31.6828	1805.38	621.82	361.08
54410	S		Remove/replace penis prosth	0386	113.9823	6495.05		1299.01
54411	C		Remov/replc penis pros, comp					
54415	T		Remove self-contd penis pros	0181	31.6828	1805.38	621.82	361.08
54416	S		Remv/repl penis contain pros	0386	113.9823	6495.05		1299.01
54417	C		Remv/replc penis pros, compl					
54420	T		Revision of penis	0181	31.6828	1805.38	621.82	361.08
54430	C		Revision of penis					
54435	T		Revision of penis	0181	31.6828	1805.38	621.82	361.08
54440	T		Repair of penis	0181	31.6828	1805.38	621.82	361.08
54450	T		Preputial stretching	0156	2.4782	141.22	40.52	28.24
54500	T		Biopsy of testis	0037	9.3421	532.34	234.20	106.47
54505	T		Biopsy of testis	0183	23.0563	1313.82		262.76
54512	T		Excise lesion testis	0183	23.0563	1313.82		262.76
54520	T		Removal of testis	0183	23.0563	1313.82		262.76
54522	T		Orchiectomy, partial	0183	23.0563	1313.82		262.76
54530	T		Removal of testis	0154	28.0759	1599.85	464.85	319.97
54535	C		Extensive testis surgery					
54550	T		Exploration for testis	0154	28.0759	1599.85	464.85	319.97
54560	C		Exploration for testis					
54600	T		Reduce testis torsion	0183	23.0563	1313.82		262.76
54620	T		Suspension of testis	0183	23.0563	1313.82		262.76
54640	T		Suspension of testis	0154	28.0759	1599.85	464.85	319.97
54650	C		Orchiopexy (Fowler-Stephens)					
54660	T		Revision of testis	0183	23.0563	1313.82		262.76
54670	T		Repair testis injury	0183	23.0563	1313.82		262.76
54680	T		Relocation of testis(es)	0183	23.0563	1313.82		262.76
54690	T		Laparoscopy, orchiectomy	0131	42.7526	2436.17	1001.89	487.23
54692	T		Laparoscopy, orchiopexy	0132	61.3208	3494.24	1239.22	698.85
54699	T		Laparoscope proc, testis	0130	31.6832	1805.40	659.53	361.08
54700	T		Drainage of scrotum	0183	23.0563	1313.82		262.76
54800	T		Biopsy of epididymis	0004	1.7081	97.33	22.36	19.47
54820	T		Exploration of epididymis	0183	23.0563	1313.82		262.76
54830	T		Remove epididymis lesion	0183	23.0563	1313.82		262.76

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
54840	T		Remove epididymis lesion	0183	23.0563	1313.82		262.76
54860	T		Removal of epididymis	0183	23.0563	1313.82		262.76
54861	T		Removal of epididymis	0183	23.0563	1313.82		262.76
54900	T		Fusion of spermatic ducts	0183	23.0563	1313.82		262.76
54901	T		Fusion of spermatic ducts	0183	23.0563	1313.82		262.76
55000	T		Drainage of hydrocele	0004	1.7081	97.33	22.36	19.47
55040	T		Removal of hydrocele	0154	28.0759	1599.85	464.85	319.97
55041	T		Removal of hydroceles	0154	28.0759	1599.85	464.85	319.97
55060	T		Repair of hydrocele	0183	23.0563	1313.82		262.76
55100	T		Drainage of scrotum abscess	0007	12.4496	709.42		141.88
55110	T		Explore scrotum	0183	23.0563	1313.82		262.76
55120	T		Removal of scrotum lesion	0183	23.0563	1313.82		262.76
55150	T		Removal of scrotum	0183	23.0563	1313.82		262.76
55175	T		Revision of scrotum	0183	23.0563	1313.82		262.76
55180	T		Revision of scrotum	0183	23.0563	1313.82		262.76
55200	T		Incision of sperm duct	0183	23.0563	1313.82		262.76
55250	T		Removal of sperm duct(s)	0183	23.0563	1313.82		262.76
55300	N		Prepare, sperm duct x-ray					
55400	T		Repair of sperm duct	0183	23.0563	1313.82		262.76
55450	T		Ligation of sperm duct	0183	23.0563	1313.82		262.76
55500	T		Removal of hydrocele	0183	23.0563	1313.82		262.76
55520	T		Removal of sperm cord lesion	0183	23.0563	1313.82		262.76
55530	T		Revise spermatic cord veins	0183	23.0563	1313.82		262.76
55535	T		Revise spermatic cord veins	0154	28.0759	1599.85	464.85	319.97
55540	T		Revise hernia & sperm veins	0154	28.0759	1599.85	464.85	319.97
55550	T		Laparo ligate spermatic vein	0131	42.7526	2436.17	1001.89	487.23
55559	T		Laparo proc, spermatic cord	0130	31.6832	1805.40	659.53	361.08
55600	C		Incise sperm duct pouch					
55605	C		Incise sperm duct pouch					
55650	C		Remove sperm duct pouch					
55680	T		Remove sperm pouch lesion	0183	23.0563	1313.82		262.76
55700	T		Biopsy of prostate	0184	4.1543	236.72	96.27	47.34
55705	T		Biopsy of prostate	0184	4.1543	236.72	96.27	47.34
55720	T		Drainage of prostate abscess	0162	23.0182	1311.65		262.33
55725	T		Drainage of prostate abscess	0162	23.0182	1311.65		262.33
55801	C		Removal of prostate					
55810	C		Extensive prostate surgery					
55812	C		Extensive prostate surgery					
55815	C		Extensive prostate surgery					
55821	C		Removal of prostate					
55831	C		Removal of prostate					
55840	C		Extensive prostate surgery					
55842	C		Extensive prostate surgery					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
55845	C		Extensive prostate surgery					
55859	T		Percut/needle insert, pros	0163	36.0744	2055.63		411.13
55860	T		Surgical exposure, prostate	0165	16.0415	914.09		182.82
55862	C		Extensive prostate surgery					
55865	C		Extensive prostate surgery					
55866	C		Laparo radical prostatectomy					
55870	T		Electroejaculation	0197	2.2368	127.46		25.49
55873	T		Cryoablate prostate	0674	112.1858	6392.68		1278.54
55899	T		Genital surgery procedure	0164	1.2563	71.59	17.59	14.32
55970	E		Sex transformation, M to F					
55980	E		Sex transformation, F to M					
56405	T		I & D of vulva/perineum	0192	3.8280	218.13		43.63
56420	T		Drainage of gland abscess	0189	2.1451	122.23		24.45
56440	T		Surgery for vulva lesion	0194	19.1146	1089.21	397.84	217.84
56441	T		Lysis of labial lesion(s)	0193	13.3052	758.17	158.05	151.63
56501	T		Destroy, vulva lesions, sim	0017	17.3894	990.90	227.84	198.18
56515	T		Destroy vulva lesion/s compl	0695	20.5193	1169.25	266.59	233.85
56605	T		Biopsy of vulva/perineum	0019	4.1677	237.49	71.87	47.50
56606	T		Biopsy of vulva/perineum	0019	4.1677	237.49	71.87	47.50
56620	T		Partial removal of vulva	0195	26.4573	1507.62	483.80	301.52
56625	T		Complete removal of vulva	0195	26.4573	1507.62	483.80	301.52
56630	C		Extensive vulva surgery					
56631	C		Extensive vulva surgery					
56632	C		Extensive vulva surgery					
56633	C		Extensive vulva surgery					
56634	C		Extensive vulva surgery					
56637	C		Extensive vulva surgery					
56640	C		Extensive vulva surgery					
56700	T		Partial removal of hymen	0194	19.1146	1089.21	397.84	217.84
56720	T		Incision of hymen	0193	13.3052	758.17	158.05	151.63
56740	T		Remove vagina gland lesion	0194	19.1146	1089.21	397.84	217.84
56800	T		Repair of vagina	0194	19.1146	1089.21	397.84	217.84
56805	T		Repair clitoris	0194	19.1146	1089.21	397.84	217.84
56810	T		Repair of perineum	0194	19.1146	1089.21	397.84	217.84
56820	T		Exam of vulva w/scope	0188	1.1045	62.94		12.59
56821	T		Exam/biopsy of vulva w/scope	0189	2.1451	122.23		24.45
57000	T		Exploration of vagina	0194	19.1146	1089.21	397.84	217.84
57010	T		Drainage of pelvic abscess	0194	19.1146	1089.21	397.84	217.84
57020	T		Drainage of pelvic fluid	0192	3.8280	218.13		43.63
57022	T		I & d vaginal hematoma, pp	0007	12.4496	709.42		141.88
57023	T		I & d vag hematoma, non-ob	0007	12.4496	709.42		141.88
57061	T		Destroy vag lesions, simple	0194	19.1146	1089.21	397.84	217.84
57065	T		Destroy vag lesions, complex	0194	19.1146	1089.21	397.84	217.84

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
57100	T		Biopsy of vagina	0192	3.8280	218.13		43.63
57105	T		Biopsy of vagina	0194	19.1146	1089.21	397.84	217.84
57106	T		Remove vagina wall, partial	0194	19.1146	1089.21	397.84	217.84
57107	T		Remove vagina tissue, part	0195	26.4573	1507.62	483.80	301.52
57109	T		Vaginectomy partial w/nodes	0195	26.4573	1507.62	483.80	301.52
57110	C		Remove vagina wall, complete					
57111	C		Remove vagina tissue, compl					
57112	C		Vaginectomy w/nodes, compl					
57120	T		Closure of vagina	0195	26.4573	1507.62	483.80	301.52
57130	T		Remove vagina lesion	0194	19.1146	1089.21	397.84	217.84
57135	T		Remove vagina lesion	0194	19.1146	1089.21	397.84	217.84
57150	T		Treat vagina infection	0191	0.1831	10.43	2.93	2.09
57155	T		Insert uteri tandems/ovoids	0193	13.3052	758.17	158.05	151.63
57160	T		Insert pessary/other device	0188	1.1045	62.94		12.59
57170	T		Fitting of diaphragm/cap	0191	0.1831	10.43	2.93	2.09
57180	T		Treat vaginal bleeding	0189	2.1451	122.23		24.45
57200	T		Repair of vagina	0194	19.1146	1089.21	397.84	217.84
57210	T		Repair vagina/perineum	0194	19.1146	1089.21	397.84	217.84
57220	T		Revision of urethra	0202	39.6674	2260.37	1017.16	452.07
57230	T		Repair of urethral lesion	0195	26.4573	1507.62	483.80	301.52
57240	T		Repair bladder & vagina	0195	26.4573	1507.62	483.80	301.52
57250	T		Repair rectum & vagina	0195	26.4573	1507.62	483.80	301.52
57260	T		Repair of vagina	0195	26.4573	1507.62	483.80	301.52
57265	T		Extensive repair of vagina	0202	39.6674	2260.37	1017.16	452.07
57267	T	NI	Insert mesh/pelvic flr addon	0154	28.0759	1599.85	464.85	319.97
57268	T		Repair of bowel bulge	0195	26.4573	1507.62	483.80	301.52
57270	C		Repair of bowel pouch					
57280	C		Suspension of vagina					
57282	C		Colpopexy, extraperitoneal					
57283	C	NI	Colpopexy, intraperitoneal					
57284	T		Repair paravaginal defect	0202	39.6674	2260.37	1017.16	452.07
57287	T		Revise/remove sling repair	0202	39.6674	2260.37	1017.16	452.07
57288	T		Repair bladder defect	0202	39.6674	2260.37	1017.16	452.07
57289	T		Repair bladder & vagina	0195	26.4573	1507.62	483.80	301.52
57291	T		Construction of vagina	0195	26.4573	1507.62	483.80	301.52
57292	C		Construct vagina with graft					
57300	T		Repair rectum-vagina fistula	0195	26.4573	1507.62	483.80	301.52
57305	C		Repair rectum-vagina fistula					
57307	C		Fistula repair & colostomy					
57308	C		Fistula repair, transperine					
57310	T		Repair urethrovaginal lesion	0202	39.6674	2260.37	1017.16	452.07
57311	C		Repair urethrovaginal lesion					
57320	T		Repair bladder-vagina lesion	0195	26.4573	1507.62	483.80	301.52

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
57330	T		Repair bladder-vagina lesion	0195	26.4573	1507.62	483.80	301.52
57335	C		Repair vagina					
57400	T		Dilation of vagina	0194	19.1146	1089.21	397.84	217.84
57410	T		Pelvic examination	0194	19.1146	1089.21	397.84	217.84
57415	T		Remove vaginal foreign body	0194	19.1146	1089.21	397.84	217.84
57420	T		Exam of vagina w/scope	0189	2.1451	122.23		24.45
57421	T		Exam/biopsy of vag w/scope	0189	2.1451	122.23		24.45
57425	T		Laparoscopy, surg, colpopexy	0130	31.6832	1805.40	659.53	361.08
57452	T		Exam of cervix w/scope	0189	2.1451	122.23		24.45
57454	T		Bx/curett of cervix w/scope	0189	2.1451	122.23		24.45
57455	T		Biopsy of cervix w/scope	0189	2.1451	122.23		24.45
57456	T		Endocerv curettage w/scope	0189	2.1451	122.23		24.45
57460	T		Bx of cervix w/scope, leep	0193	13.3052	758.17	158.05	151.63
57461	T		Conz of cervix w/scope, leep	0194	19.1146	1089.21	397.84	217.84
57500	T		Biopsy of cervix	0192	3.8280	218.13		43.63
57505	T		Endocervical curettage	0189	2.1451	122.23		24.45
57510	T		Cauterization of cervix	0193	13.3052	758.17	158.05	151.63
57511	T		Cryocautery of cervix	0189	2.1451	122.23		24.45
57513	T		Laser surgery of cervix	0193	13.3052	758.17	158.05	151.63
57520	T		Conization of cervix	0194	19.1146	1089.21	397.84	217.84
57522	T		Conization of cervix	0195	26.4573	1507.62	483.80	301.52
57530	T		Removal of cervix	0195	26.4573	1507.62	483.80	301.52
57531	C		Removal of cervix, radical					
57540	C		Removal of residual cervix					
57545	C		Remove cervix/repair pelvis					
57550	T		Removal of residual cervix	0195	26.4573	1507.62	483.80	301.52
57555	T		Remove cervix/repair vagina	0195	26.4573	1507.62	483.80	301.52
57556	T		Remove cervix, repair bowel	0202	39.6674	2260.37	1017.16	452.07
57700	T		Revision of cervix	0194	19.1146	1089.21	397.84	217.84
57720	T		Revision of cervix	0194	19.1146	1089.21	397.84	217.84
57800	T		Dilation of cervical canal	0193	13.3052	758.17	158.05	151.63
57820	T		D & c of residual cervix	0196	16.9266	964.53	338.23	192.91
58100	T		Biopsy of uterus lining	0188	1.1045	62.94		12.59
58120	T		Dilation and curettage	0196	16.9266	964.53	338.23	192.91
58140	C		Myomectomy abdom method					
58145	T		Myomectomy vag method	0195	26.4573	1507.62	483.80	301.52
58146	C		Myomectomy abdom complex					
58150	C		Total hysterectomy					
58152	C		Total hysterectomy					
58180	C		Partial hysterectomy					
58200	C		Extensive hysterectomy					
58210	C		Extensive hysterectomy					
58240	C		Removal of pelvis contents					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
58260	C		Vaginal hysterectomy					
58262	C		Vag hyst including t/o					
58263	C		Vag hyst w/t/o & vag repair					
58267	C		Vag hyst w/urinary repair					
58270	C		Vag hyst w/enterocele repair					
58275	C		Hysterectomy/revise vagina					
58280	C		Hysterectomy/revise vagina					
58285	C		Extensive hysterectomy					
58290	C		Vag hyst complex					
58291	C		Vag hyst incl t/o, complex					
58292	C		Vag hyst t/o & repair, compl					
58293	C		Vag hyst w/uro repair, compl					
58294	C		Vag hyst w/enterocele, compl					
58300	E		Insert intrauterine device					
58301	T		Remove intrauterine device	0189	2.1451	122.23		24.45
58321	T		Artificial insemination	0197	2.2368	127.46		25.49
58322	T		Artificial insemination	0197	2.2368	127.46		25.49
58323	T		Sperm washing	0197	2.2368	127.46		25.49
58340	N		Catheter for hysterography					
58345	T		Reopen fallopian tube	0194	19.1146	1089.21	397.84	217.84
58346	T		Insert heyman uteri capsule	0193	13.3052	758.17	158.05	151.63
58350	T		Reopen fallopian tube	0195	26.4573	1507.62	483.80	301.52
58353	T		Endometr ablate, thermal	0195	26.4573	1507.62	483.80	301.52
58356	T	NI	Endometrial cryoablation	0202	39.6674	2260.37	1017.16	452.07
58400	C		Suspension of uterus					
58410	C		Suspension of uterus					
58520	C		Repair of ruptured uterus					
58540	C		Revision of uterus					
58545	T		Laparoscopic myomectomy	0130	31.6832	1805.40	659.53	361.08
58546	T		Laparo-myomectomy, complex	0131	42.7526	2436.17	1001.89	487.23
58550	T		Laparo-asst vag hysterectomy	0132	61.3208	3494.24	1239.22	698.85
58552	T		Laparo-vag hyst incl t/o	0131	42.7526	2436.17	1001.89	487.23
58553	T		Laparo-vag hyst, complex	0131	42.7526	2436.17	1001.89	487.23
58554	T		Laparo-vag hyst w/t/o, compl	0131	42.7526	2436.17	1001.89	487.23
58555	T		Hysteroscopy, dx, sep proc	0190	20.5171	1169.13	424.28	233.83
58558	T		Hysteroscopy, biopsy	0190	20.5171	1169.13	424.28	233.83
58559	T		Hysteroscopy, lysis	0190	20.5171	1169.13	424.28	233.83
58560	T		Hysteroscopy, resect septum	0387	30.3356	1728.61	655.55	345.72
58561	T		Hysteroscopy, remove myoma	0387	30.3356	1728.61	655.55	345.72
58562	T		Hysteroscopy, remove fb	0190	20.5171	1169.13	424.28	233.83
58563	T		Hysteroscopy, ablation	0387	30.3356	1728.61	655.55	345.72
58565	T	NI	Hysteroscopy, sterilization	0202	39.6674	2260.37	1017.16	452.07
58578	T		Laparo proc, uterus	0130	31.6832	1805.40	659.53	361.08

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
58579	T		Hysteroscope procedure	0190	20.5171	1169.13	424.28	233.83
58600	T		Division of fallopian tube	0195	26.4573	1507.62	483.80	301.52
58605	C		Division of fallopian tube					
58611	C		Ligate oviduct(s) add-on					
58615	T		Occlude fallopian tube(s)	0194	19.1146	1089.21	397.84	217.84
58660	T		Laparoscopy, lysis	0131	42.7526	2436.17	1001.89	487.23
58661	T		Laparoscopy, remove adnexa	0131	42.7526	2436.17	1001.89	487.23
58662	T		Laparoscopy, excise lesions	0131	42.7526	2436.17	1001.89	487.23
58670	T		Laparoscopy, tubal cautery	0131	42.7526	2436.17	1001.89	487.23
58671	T		Laparoscopy, tubal block	0131	42.7526	2436.17	1001.89	487.23
58672	T		Laparoscopy, fimbrioplasty	0131	42.7526	2436.17	1001.89	487.23
58673	T		Laparoscopy, salpingostomy	0131	42.7526	2436.17	1001.89	487.23
58679	T		Laparo proc, oviduct-ovary	0130	31.6832	1805.40	659.53	361.08
58700	C		Removal of fallopian tube					
58720	C		Removal of ovary/tube(s)					
58740	C		Revise fallopian tube(s)					
58750	C		Repair oviduct					
58752	C		Revise ovarian tube(s)					
58760	C		Remove tubal obstruction					
58770	T		Create new tubal opening	0195	26.4573	1507.62	483.80	301.52
58800	T		Drainage of ovarian cyst(s)	0193	13.3052	758.17	158.05	151.63
58805	C		Drainage of ovarian cyst(s)					
58820	T		Drain ovary abscess, open	0195	26.4573	1507.62	483.80	301.52
58822	C		Drain ovary abscess, percut					
58823	T		Drain pelvic abscess, percut	0193	13.3052	758.17	158.05	151.63
58825	C		Transposition, ovary(s)					
58900	T		Biopsy of ovary(s)	0193	13.3052	758.17	158.05	151.63
58920	T		Partial removal of ovary(s)	0195	26.4573	1507.62	483.80	301.52
58925	T		Removal of ovarian cyst(s)	0195	26.4573	1507.62	483.80	301.52
58940	C		Removal of ovary(s)					
58943	C		Removal of ovary(s)					
58950	C		Resect ovarian malignancy					
58951	C		Resect ovarian malignancy					
58952	C		Resect ovarian malignancy					
58953	C		Tah, rad dissect for debulk					
58954	C		Tah rad debulk/lymph remove					
58956	C	NI	Bso, omentectomy w/tah					
58960	C		Exploration of abdomen					
58970	T		Retrieval of oocyte	0194	19.1146	1089.21	397.84	217.84
58974	T		Transfer of embryo	0197	2.2368	127.46		25.49
58976	T		Transfer of embryo	0197	2.2368	127.46		25.49
58999	T		Genital surgery procedure	0191	0.1831	10.43	2.93	2.09
59000	T		Amniocentesis, diagnostic	0198	1.3503	76.94	32.19	15.39

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
59001	T		Amniocentesis, therapeutic	0198	1.3503	76.94	32.19	15.39
59012	T		Fetal cord puncture,prenatal	0198	1.3503	76.94	32.19	15.39
59015	T		Chorion biopsy	0198	1.3503	76.94	32.19	15.39
59020	T		Fetal contract stress test	0198	1.3503	76.94	32.19	15.39
59025	T		Fetal non-stress test	0198	1.3503	76.94	32.19	15.39
59030	T		Fetal scalp blood sample	0198	1.3503	76.94	32.19	15.39
59050	E		Fetal monitor w/report					
59051	B		Fetal monitor/interpret only					
59070	T		Transabdom amnioinfus w/us	0198	1.3503	76.94	32.19	15.39
59072	T		Umbilical cord occlud w/us	0198	1.3503	76.94	32.19	15.39
59074	T		Fetal fluid drainage w/us	0198	1.3503	76.94	32.19	15.39
59076	T		Fetal shunt placement, w/us	0198	1.3503	76.94	32.19	15.39
59100	C		Remove uterus lesion					
59120	C		Treat ectopic pregnancy					
59121	C		Treat ectopic pregnancy					
59130	C		Treat ectopic pregnancy					
59135	C		Treat ectopic pregnancy					
59136	C		Treat ectopic pregnancy					
59140	C		Treat ectopic pregnancy					
59150	T		Treat ectopic pregnancy	0131	42.7526	2436.17	1001.89	487.23
59151	T		Treat ectopic pregnancy	0131	42.7526	2436.17	1001.89	487.23
59160	T		D & c after delivery	0196	16.9266	964.53	338.23	192.91
59200	T		Insert cervical dilator	0189	2.1451	122.23		24.45
59300	T		Episiotomy or vaginal repair	0193	13.3052	758.17	158.05	151.63
59320	T		Revision of cervix	0194	19.1146	1089.21	397.84	217.84
59325	C		Revision of cervix					
59350	C		Repair of uterus					
59400	B		Obstetrical care					
59409	T		Obstetrical care	0194	19.1146	1089.21	397.84	217.84
59410	B		Obstetrical care					
59412	T		Antepartum manipulation	0700	3.6661	208.91		41.78
59414	T		Deliver placenta	0194	19.1146	1089.21	397.84	217.84
59425	B		Antepartum care only					
59426	B		Antepartum care only					
59430	B		Care after delivery					
59510	E		Cesarean delivery					
59514	C		Cesarean delivery only					
59515	E		Cesarean delivery					
59525	C		Remove uterus after cesarean					
59610	E		Vbac delivery					
59612	T		Vbac delivery only	0194	19.1146	1089.21	397.84	217.84
59614	E		Vbac care after delivery					
59618	E		Attempted vbac delivery					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
59620	C		Attempted vbac delivery only					
59622	E		Attempted vbac after care					
59812	T		Treatment of miscarriage	0201	18.0011	1025.76	329.65	205.15
59820	T		Care of miscarriage	0201	18.0011	1025.76	329.65	205.15
59821	T		Treatment of miscarriage	0201	18.0011	1025.76	329.65	205.15
59830	C		Treat uterus infection					
59840	T		Abortion	0200	14.7568	840.89	263.69	168.18
59841	T		Abortion	0200	14.7568	840.89	263.69	168.18
59850	C		Abortion					
59851	C		Abortion					
59852	C		Abortion					
59855	C		Abortion					
59856	C		Abortion					
59857	C		Abortion					
59866	T		Abortion (mpr)	0198	1.3503	76.94	32.19	15.39
59870	T		Evacuate mole of uterus	0201	18.0011	1025.76	329.65	205.15
59871	T		Remove cerclage suture	0194	19.1146	1089.21	397.84	217.84
59897	T		Fetal invas px w/us	0198	1.3503	76.94	32.19	15.39
59898	T		Laparo proc, ob care/deliver	0130	31.6832	1805.40	659.53	361.08
59899	T		Maternity care procedure	0198	1.3503	76.94	32.19	15.39
60000	T		Drain thyroid/tongue cyst	0252	6.5183	371.43	113.41	74.29
60001	T		Aspirate/inject thyriod cyst	0004	1.7081	97.33	22.36	19.47
60100	T		Biopsy of thyroid	0004	1.7081	97.33	22.36	19.47
60200	T		Remove thyroid lesion	0114	39.6713	2260.59	485.91	452.12
60210	T		Partial thyroid excision	0114	39.6713	2260.59	485.91	452.12
60212	T		Partial thyroid excision	0114	39.6713	2260.59	485.91	452.12
60220	T		Partial removal of thyroid	0114	39.6713	2260.59	485.91	452.12
60225	T		Partial removal of thyroid	0114	39.6713	2260.59	485.91	452.12
60240	T		Removal of thyroid	0114	39.6713	2260.59	485.91	452.12
60252	T		Removal of thyroid	0256	36.9298	2104.37		420.87
60254	C		Extensive thyroid surgery					
60260	T		Repeat thyroid surgery	0256	36.9298	2104.37		420.87
60270	C		Removal of thyroid					
60271	C		Removal of thyroid					
60280	T		Remove thyroid duct lesion	0114	39.6713	2260.59	485.91	452.12
60281	T		Remove thyroid duct lesion	0114	39.6713	2260.59	485.91	452.12
60500	T		Explore parathyroid glands	0256	36.9298	2104.37		420.87
60502	C		Re-explore parathyroids					
60505	C		Explore parathyroid glands					
60512	T		Autotransplant parathyroid	0022	19.3700	1103.76	354.45	220.75
60520	C		Removal of thymus gland					
60521	C		Removal of thymus gland					
60522	C		Removal of thymus gland					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
60540	C		Explore adrenal gland		.	.	.	.
60545	C		Explore adrenal gland		.	.	.	.
60600	C		Remove carotid body lesion		.	.	.	.
60605	C		Remove carotid body lesion		.	.	.	.
60650	C		Laparoscopy adrenalectomy		.	.	.	.
60659	T		Laparo proc, endocrine	0130	31.6832	1805.40	659.53	361.08
60699	T		Endocrine surgery procedure	0114	39.6713	2260.59	485.91	452.12
61000	T		Remove cranial cavity fluid	0212	2.9465	167.90	74.67	33.58
61001	T		Remove cranial cavity fluid	0212	2.9465	167.90	74.67	33.58
61020	T		Remove brain cavity fluid	0212	2.9465	167.90	74.67	33.58
61026	T		Injection into brain canal	0212	2.9465	167.90	74.67	33.58
61050	T		Remove brain canal fluid	0212	2.9465	167.90	74.67	33.58
61055	T		Injection into brain canal	0212	2.9465	167.90	74.67	33.58
61070	T		Brain canal shunt procedure	0212	2.9465	167.90	74.67	33.58
61105	C		Twist drill hole		.	.	.	.
61107	C		Drill skull for implantation		.	.	.	.
61108	C		Drill skull for drainage		.	.	.	.
61120	C		Burr hole for puncture		.	.	.	.
61140	C		Pierce skull for biopsy		.	.	.	.
61150	C		Pierce skull for drainage		.	.	.	.
61151	C		Pierce skull for drainage		.	.	.	.
61154	C		Pierce skull & remove clot		.	.	.	.
61156	C		Pierce skull for drainage		.	.	.	.
61210	C		Pierce skull, implant device		.	.	.	.
61215	T		Insert brain-fluid device	0224	38.8952	2216.37	453.41	443.27
61250	C		Pierce skull & explore		.	.	.	.
61253	C		Pierce skull & explore		.	.	.	.
61304	C		Open skull for exploration		.	.	.	.
61305	C		Open skull for exploration		.	.	.	.
61312	C		Open skull for drainage		.	.	.	.
61313	C		Open skull for drainage		.	.	.	.
61314	C		Open skull for drainage		.	.	.	.
61315	C		Open skull for drainage		.	.	.	.
61316	C		Implt cran bone flap to abdo		.	.	.	.
61320	C		Open skull for drainage		.	.	.	.
61321	C		Open skull for drainage		.	.	.	.
61322	C		Decompressive craniotomy		.	.	.	.
61323	C		Decompressive lobectomy		.	.	.	.
61330	T		Decompress eye socket	0256	36.9298	2104.37		420.87
61332	C		Explore/biopsy eye socket		.	.	.	.
61333	C		Explore orbit/remove lesion		.	.	.	.
61334	C		Explore orbit/remove object		.	.	.	.
61340	C		Subtemporal decompression		.	.	.	.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
61343	C		Incise skull (press relief)					
61345	C		Relieve cranial pressure					
61440	C		Incise skull for surgery					
61450	C		Incise skull for surgery					
61458	C		Incise skull for brain wound					
61460	C		Incise skull for surgery					
61470	C		Incise skull for surgery					
61480	C		Incise skull for surgery					
61490	C		Incise skull for surgery					
61500	C		Removal of skull lesion					
61501	C		Remove infected skull bone					
61510	C		Removal of brain lesion					
61512	C		Remove brain lining lesion					
61514	C		Removal of brain abscess					
61516	C		Removal of brain lesion					
61517	C		Implt brain chemotx add-on					
61518	C		Removal of brain lesion					
61519	C		Remove brain lining lesion					
61520	C		Removal of brain lesion					
61521	C		Removal of brain lesion					
61522	C		Removal of brain abscess					
61524	C		Removal of brain lesion					
61526	C		Removal of brain lesion					
61530	C		Removal of brain lesion					
61531	C		Implant brain electrodes					
61533	C		Implant brain electrodes					
61534	C		Removal of brain lesion					
61535	C		Remove brain electrodes					
61536	C		Removal of brain lesion					
61537	C		Removal of brain tissue					
61538	C		Removal of brain tissue					
61539	C		Removal of brain tissue					
61540	C		Removal of brain tissue					
61541	C		Incision of brain tissue					
61542	C		Removal of brain tissue					
61543	C		Removal of brain tissue					
61544	C		Remove & treat brain lesion					
61545	C		Excision of brain tumor					
61546	C		Removal of pituitary gland					
61548	C		Removal of pituitary gland					
61550	C		Release of skull seams					
61552	C		Release of skull seams					
61556	C		Incise skull/sutures					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
61557	C		Incise skull/sutures					
61558	C		Excision of skull/sutures					
61559	C		Excision of skull/sutures					
61563	C		Excision of skull tumor					
61564	C		Excision of skull tumor					
61566	C		Removal of brain tissue					
61567	C		Incision of brain tissue					
61570	C		Remove foreign body, brain					
61571	C		Incise skull for brain wound					
61575	C		Skull base/brainstem surgery					
61576	C		Skull base/brainstem surgery					
61580	C		Craniofacial approach, skull					
61581	C		Craniofacial approach, skull					
61582	C		Craniofacial approach, skull					
61583	C		Craniofacial approach, skull					
61584	C		Orbitocranial approach/skull					
61585	C		Orbitocranial approach/skull					
61586	C		Resect nasopharynx, skull					
61590	C		Infratemporal approach/skull					
61591	C		Infratemporal approach/skull					
61592	C		Orbitocranial approach/skull					
61595	C		Transtemporal approach/skull					
61596	C		Transcochlear approach/skull					
61597	C		Transcondylar approach/skull					
61598	C		Transpetrosal approach/skull					
61600	C		Resect/excise cranial lesion					
61601	C		Resect/excise cranial lesion					
61605	C		Resect/excise cranial lesion					
61606	C		Resect/excise cranial lesion					
61607	C		Resect/excise cranial lesion					
61608	C		Resect/excise cranial lesion					
61609	C		Transect artery, sinus					
61610	C		Transect artery, sinus					
61611	C		Transect artery, sinus					
61612	C		Transect artery, sinus					
61613	C		Remove aneurysm, sinus					
61615	C		Resect/excise lesion, skull					
61616	C		Resect/excise lesion, skull					
61618	C		Repair dura					
61619	C		Repair dura					
61623	T		Endovasc tempory vessel occl	1555		1650.00		330.00
61624	C		Transcath occlusion, cns					
61626	T		Transcath occlusion, non-cns	0081	32.7548	1866.47		373.29

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
61680	C		Intracranial vessel surgery					
61682	C		Intracranial vessel surgery					
61684	C		Intracranial vessel surgery					
61686	C		Intracranial vessel surgery					
61690	C		Intracranial vessel surgery					
61692	C		Intracranial vessel surgery					
61697	C		Brain aneurysm repr, complx					
61698	C		Brain aneurysm repr, complx					
61700	C		Brain aneurysm repr, simple					
61702	C		Inner skull vessel surgery					
61703	C		Clamp neck artery					
61705	C		Revise circulation to head					
61708	C		Revise circulation to head					
61710	C		Revise circulation to head					
61711	C		Fusion of skull arteries					
61720	C		Incise skull/brain surgery					
61735	C		Incise skull/brain surgery					
61750	C		Incise skull/brain biopsy					
61751	C		Brain biopsy w/ct/mr guide					
61760	C		Implant brain electrodes					
61770	C		Incise skull for treatment					
61790	T		Treat trigeminal nerve	0220	17.2963	985.60		197.12
61791	T		Treat trigeminal tract	0206	5.4311	309.48	75.55	61.90
61793	E		Focus radiation beam					
61795	S		Brain surgery using computer	0302	5.4315	309.50	117.25	61.90
61850	C		Implant neuroelectrodes					
61860	C		Implant neuroelectrodes					
61863	C		Implant neuroelectrode					
61864	C		Implant neuroelectrde, add'l					
61867	C		Implant neuroelectrode					
61868	C		Implant neuroelectrde, add'l					
61870	C		Implant neuroelectrodes					
61875	C		Implant neuroelectrodes					
61880	T		Revise/remove neuroelectrode	0687	20.0762	1144.00	513.05	228.80
61885	S		Insrt/redo neurostim 1 array	0039	219.9203	12531.72		2506.34
61886	T		Implant neurostim arrays	0315	352.3658	20078.86		4015.77
61888	T		Revise/remove neuroreceiver	0688	41.7281	2377.79	1070.00	475.56
62000	C		Treat skull fracture					
62005	C		Treat skull fracture					
62010	C		Treatment of head injury					
62100	C		Repair brain fluid leakage					
62115	C		Reduction of skull defect					
62116	C		Reduction of skull defect					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
62117	C		Reduction of skull defect					
62120	C		Repair skull cavity lesion					
62121	C		Incise skull repair					
62140	C		Repair of skull defect					
62141	C		Repair of skull defect					
62142	C		Remove skull plate/flap					
62143	C		Replace skull plate/flap					
62145	C		Repair of skull & brain					
62146	C		Repair of skull with graft					
62147	C		Repair of skull with graft					
62148	C		Retr bone flap to fix skull					
62160	C		Neuroendoscopy add-on					
62161	C		Dissect brain w/scope					
62162	C		Remove colloid cyst w/scope					
62163	C		Neuroendoscopy w/fb removal					
62164	C		Remove brain tumor w/scope					
62165	C		Remove pituit tumor w/scope					
62180	C		Establish brain cavity shunt					
62190	C		Establish brain cavity shunt					
62192	C		Establish brain cavity shunt					
62194	T		Replace/irrigate catheter	0121	2.2909	130.54	43.80	26.11
62200	C		Establish brain cavity shunt					
62201	C		Brain cavity shunt w/scope					
62220	C		Establish brain cavity shunt					
62223	C		Establish brain cavity shunt					
62225	T		Replace/irrigate catheter	0122	8.2869	472.21	96.84	94.44
62230	T		Replace/revise brain shunt	0224	38.8952	2216.37	453.41	443.27
62252	S		Csf shunt reprogram	0691	2.5289	144.10	64.84	28.82
62256	C		Remove brain cavity shunt					
62258	C		Replace brain cavity shunt					
62263	T		Epidural lysis mult sessions	0203	10.9230	622.43	272.25	124.49
62264	T		Epidural lysis on single day	0203	10.9230	622.43	272.25	124.49
62268	T		Drain spinal cord cyst	0212	2.9465	167.90	74.67	33.58
62269	T		Needle biopsy, spinal cord	0685	5.8806	335.09	115.47	67.02
62270	T		Spinal fluid tap, diagnostic	0204	2.1801	124.23	40.13	24.85
62272	T		Drain cerebro spinal fluid	0204	2.1801	124.23	40.13	24.85
62273	T		Inject epidural patch	0206	5.4311	309.48	75.55	61.90
62280	T		Treat spinal cord lesion	0207	5.8248	331.91	86.92	66.38
62281	T		Treat spinal cord lesion	0207	5.8248	331.91	86.92	66.38
62282	T		Treat spinal canal lesion	0207	5.8248	331.91	86.92	66.38
62284	N		Injection for myelogram					
62287	T		Percutaneous diskectomy	0221	28.7081	1635.87	463.62	327.17
62290	N		Inject for spine disk x-ray					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
62291	N		Inject for spine disk x-ray					
62292	T		Injection into disk lesion	0212	2.9465	167.90	74.67	33.58
62294	T		Injection into spinal artery	0212	2.9465	167.90	74.67	33.58
62310	T		Inject spine c/t	0207	5.8248	331.91	86.92	66.38
62311	T		Inject spine l/s (cd)	0207	5.8248	331.91	86.92	66.38
62318	T		Inject spine w/cath, c/t	0207	5.8248	331.91	86.92	66.38
62319	T		Inject spine w/cath l/s (cd)	0207	5.8248	331.91	86.92	66.38
62350	T		Implant spinal canal cath	0223	26.2731	1497.12		299.42
62351	T		Implant spinal canal cath	0208	42.5700	2425.77		485.15
62355	T		Remove spinal canal catheter	0203	10.9230	622.43	272.25	124.49
62360	T		Insert spine infusion device	0226	43.4005	2473.09		494.62
62361	T		Implant spine infusion pump	0227	150.3961	8570.02		1714.00
62362	T		Implant spine infusion pump	0227	150.3961	8570.02		1714.00
62365	T		Remove spine infusion device	0221	28.7081	1635.87	463.62	327.17
62367	S		Analyze spine infusion pump	0691	2.5289	144.10	64.84	28.82
62368	S		Analyze spine infusion pump	0691	2.5289	144.10	64.84	28.82
63001	T		Removal of spinal lamina	0208	42.5700	2425.77		485.15
63003	T		Removal of spinal lamina	0208	42.5700	2425.77		485.15
63005	T		Removal of spinal lamina	0208	42.5700	2425.77		485.15
63011	T		Removal of spinal lamina	0208	42.5700	2425.77		485.15
63012	T		Removal of spinal lamina	0208	42.5700	2425.77		485.15
63015	T		Removal of spinal lamina	0208	42.5700	2425.77		485.15
63016	T		Removal of spinal lamina	0208	42.5700	2425.77		485.15
63017	T		Removal of spinal lamina	0208	42.5700	2425.77		485.15
63020	T		Neck spine disk surgery	0208	42.5700	2425.77		485.15
63030	T		Low back disk surgery	0208	42.5700	2425.77		485.15
63035	T		Spinal disk surgery add-on	0208	42.5700	2425.77		485.15
63040	T		Laminotomy, single cervical	0208	42.5700	2425.77		485.15
63042	T		Laminotomy, single lumbar	0208	42.5700	2425.77		485.15
63043	C		Laminotomy, add'l cervical					
63044	C		Laminotomy, add'l lumbar					
63045	T		Removal of spinal lamina	0208	42.5700	2425.77		485.15
63046	T		Removal of spinal lamina	0208	42.5700	2425.77		485.15
63047	T		Removal of spinal lamina	0208	42.5700	2425.77		485.15
63048	T		Remove spinal lamina add-on	0208	42.5700	2425.77		485.15
63050	C	NI	Cervical laminoplasty					
63051	C	NI	C-laminoplasty w/graft/plate					
63055	T		Decompress spinal cord	0208	42.5700	2425.77		485.15
63056	T		Decompress spinal cord	0208	42.5700	2425.77		485.15
63057	T		Decompress spine cord add-on	0208	42.5700	2425.77		485.15
63064	T		Decompress spinal cord	0208	42.5700	2425.77		485.15
63066	T		Decompress spine cord add-on	0208	42.5700	2425.77		485.15
63075	C		Neck spine disk surgery					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
63076	C		Neck spine disk surgery					
63077	C		Spine disk surgery, thorax					
63078	C		Spine disk surgery, thorax					
63081	C		Removal of vertebral body					
63082	C		Remove vertebral body add-on					
63085	C		Removal of vertebral body					
63086	C		Remove vertebral body add-on					
63087	C		Removal of vertebral body					
63088	C		Remove vertebral body add-on					
63090	C		Removal of vertebral body					
63091	C		Remove vertebral body add-on					
63101	C		Removal of vertebral body					
63102	C		Removal of vertebral body					
63103	C		Remove vertebral body add-on					
63170	C		Incise spinal cord tract(s)					
63172	C		Drainage of spinal cyst					
63173	C		Drainage of spinal cyst					
63180	C		Revise spinal cord ligaments					
63182	C		Revise spinal cord ligaments					
63185	C		Incise spinal column/nerves					
63190	C		Incise spinal column/nerves					
63191	C		Incise spinal column/nerves					
63194	C		Incise spinal column & cord					
63195	C		Incise spinal column & cord					
63196	C		Incise spinal column & cord					
63197	C		Incise spinal column & cord					
63198	C		Incise spinal column & cord					
63199	C		Incise spinal column & cord					
63200	C		Release of spinal cord					
63250	C		Revise spinal cord vessels					
63251	C		Revise spinal cord vessels					
63252	C		Revise spinal cord vessels					
63265	C		Excise intraspinal lesion					
63266	C		Excise intraspinal lesion					
63267	C		Excise intraspinal lesion					
63268	C		Excise intraspinal lesion					
63270	C		Excise intraspinal lesion					
63271	C		Excise intraspinal lesion					
63272	C		Excise intraspinal lesion					
63273	C		Excise intraspinal lesion					
63275	C		Biopsy/excise spinal tumor					
63276	C		Biopsy/excise spinal tumor					
63277	C		Biopsy/excise spinal tumor					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
63278	C		Biopsy/excise spinal tumor		.	.	.	.
63280	C		Biopsy/excise spinal tumor		.	.	.	.
63281	C		Biopsy/excise spinal tumor		.	.	.	.
63282	C		Biopsy/excise spinal tumor		.	.	.	.
63283	C		Biopsy/excise spinal tumor		.	.	.	.
63285	C		Biopsy/excise spinal tumor		.	.	.	.
63286	C		Biopsy/excise spinal tumor		.	.	.	.
63287	C		Biopsy/excise spinal tumor		.	.	.	.
63290	C		Biopsy/excise spinal tumor		.	.	.	.
63295	C	NI	Repair of laminectomy defect		.	.	.	.
63300	C		Removal of vertebral body		.	.	.	.
63301	C		Removal of vertebral body		.	.	.	.
63302	C		Removal of vertebral body		.	.	.	.
63303	C		Removal of vertebral body		.	.	.	.
63304	C		Removal of vertebral body		.	.	.	.
63305	C		Removal of vertebral body		.	.	.	.
63306	C		Removal of vertebral body		.	.	.	.
63307	C		Removal of vertebral body		.	.	.	.
63308	C		Remove vertebral body add-on		.	.	.	.
63600	T		Remove spinal cord lesion	0220	17.2963	985.60	.	197.12
63610	T		Stimulation of spinal cord	0220	17.2963	985.60	.	197.12
63615	T		Remove lesion of spinal cord	0220	17.2963	985.60	.	197.12
63650	S		Implant neuroelectrodes	0040	49.2740	2807.78	.	561.56
63655	S		Implant neuroelectrodes	0225	210.5195	11996.03	.	2399.21
63660	T		Revise/remove neuroelectrode	0687	20.0762	1144.00	513.05	228.80
63685	T		Insrt/redo spine n generator	0222	217.1298	12372.71	.	2474.54
63688	T		Revise/remove neuroreceiver	0688	41.7281	2377.79	1070.00	475.56
63700	C		Repair of spinal herniation		.	.	.	.
63702	C		Repair of spinal herniation		.	.	.	.
63704	C		Repair of spinal herniation		.	.	.	.
63706	C		Repair of spinal herniation		.	.	.	.
63707	C		Repair spinal fluid leakage		.	.	.	.
63709	C		Repair spinal fluid leakage		.	.	.	.
63710	C		Graft repair of spine defect		.	.	.	.
63740	C		Install spinal shunt		.	.	.	.
63741	T		Install spinal shunt	0228	42.1332	2400.88	537.78	480.18
63744	T		Revision of spinal shunt	0228	42.1332	2400.88	537.78	480.18
63746	T		Removal of spinal shunt	0109	7.5181	428.40	131.49	85.68
64400	T		N block inj, trigeminal	0204	2.1801	124.23	40.13	24.85
64402	T		N block inj, facial	0204	2.1801	124.23	40.13	24.85
64405	T		N block inj, occipital	0204	2.1801	124.23	40.13	24.85
64408	T		N block inj, vagus	0204	2.1801	124.23	40.13	24.85
64410	T		N block inj, phrenic	0206	5.4311	309.48	75.55	61.90

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
64412	T		N block inj, spinal accessor	0206	5.4311	309.48	75.55	61.90
64413	T		N block inj, cervical plexus	0204	2.1801	124.23	40.13	24.85
64415	T		N block inj, brachial plexus	0204	2.1801	124.23	40.13	24.85
64416	T		N block cont infuse, b plex	0204	2.1801	124.23	40.13	24.85
64417	T		N block inj, axillary	0204	2.1801	124.23	40.13	24.85
64418	T		N block inj, suprascapular	0204	2.1801	124.23	40.13	24.85
64420	T		N block inj, intercost, sng	0204	2.1801	124.23	40.13	24.85
64421	T		N block inj, intercost, mlt	0206	5.4311	309.48	75.55	61.90
64425	T		N block inj, ilio-ing/hypogi	0204	2.1801	124.23	40.13	24.85
64430	T		N block inj, pudendal	0204	2.1801	124.23	40.13	24.85
64435	T		N block inj, paracervical	0204	2.1801	124.23	40.13	24.85
64445	T		N block inj, sciatic, sng	0204	2.1801	124.23	40.13	24.85
64446	T		N blk inj, sciatic, cont inf	0206	5.4311	309.48	75.55	61.90
64447	T		N block inj fem, single	0204	2.1801	124.23	40.13	24.85
64448	T		N block inj fem, cont inf	0204	2.1801	124.23	40.13	24.85
64449	T		N block inj, lumbar plexus	0204	2.1801	124.23	40.13	24.85
64450	T		N block, other peripheral	0204	2.1801	124.23	40.13	24.85
64470	T		Inj paravertebral c/t	0207	5.8248	331.91	86.92	66.38
64472	T		Inj paravertebral c/t add-on	0206	5.4311	309.48	75.55	61.90
64475	T		Inj paravertebral l/s	0207	5.8248	331.91	86.92	66.38
64476	T		Inj paravertebral l/s add-on	0206	5.4311	309.48	75.55	61.90
64479	T		Inj foramen epidural c/t	0207	5.8248	331.91	86.92	66.38
64480	T		Inj foramen epidural add-on	0207	5.8248	331.91	86.92	66.38
64483	T		Inj foramen epidural l/s	0207	5.8248	331.91	86.92	66.38
64484	T		Inj foramen epidural add-on	0207	5.8248	331.91	86.92	66.38
64505	T		N block, spenopalatine gangl	0204	2.1801	124.23	40.13	24.85
64508	T		N block, carotid sinus s/p	0204	2.1801	124.23	40.13	24.85
64510	T		N block, stellate ganglion	0207	5.8248	331.91	86.92	66.38
64517	T		N block inj, hypogas plxs	0204	2.1801	124.23	40.13	24.85
64520	T		N block, lumbar/thoracic	0207	5.8248	331.91	86.92	66.38
64530	T		N block inj, celiac pelus	0207	5.8248	331.91	86.92	66.38
64550	A		Apply neurostimulator					
64553	S		Implant neuroelectrodes	0225	210.5195	11996.03		2399.21
64555	S		Implant neuroelectrodes	0040	49.2740	2807.78		561.56
64560	S		Implant neuroelectrodes	0040	49.2740	2807.78		561.56
64561	S		Implant neuroelectrodes	0040	49.2740	2807.78		561.56
64565	S		Implant neuroelectrodes	0040	49.2740	2807.78		561.56
64573	S		Implant neuroelectrodes	0225	210.5195	11996.03		2399.21
64575	S		Implant neuroelectrodes	0040	49.2740	2807.78		561.56
64577	S		Implant neuroelectrodes	0225	210.5195	11996.03		2399.21
64580	S		Implant neuroelectrodes	0225	210.5195	11996.03		2399.21
64581	S		Implant neuroelectrodes	0040	49.2740	2807.78		561.56
64585	T		Revise/remove neuroelectrode	0687	20.0762	1144.00	513.05	228.80

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
64590	T		Insrt/redo perph n generator	0222	217.1298	12372.71		2474.54
64595	T		Revise/remove neuroreceiver	0688	41.7281	2377.79	1070.00	475.56
64600	T		Injection treatment of nerve	0203	10.9230	622.43	272.25	124.49
64605	T		Injection treatment of nerve	0203	10.9230	622.43	272.25	124.49
64610	T		Injection treatment of nerve	0203	10.9230	622.43	272.25	124.49
64612	T		Destroy nerve, face muscle	0204	2.1801	124.23	40.13	24.85
64613	T		Destroy nerve, spine muscle	0204	2.1801	124.23	40.13	24.85
64614	T		Destroy nerve, extrem musc	0204	2.1801	124.23	40.13	24.85
64620	T		Injection treatment of nerve	0203	10.9230	622.43	272.25	124.49
64622	T		Destr paravertebrl nerve l/s	0203	10.9230	622.43	272.25	124.49
64623	T		Destr paravertebral n add-on	0207	5.8248	331.91	86.92	66.38
64626	T		Destr paravertebrl nerve c/t	0203	10.9230	622.43	272.25	124.49
64627	T		Destr paravertebral n add-on	0207	5.8248	331.91	86.92	66.38
64630	T		Injection treatment of nerve	0206	5.4311	309.48	75.55	61.90
64640	T		Injection treatment of nerve	0206	5.4311	309.48	75.55	61.90
64680	T		Injection treatment of nerve	0207	5.8248	331.91	86.92	66.38
64681	T		Injection treatment of nerve	0203	10.9230	622.43	272.25	124.49
64702	T		Revise finger/toe nerve	0220	17.2963	985.60		197.12
64704	T		Revise hand/foot nerve	0220	17.2963	985.60		197.12
64708	T		Revise arm/leg nerve	0220	17.2963	985.60		197.12
64712	T		Revision of sciatic nerve	0220	17.2963	985.60		197.12
64713	T		Revision of arm nerve(s)	0220	17.2963	985.60		197.12
64714	T		Revise low back nerve(s)	0220	17.2963	985.60		197.12
64716	T		Revision of cranial nerve	0220	17.2963	985.60		197.12
64718	T		Revise ulnar nerve at elbow	0220	17.2963	985.60		197.12
64719	T		Revise ulnar nerve at wrist	0220	17.2963	985.60		197.12
64721	T		Carpal tunnel surgery	0220	17.2963	985.60		197.12
64722	T		Relieve pressure on nerve(s)	0220	17.2963	985.60		197.12
64726	T		Release foot/toe nerve	0220	17.2963	985.60		197.12
64727	T		Internal nerve revision	0220	17.2963	985.60		197.12
64732	T		Incision of brow nerve	0220	17.2963	985.60		197.12
64734	T		Incision of cheek nerve	0220	17.2963	985.60		197.12
64736	T		Incision of chin nerve	0220	17.2963	985.60		197.12
64738	T		Incision of jaw nerve	0220	17.2963	985.60		197.12
64740	T		Incision of tongue nerve	0220	17.2963	985.60		197.12
64742	T		Incision of facial nerve	0220	17.2963	985.60		197.12
64744	T		Incise nerve, back of head	0220	17.2963	985.60		197.12
64746	T		Incise diaphragm nerve	0220	17.2963	985.60		197.12
64752	C		Incision of vagus nerve					
64755	C		Incision of stomach nerves					
64760	C		Incision of vagus nerve					
64761	T		Incision of pelvis nerve	0220	17.2963	985.60		197.12
64763	C		Incise hip/thigh nerve					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
64766	C		Incise hip/thigh nerve					
64771	T		Sever cranial nerve	0220	17.2963	985.60		197.12
64772	T		Incision of spinal nerve	0220	17.2963	985.60		197.12
64774	T		Remove skin nerve lesion	0220	17.2963	985.60		197.12
64776	T		Remove digit nerve lesion	0220	17.2963	985.60		197.12
64778	T		Digit nerve surgery add-on	0220	17.2963	985.60		197.12
64782	T		Remove limb nerve lesion	0220	17.2963	985.60		197.12
64783	T		Limb nerve surgery add-on	0220	17.2963	985.60		197.12
64784	T		Remove nerve lesion	0220	17.2963	985.60		197.12
64786	T		Remove sciatic nerve lesion	0221	28.7081	1635.87	463.62	327.17
64787	T		Implant nerve end	0220	17.2963	985.60		197.12
64788	T		Remove skin nerve lesion	0220	17.2963	985.60		197.12
64790	T		Removal of nerve lesion	0220	17.2963	985.60		197.12
64792	T		Removal of nerve lesion	0221	28.7081	1635.87	463.62	327.17
64795	T		Biopsy of nerve	0220	17.2963	985.60		197.12
64802	T		Remove sympathetic nerves	0220	17.2963	985.60		197.12
64804	C		Remove sympathetic nerves					
64809	C		Remove sympathetic nerves					
64818	C		Remove sympathetic nerves					
64820	T		Remove sympathetic nerves	0220	17.2963	985.60		197.12
64821	T		Remove sympathetic nerves	0054	24.8731	1417.34		283.47
64822	T		Remove sympathetic nerves	0054	24.8731	1417.34		283.47
64823	T		Remove sympathetic nerves	0054	24.8731	1417.34		283.47
64831	T		Repair of digit nerve	0221	28.7081	1635.87	463.62	327.17
64832	T		Repair nerve add-on	0221	28.7081	1635.87	463.62	327.17
64834	T		Repair of hand or foot nerve	0221	28.7081	1635.87	463.62	327.17
64835	T		Repair of hand or foot nerve	0221	28.7081	1635.87	463.62	327.17
64836	T		Repair of hand or foot nerve	0221	28.7081	1635.87	463.62	327.17
64837	T		Repair nerve add-on	0221	28.7081	1635.87	463.62	327.17
64840	T		Repair of leg nerve	0221	28.7081	1635.87	463.62	327.17
64856	T		Repair/transpose nerve	0221	28.7081	1635.87	463.62	327.17
64857	T		Repair arm/leg nerve	0221	28.7081	1635.87	463.62	327.17
64858	T		Repair sciatic nerve	0221	28.7081	1635.87	463.62	327.17
64859	T		Nerve surgery	0221	28.7081	1635.87	463.62	327.17
64861	T		Repair of arm nerves	0221	28.7081	1635.87	463.62	327.17
64862	T		Repair of low back nerves	0221	28.7081	1635.87	463.62	327.17
64864	T		Repair of facial nerve	0221	28.7081	1635.87	463.62	327.17
64865	T		Repair of facial nerve	0221	28.7081	1635.87	463.62	327.17
64866	C		Fusion of facial/other nerve					
64868	C		Fusion of facial/other nerve					
64870	T		Fusion of facial/other nerve	0221	28.7081	1635.87	463.62	327.17
64872	T		Subsequent repair of nerve	0221	28.7081	1635.87	463.62	327.17
64874	T		Repair & revise nerve add-on	0221	28.7081	1635.87	463.62	327.17

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
64876	T		Repair nerve/shorten bone	0221	28.7081	1635.87	463.62	327.17
64885	T		Nerve graft, head or neck	0221	28.7081	1635.87	463.62	327.17
64886	T		Nerve graft, head or neck	0221	28.7081	1635.87	463.62	327.17
64890	T		Nerve graft, hand or foot	0221	28.7081	1635.87	463.62	327.17
64891	T		Nerve graft, hand or foot	0221	28.7081	1635.87	463.62	327.17
64892	T		Nerve graft, arm or leg	0221	28.7081	1635.87	463.62	327.17
64893	T		Nerve graft, arm or leg	0221	28.7081	1635.87	463.62	327.17
64895	T		Nerve graft, hand or foot	0221	28.7081	1635.87	463.62	327.17
64896	T		Nerve graft, hand or foot	0221	28.7081	1635.87	463.62	327.17
64897	T		Nerve graft, arm or leg	0221	28.7081	1635.87	463.62	327.17
64898	T		Nerve graft, arm or leg	0221	28.7081	1635.87	463.62	327.17
64901	T		Nerve graft add-on	0221	28.7081	1635.87	463.62	327.17
64902	T		Nerve graft add-on	0221	28.7081	1635.87	463.62	327.17
64905	T		Nerve pedicle transfer	0221	28.7081	1635.87	463.62	327.17
64907	T		Nerve pedicle transfer	0221	28.7081	1635.87	463.62	327.17
64999	T		Nervous system surgery	0204	2.1801	124.23	40.13	24.85
65091	T		Revise eye	0242	30.2444	1723.42	597.36	344.68
65093	T		Revise eye with implant	0241	23.5349	1341.09	384.47	268.22
65101	T		Removal of eye	0242	30.2444	1723.42	597.36	344.68
65103	T		Remove eye/insert implant	0242	30.2444	1723.42	597.36	344.68
65105	T		Remove eye/attach implant	0242	30.2444	1723.42	597.36	344.68
65110	T		Removal of eye	0242	30.2444	1723.42	597.36	344.68
65112	T		Remove eye/revise socket	0242	30.2444	1723.42	597.36	344.68
65114	T		Remove eye/revise socket	0242	30.2444	1723.42	597.36	344.68
65125	T		Revise ocular implant	0240	18.0715	1029.77	315.31	205.95
65130	T		Insert ocular implant	0241	23.5349	1341.09	384.47	268.22
65135	T		Insert ocular implant	0241	23.5349	1341.09	384.47	268.22
65140	T		Attach ocular implant	0242	30.2444	1723.42	597.36	344.68
65150	T		Revise ocular implant	0241	23.5349	1341.09	384.47	268.22
65155	T		Reinsert ocular implant	0242	30.2444	1723.42	597.36	344.68
65175	T		Removal of ocular implant	0240	18.0715	1029.77	315.31	205.95
65205	S		Remove foreign body from eye	0698	1.4649	83.47	18.72	16.69
65210	S		Remove foreign body from eye	0698	1.4649	83.47	18.72	16.69
65220	S		Remove foreign body from eye	0698	1.4649	83.47	18.72	16.69
65222	S		Remove foreign body from eye	0698	1.4649	83.47	18.72	16.69
65235	T		Remove foreign body from eye	0233	14.6847	836.78	266.33	167.36
65260	T		Remove foreign body from eye	0236	21.3506	1216.62		243.32
65265	T		Remove foreign body from eye	0236	21.3506	1216.62		243.32
65270	T		Repair of eye wound	0240	18.0715	1029.77	315.31	205.95
65272	T		Repair of eye wound	0234	22.1360	1261.38	511.31	252.28
65273	C		Repair of eye wound					
65275	T		Repair of eye wound	0234	22.1360	1261.38	511.31	252.28
65280	T		Repair of eye wound	0236	21.3506	1216.62		243.32

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
65285	T		Repair of eye wound	0236	21.3506	1216.62		243.32
65286	T		Repair of eye wound	0232	6.9120	393.87	103.17	78.77
65290	T		Repair of eye socket wound	0243	22.4844	1281.23	431.39	256.25
65400	T		Removal of eye lesion	0233	14.6847	836.78	266.33	167.36
65410	T		Biopsy of cornea	0233	14.6847	836.78	266.33	167.36
65420	T		Removal of eye lesion	0233	14.6847	836.78	266.33	167.36
65426	T		Removal of eye lesion	0234	22.1360	1261.38	511.31	252.28
65430	S		Corneal smear	0230	0.8019	45.69	14.97	9.14
65435	T		Curette/treat cornea	0239	6.7015	381.87		76.37
65436	T		Curette/treat cornea	0233	14.6847	836.78	266.33	167.36
65450	S		Treatment of corneal lesion	0231	2.0073	114.38	44.61	22.88
65600	T		Revision of cornea	0240	18.0715	1029.77	315.31	205.95
65710	T		Corneal transplant	0244	39.6990	2262.17	803.26	452.43
65730	T		Corneal transplant	0244	39.6990	2262.17	803.26	452.43
65750	T		Corneal transplant	0244	39.6990	2262.17	803.26	452.43
65755	T		Corneal transplant	0244	39.6990	2262.17	803.26	452.43
65760	E		Revision of cornea					
65765	E		Revision of cornea					
65767	E		Corneal tissue transplant					
65770	T		Revise cornea with implant	0244	39.6990	2262.17	803.26	452.43
65771	E		Radial keratotomy					
65772	T		Correction of astigmatism	0233	14.6847	836.78	266.33	167.36
65775	T		Correction of astigmatism	0233	14.6847	836.78	266.33	167.36
65780	T		Ocular reconst, transplant	0244	39.6990	2262.17	803.26	452.43
65781	T		Ocular reconst, transplant	0244	39.6990	2262.17	803.26	452.43
65782	T		Ocular reconst, transplant	0244	39.6990	2262.17	803.26	452.43
65800	T		Drainage of eye	0233	14.6847	836.78	266.33	167.36
65805	T		Drainage of eye	0233	14.6847	836.78	266.33	167.36
65810	T		Drainage of eye	0234	22.1360	1261.38	511.31	252.28
65815	T		Drainage of eye	0234	22.1360	1261.38	511.31	252.28
65820	T		Relieve inner eye pressure	0232	6.9120	393.87	103.17	78.77
65850	T		Incision of eye	0234	22.1360	1261.38	511.31	252.28
65855	T		Laser surgery of eye	0247	5.0892	290.00	104.31	58.00
65860	T		Incise inner eye adhesions	0247	5.0892	290.00	104.31	58.00
65865	T		Incise inner eye adhesions	0233	14.6847	836.78	266.33	167.36
65870	T		Incise inner eye adhesions	0234	22.1360	1261.38	511.31	252.28
65875	T		Incise inner eye adhesions	0234	22.1360	1261.38	511.31	252.28
65880	T		Incise inner eye adhesions	0233	14.6847	836.78	266.33	167.36
65900	T		Remove eye lesion	0233	14.6847	836.78	266.33	167.36
65920	T		Remove implant of eye	0234	22.1360	1261.38	511.31	252.28
65930	T		Remove blood clot from eye	0234	22.1360	1261.38	511.31	252.28
66020	T		Injection treatment of eye	0233	14.6847	836.78	266.33	167.36
66030	T		Injection treatment of eye	0232	6.9120	393.87	103.17	78.77

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
66130	T		Remove eye lesion	0234	22.1360	1261.38	511.31	252.28
66150	T		Glaucoma surgery	0234	22.1360	1261.38	511.31	252.28
66155	T		Glaucoma surgery	0234	22.1360	1261.38	511.31	252.28
66160	T		Glaucoma surgery	0234	22.1360	1261.38	511.31	252.28
66165	T		Glaucoma surgery	0234	22.1360	1261.38	511.31	252.28
66170	T		Glaucoma surgery	0234	22.1360	1261.38	511.31	252.28
66172	T		Incision of eye	0673	29.0816	1657.16	649.56	331.43
66180	T		Implant eye shunt	0673	29.0816	1657.16	649.56	331.43
66185	T		Revise eye shunt	0673	29.0816	1657.16	649.56	331.43
66220	T		Repair eye lesion	0236	21.3506	1216.62		243.32
66225	T		Repair/graft eye lesion	0673	29.0816	1657.16	649.56	331.43
66250	T		Follow-up surgery of eye	0233	14.6847	836.78	266.33	167.36
66500	T		Incision of iris	0232	6.9120	393.87	103.17	78.77
66505	T		Incision of iris	0232	6.9120	393.87	103.17	78.77
66600	T		Remove iris and lesion	0234	22.1360	1261.38	511.31	252.28
66605	T		Removal of iris	0234	22.1360	1261.38	511.31	252.28
66625	T		Removal of iris	0232	6.9120	393.87	103.17	78.77
66630	T		Removal of iris	0234	22.1360	1261.38	511.31	252.28
66635	T		Removal of iris	0234	22.1360	1261.38	511.31	252.28
66680	T		Repair iris & ciliary body	0234	22.1360	1261.38	511.31	252.28
66682	T		Repair iris & ciliary body	0234	22.1360	1261.38	511.31	252.28
66700	T		Destruction, ciliary body	0233	14.6847	836.78	266.33	167.36
66710	T		Ciliary transsleral therapy	0233	14.6847	836.78	266.33	167.36
66711	T	NI	Ciliary endoscopic ablation	0233	14.6847	836.78	266.33	167.36
66720	T		Destruction, ciliary body	0233	14.6847	836.78	266.33	167.36
66740	T		Destruction, ciliary body	0234	22.1360	1261.38	511.31	252.28
66761	T		Revision of iris	0247	5.0892	290.00	104.31	58.00
66762	T		Revision of iris	0247	5.0892	290.00	104.31	58.00
66770	T		Removal of inner eye lesion	0247	5.0892	290.00	104.31	58.00
66820	T		Incision, secondary cataract	0232	6.9120	393.87	103.17	78.77
66821	T		After cataract laser surgery	0247	5.0892	290.00	104.31	58.00
66825	T		Reposition intraocular lens	0234	22.1360	1261.38	511.31	252.28
66830	T		Removal of lens lesion	0232	6.9120	393.87	103.17	78.77
66840	T		Removal of lens material	0245	13.9367	794.15	222.22	158.83
66850	T		Removal of lens material	0249	28.4617	1621.83	524.67	324.37
66852	T		Removal of lens material	0249	28.4617	1621.83	524.67	324.37
66920	T		Extraction of lens	0249	28.4617	1621.83	524.67	324.37
66930	T		Extraction of lens	0249	28.4617	1621.83	524.67	324.37
66940	T		Extraction of lens	0245	13.9367	794.15	222.22	158.83
66982	T		Cataract surgery, complex	0246	23.3312	1329.48	495.96	265.90
66983	T		Cataract surg w/iol, 1 stage	0246	23.3312	1329.48	495.96	265.90
66984	T		Cataract surg w/iol, 1 stage	0246	23.3312	1329.48	495.96	265.90
66985	T		Insert lens prosthesis	0246	23.3312	1329.48	495.96	265.90

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
66986	T		Exchange lens prosthesis	0246	23.3312	1329.48	495.96	265.90
66990	N		Ophthalmic endoscope add-on					
66999	T		Eye surgery procedure	0232	6.9120	393.87	103.17	78.77
67005	T		Partial removal of eye fluid	0237	34.5277	1967.49	818.54	393.50
67010	T		Partial removal of eye fluid	0237	34.5277	1967.49	818.54	393.50
67015	T		Release of eye fluid	0237	34.5277	1967.49	818.54	393.50
67025	T		Replace eye fluid	0236	21.3506	1216.62		243.32
67027	T		Implant eye drug system	0237	34.5277	1967.49	818.54	393.50
67028	T		Injection eye drug	0235	5.1864	295.54	72.04	59.11
67030	T		Incise inner eye strands	0236	21.3506	1216.62		243.32
67031	T		Laser surgery, eye strands	0247	5.0892	290.00	104.31	58.00
67036	T		Removal of inner eye fluid	0237	34.5277	1967.49	818.54	393.50
67038	T		Strip retinal membrane	0237	34.5277	1967.49	818.54	393.50
67039	T		Laser treatment of retina	0237	34.5277	1967.49	818.54	393.50
67040	T		Laser treatment of retina	0672	39.9292	2275.29	988.43	455.06
67101	T		Repair detached retina	0235	5.1864	295.54	72.04	59.11
67105	T		Repair detached retina	0248	4.9276	280.79	95.08	56.16
67107	T		Repair detached retina	0672	39.9292	2275.29	988.43	455.06
67108	T		Repair detached retina	0672	39.9292	2275.29	988.43	455.06
67110	T		Repair detached retina	0236	21.3506	1216.62		243.32
67112	T		Rerepair detached retina	0672	39.9292	2275.29	988.43	455.06
67115	T		Release encircling material	0236	21.3506	1216.62		243.32
67120	T		Remove eye implant material	0236	21.3506	1216.62		243.32
67121	T		Remove eye implant material	0236	21.3506	1216.62		243.32
67141	T		Treatment of retina	0235	5.1864	295.54	72.04	59.11
67145	T		Treatment of retina	0248	4.9276	280.79	95.08	56.16
67208	T		Treatment of retinal lesion	0235	5.1864	295.54	72.04	59.11
67210	T		Treatment of retinal lesion	0248	4.9276	280.79	95.08	56.16
67218	T		Treatment of retinal lesion	0236	21.3506	1216.62		243.32
67220	T		Treatment of choroid lesion	0235	5.1864	295.54	72.04	59.11
67221	T		Ocular photodynamic ther	0235	5.1864	295.54	72.04	59.11
67225	T		Eye photodynamic ther add-on	0235	5.1864	295.54	72.04	59.11
67227	T		Treatment of retinal lesion	0235	5.1864	295.54	72.04	59.11
67228	T		Treatment of retinal lesion	0248	4.9276	280.79	95.08	56.16
67250	T		Reinforce eye wall	0240	18.0715	1029.77	315.31	205.95
67255	T		Reinforce/graft eye wall	0237	34.5277	1967.49	818.54	393.50
67299	T		Eye surgery procedure	0235	5.1864	295.54	72.04	59.11
67311	T		Revise eye muscle	0243	22.4844	1281.23	431.39	256.25
67312	T		Revise two eye muscles	0243	22.4844	1281.23	431.39	256.25
67314	T		Revise eye muscle	0243	22.4844	1281.23	431.39	256.25
67316	T		Revise two eye muscles	0243	22.4844	1281.23	431.39	256.25
67318	T		Revise eye muscle(s)	0243	22.4844	1281.23	431.39	256.25
67320	T		Revise eye muscle(s) add-on	0243	22.4844	1281.23	431.39	256.25

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
67331	T		Eye surgery follow-up add-on	0243	22.4844	1281.23	431.39	256.25
67332	T		Rerevise eye muscles add-on	0243	22.4844	1281.23	431.39	256.25
67334	T		Revise eye muscle w/suture	0243	22.4844	1281.23	431.39	256.25
67335	T		Eye suture during surgery	0243	22.4844	1281.23	431.39	256.25
67340	T		Revise eye muscle add-on	0243	22.4844	1281.23	431.39	256.25
67343	T		Release eye tissue	0243	22.4844	1281.23	431.39	256.25
67345	T		Destroy nerve of eye muscle	0238	2.9594	168.64		33.73
67350	T		Biopsy eye muscle	0699	9.7041	552.97		110.59
67399	T		Eye muscle surgery procedure	0243	22.4844	1281.23	431.39	256.25
67400	T		Explore/biopsy eye socket	0241	23.5349	1341.09	384.47	268.22
67405	T		Explore/drain eye socket	0241	23.5349	1341.09	384.47	268.22
67412	T		Explore/treat eye socket	0241	23.5349	1341.09	384.47	268.22
67413	T		Explore/treat eye socket	0241	23.5349	1341.09	384.47	268.22
67414	T		Explr/decompress eye socket	0242	30.2444	1723.42	597.36	344.68
67415	T		Aspiration, orbital contents	0240	18.0715	1029.77	315.31	205.95
67420	T		Explore/treat eye socket	0242	30.2444	1723.42	597.36	344.68
67430	T		Explore/treat eye socket	0242	30.2444	1723.42	597.36	344.68
67440	T		Explore/drain eye socket	0242	30.2444	1723.42	597.36	344.68
67445	T		Explr/decompress eye socket	0242	30.2444	1723.42	597.36	344.68
67450	T		Explore/biopsy eye socket	0242	30.2444	1723.42	597.36	344.68
67500	S		Inject/treat eye socket	0231	2.0073	114.38	44.61	22.88
67505	T		Inject/treat eye socket	0238	2.9594	168.64		33.73
67515	T		Inject/treat eye socket	0238	2.9594	168.64		33.73
67550	T		Insert eye socket implant	0242	30.2444	1723.42	597.36	344.68
67560	T		Revise eye socket implant	0241	23.5349	1341.09	384.47	268.22
67570	T		Decompress optic nerve	0242	30.2444	1723.42	597.36	344.68
67599	T		Orbit surgery procedure	0238	2.9594	168.64		33.73
67700	T		Drainage of eyelid abscess	0238	2.9594	168.64		33.73
67710	T		Incision of eyelid	0239	6.7015	381.87		76.37
67715	T		Incision of eyelid fold	0240	18.0715	1029.77	315.31	205.95
67800	T		Remove eyelid lesion	0238	2.9594	168.64		33.73
67801	T		Remove eyelid lesions	0239	6.7015	381.87		76.37
67805	T		Remove eyelid lesions	0238	2.9594	168.64		33.73
67808	T		Remove eyelid lesion(s)	0240	18.0715	1029.77	315.31	205.95
67810	T		Biopsy of eyelid	0238	2.9594	168.64		33.73
67820	S		Revise eyelashes	0698	1.4649	83.47	18.72	16.69
67825	T		Revise eyelashes	0238	2.9594	168.64		33.73
67830	T		Revise eyelashes	0239	6.7015	381.87		76.37
67835	T		Revise eyelashes	0240	18.0715	1029.77	315.31	205.95
67840	T		Remove eyelid lesion	0239	6.7015	381.87		76.37
67850	T		Treat eyelid lesion	0239	6.7015	381.87		76.37
67875	T		Closure of eyelid by suture	0239	6.7015	381.87		76.37
67880	T		Revision of eyelid	0233	14.6847	836.78	266.33	167.36

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
67882	T		Revision of eyelid	0240	18.0715	1029.77	315.31	205.95
67900	T		Repair brow defect	0240	18.0715	1029.77	315.31	205.95
67901	T		Repair eyelid defect	0240	18.0715	1029.77	315.31	205.95
67902	T		Repair eyelid defect	0240	18.0715	1029.77	315.31	205.95
67903	T		Repair eyelid defect	0240	18.0715	1029.77	315.31	205.95
67904	T		Repair eyelid defect	0240	18.0715	1029.77	315.31	205.95
67906	T		Repair eyelid defect	0240	18.0715	1029.77	315.31	205.95
67908	T		Repair eyelid defect	0240	18.0715	1029.77	315.31	205.95
67909	T		Revise eyelid defect	0240	18.0715	1029.77	315.31	205.95
67911	T		Revise eyelid defect	0240	18.0715	1029.77	315.31	205.95
67912	T		Correction eyelid w/implant	0239	6.7015	381.87		76.37
67914	T		Repair eyelid defect	0240	18.0715	1029.77	315.31	205.95
67915	T		Repair eyelid defect	0239	6.7015	381.87		76.37
67916	T		Repair eyelid defect	0240	18.0715	1029.77	315.31	205.95
67917	T		Repair eyelid defect	0240	18.0715	1029.77	315.31	205.95
67921	T		Repair eyelid defect	0240	18.0715	1029.77	315.31	205.95
67922	T		Repair eyelid defect	0240	18.0715	1029.77	315.31	205.95
67923	T		Repair eyelid defect	0240	18.0715	1029.77	315.31	205.95
67924	T		Repair eyelid defect	0240	18.0715	1029.77	315.31	205.95
67930	T		Repair eyelid wound	0240	18.0715	1029.77	315.31	205.95
67935	T		Repair eyelid wound	0240	18.0715	1029.77	315.31	205.95
67938	S		Remove eyelid foreign body	0698	1.4649	83.47	18.72	16.69
67950	T		Revision of eyelid	0240	18.0715	1029.77	315.31	205.95
67961	T		Revision of eyelid	0240	18.0715	1029.77	315.31	205.95
67966	T		Revision of eyelid	0240	18.0715	1029.77	315.31	205.95
67971	T		Reconstruction of eyelid	0241	23.5349	1341.09	384.47	268.22
67973	T		Reconstruction of eyelid	0241	23.5349	1341.09	384.47	268.22
67974	T		Reconstruction of eyelid	0241	23.5349	1341.09	384.47	268.22
67975	T		Reconstruction of eyelid	0240	18.0715	1029.77	315.31	205.95
67999	T		Revision of eyelid	0238	2.9594	168.64		33.73
68020	T		Incise/drain eyelid lining	0240	18.0715	1029.77	315.31	205.95
68040	S		Treatment of eyelid lesions	0698	1.4649	83.47	18.72	16.69
68100	T		Biopsy of eyelid lining	0232	6.9120	393.87	103.17	78.77
68110	T		Remove eyelid lining lesion	0699	9.7041	552.97		110.59
68115	T		Remove eyelid lining lesion	0240	18.0715	1029.77	315.31	205.95
68130	T		Remove eyelid lining lesion	0233	14.6847	836.78	266.33	167.36
68135	T		Remove eyelid lining lesion	0239	6.7015	381.87		76.37
68200	S		Treat eyelid by injection	0230	0.8019	45.69	14.97	9.14
68320	T		Revise/graft eyelid lining	0240	18.0715	1029.77	315.31	205.95
68325	T		Revise/graft eyelid lining	0242	30.2444	1723.42	597.36	344.68
68326	T		Revise/graft eyelid lining	0241	23.5349	1341.09	384.47	268.22
68328	T		Revise/graft eyelid lining	0241	23.5349	1341.09	384.47	268.22
68330	T		Revise eyelid lining	0234	22.1360	1261.38	511.31	252.28

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
68335	T		Revise/graft eyelid lining	0241	23.5349	1341.09	384.47	268.22
68340	T		Separate eyelid adhesions	0240	18.0715	1029.77	315.31	205.95
68360	T		Revise eyelid lining	0234	22.1360	1261.38	511.31	252.28
68362	T		Revise eyelid lining	0234	22.1360	1261.38	511.31	252.28
68371	T		Harvest eye tissue, alograft	0233	14.6847	836.78	266.33	167.36
68399	T		Eyelid lining surgery	0238	2.9594	168.64		33.73
68400	T		Incise/drain tear gland	0238	2.9594	168.64		33.73
68420	T		Incise/drain tear sac	0240	18.0715	1029.77	315.31	205.95
68440	T		Incise tear duct opening	0238	2.9594	168.64		33.73
68500	T		Removal of tear gland	0241	23.5349	1341.09	384.47	268.22
68505	T		Partial removal, tear gland	0241	23.5349	1341.09	384.47	268.22
68510	T		Biopsy of tear gland	0240	18.0715	1029.77	315.31	205.95
68520	T		Removal of tear sac	0241	23.5349	1341.09	384.47	268.22
68525	T		Biopsy of tear sac	0240	18.0715	1029.77	315.31	205.95
68530	T		Clearance of tear duct	0240	18.0715	1029.77	315.31	205.95
68540	T		Remove tear gland lesion	0241	23.5349	1341.09	384.47	268.22
68550	T		Remove tear gland lesion	0242	30.2444	1723.42	597.36	344.68
68700	T		Repair tear ducts	0241	23.5349	1341.09	384.47	268.22
68705	T		Revise tear duct opening	0238	2.9594	168.64		33.73
68720	T		Create tear sac drain	0242	30.2444	1723.42	597.36	344.68
68745	T		Create tear duct drain	0241	23.5349	1341.09	384.47	268.22
68750	T		Create tear duct drain	0242	30.2444	1723.42	597.36	344.68
68760	S		Close tear duct opening	0698	1.4649	83.47	18.72	16.69
68761	S		Close tear duct opening	0231	2.0073	114.38	44.61	22.88
68770	T		Close tear system fistula	0240	18.0715	1029.77	315.31	205.95
68801	S		Dilate tear duct opening	0698	1.4649	83.47	18.72	16.69
68810	T		Probe nasolacrimal duct	0699	9.7041	552.97		110.59
68811	T		Probe nasolacrimal duct	0240	18.0715	1029.77	315.31	205.95
68815	T		Probe nasolacrimal duct	0240	18.0715	1029.77	315.31	205.95
68840	S		Explore/irrigate tear ducts	0231	2.0073	114.38	44.61	22.88
68850	N		Injection for tear sac x-ray					
68899	S		Tear duct system surgery	0230	0.8019	45.69	14.97	9.14
69000	T		Drain external ear lesion	0006	1.6854	96.04	23.26	19.21
69005	T		Drain external ear lesion	0007	12.4496	709.42		141.88
69020	T		Drain outer ear canal lesion	0006	1.6854	96.04	23.26	19.21
69090	E		Pierce earlobes					
69100	T		Biopsy of external ear	0019	4.1677	237.49	71.87	47.50
69105	T		Biopsy of external ear canal	0253	15.9877	911.03	282.29	182.21
69110	T		Remove external ear, partial	0021	14.8872	848.32	219.48	169.66
69120	T		Removal of external ear	0254	23.3442	1330.22	321.35	266.04
69140	T		Remove ear canal lesion(s)	0254	23.3442	1330.22	321.35	266.04
69145	T		Remove ear canal lesion(s)	0021	14.8872	848.32	219.48	169.66
69150	T		Extensive ear canal surgery	0252	6.5183	371.43	113.41	74.29

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
69155	C		Extensive ear/neck surgery					
69200	X		Clear outer ear canal	0340	0.6328	36.06		7.21
69205	T		Clear outer ear canal	0022	19.3700	1103.76	354.45	220.75
69210	X		Remove impacted ear wax	0340	0.6328	36.06		7.21
69220	T		Clean out mastoid cavity	0012	0.7477	42.61	11.18	8.52
69222	T		Clean out mastoid cavity	0253	15.9877	911.03	282.29	182.21
69300	T		Revise external ear	0254	23.3442	1330.22	321.35	266.04
69310	T		Rebuild outer ear canal	0256	36.9298	2104.37		420.87
69320	T		Rebuild outer ear canal	0256	36.9298	2104.37		420.87
69399	T		Outer ear surgery procedure	0251	1.9352	110.27		22.05
69400	T		Inflate middle ear canal	0251	1.9352	110.27		22.05
69401	T		Inflate middle ear canal	0251	1.9352	110.27		22.05
69405	T		Catheterize middle ear canal	0252	6.5183	371.43	113.41	74.29
69410	T		Inset middle ear (baffle)	0251	1.9352	110.27		22.05
69420	T		Incision of eardrum	0252	6.5183	371.43	113.41	74.29
69421	T		Incision of eardrum	0253	15.9877	911.03	282.29	182.21
69424	T		Remove ventilating tube	0252	6.5183	371.43	113.41	74.29
69433	T		Create eardrum opening	0252	6.5183	371.43	113.41	74.29
69436	T		Create eardrum opening	0253	15.9877	911.03	282.29	182.21
69440	T		Exploration of middle ear	0254	23.3442	1330.22	321.35	266.04
69450	T		Eardrum revision	0256	36.9298	2104.37		420.87
69501	T		Mastoidectomy	0256	36.9298	2104.37		420.87
69502	T		Mastoidectomy	0254	23.3442	1330.22	321.35	266.04
69505	T		Remove mastoid structures	0256	36.9298	2104.37		420.87
69511	T		Extensive mastoid surgery	0256	36.9298	2104.37		420.87
69530	T		Extensive mastoid surgery	0256	36.9298	2104.37		420.87
69535	C		Remove part of temporal bone					
69540	T		Remove ear lesion	0253	15.9877	911.03	282.29	182.21
69550	T		Remove ear lesion	0256	36.9298	2104.37		420.87
69552	T		Remove ear lesion	0256	36.9298	2104.37		420.87
69554	C		Remove ear lesion					
69601	T		Mastoid surgery revision	0256	36.9298	2104.37		420.87
69602	T		Mastoid surgery revision	0256	36.9298	2104.37		420.87
69603	T		Mastoid surgery revision	0256	36.9298	2104.37		420.87
69604	T		Mastoid surgery revision	0256	36.9298	2104.37		420.87
69605	T		Mastoid surgery revision	0256	36.9298	2104.37		420.87
69610	T		Repair of eardrum	0254	23.3442	1330.22	321.35	266.04
69620	T		Repair of eardrum	0254	23.3442	1330.22	321.35	266.04
69631	T		Repair eardrum structures	0256	36.9298	2104.37		420.87
69632	T		Rebuild eardrum structures	0256	36.9298	2104.37		420.87
69633	T		Rebuild eardrum structures	0256	36.9298	2104.37		420.87
69635	T		Repair eardrum structures	0256	36.9298	2104.37		420.87
69636	T		Rebuild eardrum structures	0256	36.9298	2104.37		420.87

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
69637	T		Rebuild eardrum structures	0256	36.9298	2104.37		420.87
69641	T		Revise middle ear & mastoid	0256	36.9298	2104.37		420.87
69642	T		Revise middle ear & mastoid	0256	36.9298	2104.37		420.87
69643	T		Revise middle ear & mastoid	0256	36.9298	2104.37		420.87
69644	T		Revise middle ear & mastoid	0256	36.9298	2104.37		420.87
69645	T		Revise middle ear & mastoid	0256	36.9298	2104.37		420.87
69646	T		Revise middle ear & mastoid	0256	36.9298	2104.37		420.87
69650	T		Release middle ear bone	0254	23.3442	1330.22	321.35	266.04
69660	T		Revise middle ear bone	0256	36.9298	2104.37		420.87
69661	T		Revise middle ear bone	0256	36.9298	2104.37		420.87
69662	T		Revise middle ear bone	0256	36.9298	2104.37		420.87
69666	T		Repair middle ear structures	0256	36.9298	2104.37		420.87
69667	T		Repair middle ear structures	0256	36.9298	2104.37		420.87
69670	T		Remove mastoid air cells	0256	36.9298	2104.37		420.87
69676	T		Remove middle ear nerve	0256	36.9298	2104.37		420.87
69700	T		Close mastoid fistula	0256	36.9298	2104.37		420.87
69710	E		Implant/replace hearing aid					
69711	T		Remove/repair hearing aid	0256	36.9298	2104.37		420.87
69714	T		Implant temple bone w/stimul	0256	36.9298	2104.37		420.87
69715	T		Temple bne implnt w/stimulat	0256	36.9298	2104.37		420.87
69717	T		Temple bone implant revision	0256	36.9298	2104.37		420.87
69718	T		Revise temple bone implant	0256	36.9298	2104.37		420.87
69720	T		Release facial nerve	0256	36.9298	2104.37		420.87
69725	T		Release facial nerve	0256	36.9298	2104.37		420.87
69740	T		Repair facial nerve	0256	36.9298	2104.37		420.87
69745	T		Repair facial nerve	0256	36.9298	2104.37		420.87
69799	T		Middle ear surgery procedure	0251	1.9352	110.27		22.05
69801	T		Incise inner ear	0256	36.9298	2104.37		420.87
69802	T		Incise inner ear	0256	36.9298	2104.37		420.87
69805	T		Explore inner ear	0256	36.9298	2104.37		420.87
69806	T		Explore inner ear	0256	36.9298	2104.37		420.87
69820	T		Establish inner ear window	0256	36.9298	2104.37		420.87
69840	T		Revise inner ear window	0256	36.9298	2104.37		420.87
69905	T		Remove inner ear	0256	36.9298	2104.37		420.87
69910	T		Remove inner ear & mastoid	0256	36.9298	2104.37		420.87
69915	T		Incise inner ear nerve	0256	36.9298	2104.37		420.87
69930	T		Implant cochlear device	0259	444.1223	25307.42	9394.83	5061.48
69949	T		Inner ear surgery procedure	0251	1.9352	110.27		22.05
69950	C		Incise inner ear nerve					
69955	T		Release facial nerve	0256	36.9298	2104.37		420.87
69960	T		Release inner ear canal	0256	36.9298	2104.37		420.87
69970	C		Remove inner ear lesion					
69979	T		Temporal bone surgery	0251	1.9352	110.27		22.05

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
69990	N		Microsurgery add-on					
70010	S		Contrast x-ray of brain	0274	3.2901	187.48	84.36	37.50
70015	S		Contrast x-ray of brain	0274	3.2901	187.48	84.36	37.50
70030	X		X-ray eye for foreign body	0260	0.7698	43.87	19.74	8.77
70100	X		X-ray exam of jaw	0260	0.7698	43.87	19.74	8.77
70110	X		X-ray exam of jaw	0260	0.7698	43.87	19.74	8.77
70120	X		X-ray exam of mastoids	0260	0.7698	43.87	19.74	8.77
70130	X		X-ray exam of mastoids	0260	0.7698	43.87	19.74	8.77
70134	X		X-ray exam of middle ear	0261	1.3351	76.08		15.22
70140	X		X-ray exam of facial bones	0260	0.7698	43.87	19.74	8.77
70150	X		X-ray exam of facial bones	0260	0.7698	43.87	19.74	8.77
70160	X		X-ray exam of nasal bones	0260	0.7698	43.87	19.74	8.77
70170	X		X-ray exam of tear duct	0264	3.4194	194.85	79.41	38.97
70190	X		X-ray exam of eye sockets	0260	0.7698	43.87	19.74	8.77
70200	X		X-ray exam of eye sockets	0260	0.7698	43.87	19.74	8.77
70210	X		X-ray exam of sinuses	0260	0.7698	43.87	19.74	8.77
70220	X		X-ray exam of sinuses	0260	0.7698	43.87	19.74	8.77
70240	X		X-ray exam, pituitary saddle	0260	0.7698	43.87	19.74	8.77
70250	X		X-ray exam of skull	0260	0.7698	43.87	19.74	8.77
70260	X		X-ray exam of skull	0261	1.3351	76.08		15.22
70300	X		X-ray exam of teeth	0262	1.4556	82.94		16.59
70310	X		X-ray exam of teeth	0262	1.4556	82.94		16.59
70320	X		Full mouth x-ray of teeth	0262	1.4556	82.94		16.59
70328	X		X-ray exam of jaw joint	0260	0.7698	43.87	19.74	8.77
70330	X		X-ray exam of jaw joints	0260	0.7698	43.87	19.74	8.77
70332	S		X-ray exam of jaw joint	0275	3.5084	199.92	69.09	39.98
70336	S		Magnetic image, jaw joint	0335	6.0472	344.59	150.64	68.92
70350	X		X-ray head for orthodontia	0260	0.7698	43.87	19.74	8.77
70355	X		Panoramic x-ray of jaws	0260	0.7698	43.87	19.74	8.77
70360	X		X-ray exam of neck	0260	0.7698	43.87	19.74	8.77
70370	X		Throat x-ray & fluoroscopy	0272	1.3880	79.09	35.59	15.82
70371	X		Speech evaluation, complex	0272	1.3880	79.09	35.59	15.82
70373	X		Contrast x-ray of larynx	0263	1.8514	105.50	38.51	21.10
70380	X		X-ray exam of salivary gland	0260	0.7698	43.87	19.74	8.77
70390	X		X-ray exam of salivary duct	0263	1.8514	105.50	38.51	21.10
70450	S		Ct head/brain w/o dye	0332	3.3910	193.23	86.95	38.65
70460	S		Ct head/brain w/dye	0283	4.7485	270.58	121.76	54.12
70470	S		Ct head/brain w/o & w/dye	0333	5.6225	320.39	144.17	64.08
70480	S		Ct orbit/ear/fossa w/o dye	0332	3.3910	193.23	86.95	38.65
70481	S		Ct orbit/ear/fossa w/dye	0283	4.7485	270.58	121.76	54.12
70482	S		Ct orbit/ear/fossa w/o&w/dye	0333	5.6225	320.39	144.17	64.08
70486	S		Ct maxillofacial w/o dye	0332	3.3910	193.23	86.95	38.65
70487	S		Ct maxillofacial w/dye	0283	4.7485	270.58	121.76	54.12

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
70488	S		Ct maxillofacial w/o & w/dye	0333	5.6225	320.39	144.17	64.08
70490	S		Ct soft tissue neck w/o dye	0332	3.3910	193.23	86.95	38.65
70491	S		Ct soft tissue neck w/dye	0283	4.7485	270.58	121.76	54.12
70492	S		Ct sft tsue nck w/o & w/dye	0333	5.6225	320.39	144.17	64.08
70496	S		Ct angiography, head	0662	5.6204	320.27	144.12	64.05
70498	S		Ct angiography, neck	0662	5.6204	320.27	144.12	64.05
70540	S		Mri orbit/face/neck w/o dye	0336	6.3150	359.85	161.93	71.97
70542	S		Mri orbit/face/neck w/dye	0284	6.7851	386.64	173.98	77.33
70543	S		Mri orbt/fac/nck w/o & w/dye	0337	9.1701	522.54	235.14	104.51
70544	S		Mr angiography head w/o dye	0336	6.3150	359.85	161.93	71.97
70545	S		Mr angiography head w/dye	0284	6.7851	386.64	173.98	77.33
70546	S		Mr angiograph head w/o&w/dye	0337	9.1701	522.54	235.14	104.51
70547	S		Mr angiography neck w/o dye	0336	6.3150	359.85	161.93	71.97
70548	S		Mr angiography neck w/dye	0284	6.7851	386.64	173.98	77.33
70549	S		Mr angiograph neck w/o&w/dye	0337	9.1701	522.54	235.14	104.51
70551	S		Mri brain w/o dye	0336	6.3150	359.85	161.93	71.97
70552	S		Mri brain w/dye	0284	6.7851	386.64	173.98	77.33
70553	S		Mri brain w/o & w/dye	0337	9.1701	522.54	235.14	104.51
70557	S		Mri brain w/o dye	0336	6.3150	359.85	161.93	71.97
70558	S		Mri brain w/dye	0284	6.7851	386.64	173.98	77.33
70559	S		Mri brain w/o & w/dye	0337	9.1701	522.54	235.14	104.51
71010	X		Chest x-ray	0260	0.7698	43.87	19.74	8.77
71015	X		Chest x-ray	0260	0.7698	43.87	19.74	8.77
71020	X		Chest x-ray	0260	0.7698	43.87	19.74	8.77
71021	X		Chest x-ray	0260	0.7698	43.87	19.74	8.77
71022	X		Chest x-ray	0260	0.7698	43.87	19.74	8.77
71023	X		Chest x-ray and fluoroscopy	0272	1.3880	79.09	35.59	15.82
71030	X		Chest x-ray	0260	0.7698	43.87	19.74	8.77
71034	X		Chest x-ray and fluoroscopy	0272	1.3880	79.09	35.59	15.82
71035	X		Chest x-ray	0260	0.7698	43.87	19.74	8.77
71040	X		Contrast x-ray of bronchi	0263	1.8514	105.50	38.51	21.10
71060	X		Contrast x-ray of bronchi	0263	1.8514	105.50	38.51	21.10
71090	X		X-ray & pacemaker insertion	0272	1.3880	79.09	35.59	15.82
71100	X		X-ray exam of ribs	0260	0.7698	43.87	19.74	8.77
71101	X		X-ray exam of ribs/chest	0260	0.7698	43.87	19.74	8.77
71110	X		X-ray exam of ribs	0260	0.7698	43.87	19.74	8.77
71111	X		X-ray exam of ribs/chest	0261	1.3351	76.08		15.22
71120	X		X-ray exam of breastbone	0260	0.7698	43.87	19.74	8.77
71130	X		X-ray exam of breastbone	0260	0.7698	43.87	19.74	8.77
71250	S		Ct thorax w/o dye	0332	3.3910	193.23	86.95	38.65
71260	S		Ct thorax w/dye	0283	4.7485	270.58	121.76	54.12
71270	S		Ct thorax w/o & w/dye	0333	5.6225	320.39	144.17	64.08
71275	S		Ct angiography, chest	0662	5.6204	320.27	144.12	64.05

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71550	S		Mri chest w/o dye	0336	6.3150	359.85	161.93	71.97
71551	S		Mri chest w/dye	0284	6.7851	386.64	173.98	77.33
71552	S		Mri chest w/o & w/dye	0337	9.1701	522.54	235.14	104.51
71555	B		Mri angio chest w or w/o dye					
72010	X		X-ray exam of spine	0261	1.3351	76.08		15.22
72020	X		X-ray exam of spine	0260	0.7698	43.87	19.74	8.77
72040	X		X-ray exam of neck spine	0260	0.7698	43.87	19.74	8.77
72050	X		X-ray exam of neck spine	0261	1.3351	76.08		15.22
72052	X		X-ray exam of neck spine	0261	1.3351	76.08		15.22
72069	X		X-ray exam of trunk spine	0260	0.7698	43.87	19.74	8.77
72070	X		X-ray exam of thoracic spine	0260	0.7698	43.87	19.74	8.77
72072	X		X-ray exam of thoracic spine	0260	0.7698	43.87	19.74	8.77
72074	X		X-ray exam of thoracic spine	0260	0.7698	43.87	19.74	8.77
72080	X		X-ray exam of trunk spine	0260	0.7698	43.87	19.74	8.77
72090	X		X-ray exam of trunk spine	0261	1.3351	76.08		15.22
72100	X		X-ray exam of lower spine	0260	0.7698	43.87	19.74	8.77
72110	X		X-ray exam of lower spine	0261	1.3351	76.08		15.22
72114	X		X-ray exam of lower spine	0261	1.3351	76.08		15.22
72120	X		X-ray exam of lower spine	0260	0.7698	43.87	19.74	8.77
72125	S		Ct neck spine w/o dye	0332	3.3910	193.23	86.95	38.65
72126	S		Ct neck spine w/dye	0283	4.7485	270.58	121.76	54.12
72127	S		Ct neck spine w/o & w/dye	0333	5.6225	320.39	144.17	64.08
72128	S		Ct chest spine w/o dye	0332	3.3910	193.23	86.95	38.65
72129	S		Ct chest spine w/dye	0283	4.7485	270.58	121.76	54.12
72130	S		Ct chest spine w/o & w/dye	0333	5.6225	320.39	144.17	64.08
72131	S		Ct lumbar spine w/o dye	0332	3.3910	193.23	86.95	38.65
72132	S		Ct lumbar spine w/dye	0283	4.7485	270.58	121.76	54.12
72133	S		Ct lumbar spine w/o & w/dye	0333	5.6225	320.39	144.17	64.08
72141	S		Mri neck spine w/o dye	0336	6.3150	359.85	161.93	71.97
72142	S		Mri neck spine w/dye	0284	6.7851	386.64	173.98	77.33
72146	S		Mri chest spine w/o dye	0336	6.3150	359.85	161.93	71.97
72147	S		Mri chest spine w/dye	0284	6.7851	386.64	173.98	77.33
72148	S		Mri lumbar spine w/o dye	0336	6.3150	359.85	161.93	71.97
72149	S		Mri lumbar spine w/dye	0284	6.7851	386.64	173.98	77.33
72156	S		Mri neck spine w/o & w/dye	0337	9.1701	522.54	235.14	104.51
72157	S		Mri chest spine w/o & w/dye	0337	9.1701	522.54	235.14	104.51
72158	S		Mri lumbar spine w/o & w/dye	0337	9.1701	522.54	235.14	104.51
72159	E		Mr angio spine w/o&w/dye					
72170	X		X-ray exam of pelvis	0260	0.7698	43.87	19.74	8.77
72190	X		X-ray exam of pelvis	0260	0.7698	43.87	19.74	8.77
72191	S		Ct angiograph pelv w/o&w/dye	0662	5.6204	320.27	144.12	64.05
72192	S		Ct pelvis w/o dye	0332	3.3910	193.23	86.95	38.65
72193	S		Ct pelvis w/dye	0283	4.7485	270.58	121.76	54.12

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72194	S		Ct pelvis w/o & w/dye	0333	5.6225	320.39	144.17	64.08
72195	S		Mri pelvis w/o dye	0336	6.3150	359.85	161.93	71.97
72196	S		Mri pelvis w/dye	0284	6.7851	386.64	173.98	77.33
72197	S		Mri pelvis w/o & w/dye	0337	9.1701	522.54	235.14	104.51
72198	B		Mr angio pelvis w/o & w/dye					
72200	X		X-ray exam sacroiliac joints	0260	0.7698	43.87	19.74	8.77
72202	X		X-ray exam sacroiliac joints	0260	0.7698	43.87	19.74	8.77
72220	X		X-ray exam of tailbone	0260	0.7698	43.87	19.74	8.77
72240	S		Contrast x-ray of neck spine	0274	3.2901	187.48	84.36	37.50
72255	S		Contrast x-ray, thorax spine	0274	3.2901	187.48	84.36	37.50
72265	S		Contrast x-ray, lower spine	0274	3.2901	187.48	84.36	37.50
72270	S		Contrast x-ray, spine	0274	3.2901	187.48	84.36	37.50
72275	S		Epidurography	0274	3.2901	187.48	84.36	37.50
72285	S		X-ray c/t spine disk	0388	11.7568	669.94	301.47	133.99
72295	S		X-ray of lower spine disk	0388	11.7568	669.94	301.47	133.99
73000	X		X-ray exam of collar bone	0260	0.7698	43.87	19.74	8.77
73010	X		X-ray exam of shoulder blade	0260	0.7698	43.87	19.74	8.77
73020	X		X-ray exam of shoulder	0260	0.7698	43.87	19.74	8.77
73030	X		X-ray exam of shoulder	0260	0.7698	43.87	19.74	8.77
73040	S		Contrast x-ray of shoulder	0275	3.5084	199.92	69.09	39.98
73050	X		X-ray exam of shoulders	0260	0.7698	43.87	19.74	8.77
73060	X		X-ray exam of humerus	0260	0.7698	43.87	19.74	8.77
73070	X		X-ray exam of elbow	0260	0.7698	43.87	19.74	8.77
73080	X		X-ray exam of elbow	0260	0.7698	43.87	19.74	8.77
73085	S		Contrast x-ray of elbow	0275	3.5084	199.92	69.09	39.98
73090	X		X-ray exam of forearm	0260	0.7698	43.87	19.74	8.77
73092	X		X-ray exam of arm, infant	0260	0.7698	43.87	19.74	8.77
73100	X		X-ray exam of wrist	0260	0.7698	43.87	19.74	8.77
73110	X		X-ray exam of wrist	0260	0.7698	43.87	19.74	8.77
73115	S		Contrast x-ray of wrist	0275	3.5084	199.92	69.09	39.98
73120	X		X-ray exam of hand	0260	0.7698	43.87	19.74	8.77
73130	X		X-ray exam of hand	0260	0.7698	43.87	19.74	8.77
73140	X		X-ray exam of finger(s)	0260	0.7698	43.87	19.74	8.77
73200	S		Ct upper extremity w/o dye	0332	3.3910	193.23	86.95	38.65
73201	S		Ct upper extremity w/dye	0283	4.7485	270.58	121.76	54.12
73202	S		Ct uppr extremity w/o&w/dye	0333	5.6225	320.39	144.17	64.08
73206	S		Ct angio upr extrm w/o&w/dye	0662	5.6204	320.27	144.12	64.05
73218	S		Mri upper extremity w/o dye	0336	6.3150	359.85	161.93	71.97
73219	S		Mri upper extremity w/dye	0284	6.7851	386.64	173.98	77.33
73220	S		Mri uppr extremity w/o&w/dye	0337	9.1701	522.54	235.14	104.51
73221	S		Mri joint upr extrem w/o dye	0336	6.3150	359.85	161.93	71.97
73222	S		Mri joint upr extrem w/dye	0284	6.7851	386.64	173.98	77.33
73223	S		Mri joint upr extr w/o&w/dye	0337	9.1701	522.54	235.14	104.51

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73225	E		Mr angio upr extr w/o&w/dye					
73500	X		X-ray exam of hip	0260	0.7698	43.87	19.74	8.77
73510	X		X-ray exam of hip	0260	0.7698	43.87	19.74	8.77
73520	X		X-ray exam of hips	0260	0.7698	43.87	19.74	8.77
73525	S		Contrast x-ray of hip	0275	3.5084	199.92	69.09	39.98
73530	X		X-ray exam of hip	0261	1.3351	76.08		15.22
73540	X		X-ray exam of pelvis & hips	0260	0.7698	43.87	19.74	8.77
73542	S		X-ray exam, sacroiliac joint	0275	3.5084	199.92	69.09	39.98
73550	X		X-ray exam of thigh	0260	0.7698	43.87	19.74	8.77
73560	X		X-ray exam of knee, 1 or 2	0260	0.7698	43.87	19.74	8.77
73562	X		X-ray exam of knee, 3	0260	0.7698	43.87	19.74	8.77
73564	X		X-ray exam, knee, 4 or more	0260	0.7698	43.87	19.74	8.77
73565	X		X-ray exam of knees	0260	0.7698	43.87	19.74	8.77
73580	S		Contrast x-ray of knee joint	0275	3.5084	199.92	69.09	39.98
73590	X		X-ray exam of lower leg	0260	0.7698	43.87	19.74	8.77
73592	X		X-ray exam of leg, infant	0260	0.7698	43.87	19.74	8.77
73600	X		X-ray exam of ankle	0260	0.7698	43.87	19.74	8.77
73610	X		X-ray exam of ankle	0260	0.7698	43.87	19.74	8.77
73615	S		Contrast x-ray of ankle	0275	3.5084	199.92	69.09	39.98
73620	X		X-ray exam of foot	0260	0.7698	43.87	19.74	8.77
73630	X		X-ray exam of foot	0260	0.7698	43.87	19.74	8.77
73650	X		X-ray exam of heel	0260	0.7698	43.87	19.74	8.77
73660	X		X-ray exam of toe(s)	0260	0.7698	43.87	19.74	8.77
73700	S		Ct lower extremity w/o dye	0332	3.3910	193.23	86.95	38.65
73701	S		Ct lower extremity w/dye	0283	4.7485	270.58	121.76	54.12
73702	S		Ct lwr extremity w/o&w/dye	0333	5.6225	320.39	144.17	64.08
73706	S		Ct angio lwr extr w/o&w/dye	0662	5.6204	320.27	144.12	64.05
73718	S		Mri lower extremity w/o dye	0336	6.3150	359.85	161.93	71.97
73719	S		Mri lower extremity w/dye	0284	6.7851	386.64	173.98	77.33
73720	S		Mri lwr extremity w/o&w/dye	0337	9.1701	522.54	235.14	104.51
73721	S		Mri jnt of lwr extre w/o dye	0336	6.3150	359.85	161.93	71.97
73722	S		Mri joint of lwr extr w/dye	0284	6.7851	386.64	173.98	77.33
73723	S		Mri joint lwr extr w/o&w/dye	0337	9.1701	522.54	235.14	104.51
73725	B		Mr ang lwr ext w or w/o dye					
74000	X		X-ray exam of abdomen	0260	0.7698	43.87	19.74	8.77
74010	X		X-ray exam of abdomen	0260	0.7698	43.87	19.74	8.77
74020	X		X-ray exam of abdomen	0260	0.7698	43.87	19.74	8.77
74022	X		X-ray exam series, abdomen	0261	1.3351	76.08		15.22
74150	S		Ct abdomen w/o dye	0332	3.3910	193.23	86.95	38.65
74160	S		Ct abdomen w/dye	0283	4.7485	270.58	121.76	54.12
74170	S		Ct abdomen w/o & w/dye	0333	5.6225	320.39	144.17	64.08
74175	S		Ct angio abdom w/o & w/dye	0662	5.6204	320.27	144.12	64.05
74181	S		Mri abdomen w/o dye	0336	6.3150	359.85	161.93	71.97

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74182	S		Mri abdomen w/dye	0284	6.7851	386.64	173.98	77.33
74183	S		Mri abdomen w/o & w/dye	0337	9.1701	522.54	235.14	104.51
74185	B		Mri angio, abdom w orw/o dye					
74190	X		X-ray exam of peritoneum	0264	3.4194	194.85	79.41	38.97
74210	S		Contrst x-ray exam of throat	0276	1.5808	90.08	40.53	18.02
74220	S		Contrast x-ray, esophagus	0276	1.5808	90.08	40.53	18.02
74230	S		Cine/vid x-ray, throat/esoph	0276	1.5808	90.08	40.53	18.02
74235	S		Remove esophagus obstruction	0296	2.4185	137.81	61.04	27.56
74240	S		X-ray exam, upper gi tract	0276	1.5808	90.08	40.53	18.02
74241	S		X-ray exam, upper gi tract	0276	1.5808	90.08	40.53	18.02
74245	S		X-ray exam, upper gi tract	0277	2.4364	138.83	60.47	27.77
74246	S		Contrst x-ray uppr gi tract	0276	1.5808	90.08	40.53	18.02
74247	S		Contrst x-ray uppr gi tract	0276	1.5808	90.08	40.53	18.02
74249	S		Contrst x-ray uppr gi tract	0277	2.4364	138.83	60.47	27.77
74250	S		X-ray exam of small bowel	0276	1.5808	90.08	40.53	18.02
74251	S		X-ray exam of small bowel	0277	2.4364	138.83	60.47	27.77
74260	S		X-ray exam of small bowel	0277	2.4364	138.83	60.47	27.77
74270	S		Contrast x-ray exam of colon	0276	1.5808	90.08	40.53	18.02
74280	S		Contrast x-ray exam of colon	0277	2.4364	138.83	60.47	27.77
74283	S		Contrast x-ray exam of colon	0276	1.5808	90.08	40.53	18.02
74290	S		Contrast x-ray, gallbladder	0276	1.5808	90.08	40.53	18.02
74291	S		Contrast x-rays, gallbladder	0276	1.5808	90.08	40.53	18.02
74300	X		X-ray bile ducts/pancreas	0263	1.8514	105.50	38.51	21.10
74301	X		X-rays at surgery add-on	0263	1.8514	105.50	38.51	21.10
74305	X		X-ray bile ducts/pancreas	0263	1.8514	105.50	38.51	21.10
74320	X		Contrast x-ray of bile ducts	0264	3.4194	194.85	79.41	38.97
74327	S		X-ray bile stone removal	0296	2.4185	137.81	61.04	27.56
74328	N		X-ray bile duct endoscopy					
74329	N		X-ray for pancreas endoscopy					
74330	N		X-ray bile/panc endoscopy					
74340	X		X-ray guide for GI tube	0272	1.3880	79.09	35.59	15.82
74350	X		X-ray guide, stomach tube	0263	1.8514	105.50	38.51	21.10
74355	X		X-ray guide, intestinal tube	0263	1.8514	105.50	38.51	21.10
74360	S		X-ray guide, GI dilation	0296	2.4185	137.81	61.04	27.56
74363	S		X-ray, bile duct dilation	0297	5.2294	297.99	122.13	59.60
74400	S		Contrst x-ray, urinary tract	0278	2.8522	162.53	66.07	32.51
74410	S		Contrst x-ray, urinary tract	0278	2.8522	162.53	66.07	32.51
74415	S		Contrst x-ray, urinary tract	0278	2.8522	162.53	66.07	32.51
74420	S		Contrst x-ray, urinary tract	0278	2.8522	162.53	66.07	32.51
74425	S		Contrst x-ray, urinary tract	0278	2.8522	162.53	66.07	32.51
74430	S		Contrast x-ray, bladder	0278	2.8522	162.53	66.07	32.51
74440	S		X-ray, male genital tract	0278	2.8522	162.53	66.07	32.51
74445	S		X-ray exam of penis	0278	2.8522	162.53	66.07	32.51

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74450	S		X-ray, urethra/bladder	0278	2.8522	162.53	66.07	32.51
74455	S		X-ray, urethra/bladder	0278	2.8522	162.53	66.07	32.51
74470	X		X-ray exam of kidney lesion	0263	1.8514	105.50	38.51	21.10
74475	S		X-ray control, cath insert	0297	5.2294	297.99	122.13	59.60
74480	S		X-ray control, cath insert	0296	2.4185	137.81	61.04	27.56
74485	S		X-ray guide, GU dilation	0296	2.4185	137.81	61.04	27.56
74710	X		X-ray measurement of pelvis	0260	0.7698	43.87	19.74	8.77
74740	X		X-ray, female genital tract	0264	3.4194	194.85	79.41	38.97
74742	X		X-ray, fallopian tube	0264	3.4194	194.85	79.41	38.97
74775	S		X-ray exam of perineum	0278	2.8522	162.53	66.07	32.51
75552	S		Heart mri for morph w/o dye	0336	6.3150	359.85	161.93	71.97
75553	S		Heart mri for morph w/dye	0284	6.7851	386.64	173.98	77.33
75554	S		Cardiac MRI/function	0335	6.0472	344.59	150.64	68.92
75555	S		Cardiac MRI/limited study	0335	6.0472	344.59	150.64	68.92
75556	E		Cardiac MRI/flow mapping					
75600	S		Contrast x-ray exam of aorta	0280	20.1741	1149.58	353.85	229.92
75605	S		Contrast x-ray exam of aorta	0280	20.1741	1149.58	353.85	229.92
75625	S		Contrast x-ray exam of aorta	0280	20.1741	1149.58	353.85	229.92
75630	S		X-ray aorta, leg arteries	0280	20.1741	1149.58	353.85	229.92
75635	S		Ct angio abdominal arteries	0662	5.6204	320.27	144.12	64.05
75650	S		Artery x-rays, head & neck	0280	20.1741	1149.58	353.85	229.92
75658	S		Artery x-rays, arm	0279	8.8113	502.09	150.03	100.42
75660	S		Artery x-rays, head & neck	0668	6.7346	383.76	114.67	76.75
75662	S		Artery x-rays, head & neck	0280	20.1741	1149.58	353.85	229.92
75665	S		Artery x-rays, head & neck	0280	20.1741	1149.58	353.85	229.92
75671	S		Artery x-rays, head & neck	0280	20.1741	1149.58	353.85	229.92
75676	S		Artery x-rays, neck	0280	20.1741	1149.58	353.85	229.92
75680	S		Artery x-rays, neck	0280	20.1741	1149.58	353.85	229.92
75685	S		Artery x-rays, spine	0280	20.1741	1149.58	353.85	229.92
75705	S		Artery x-rays, spine	0668	6.7346	383.76	114.67	76.75
75710	S		Artery x-rays, arm/leg	0280	20.1741	1149.58	353.85	229.92
75716	S		Artery x-rays, arms/legs	0280	20.1741	1149.58	353.85	229.92
75722	S		Artery x-rays, kidney	0280	20.1741	1149.58	353.85	229.92
75724	S		Artery x-rays, kidneys	0280	20.1741	1149.58	353.85	229.92
75726	S		Artery x-rays, abdomen	0280	20.1741	1149.58	353.85	229.92
75731	S		Artery x-rays, adrenal gland	0280	20.1741	1149.58	353.85	229.92
75733	S		Artery x-rays, adrenals	0668	6.7346	383.76	114.67	76.75
75736	S		Artery x-rays, pelvis	0280	20.1741	1149.58	353.85	229.92
75741	S		Artery x-rays, lung	0279	8.8113	502.09	150.03	100.42
75743	S		Artery x-rays, lungs	0280	20.1741	1149.58	353.85	229.92
75746	S		Artery x-rays, lung	0279	8.8113	502.09	150.03	100.42
75756	S		Artery x-rays, chest	0279	8.8113	502.09	150.03	100.42
75774	S		Artery x-ray, each vessel	0279	8.8113	502.09	150.03	100.42

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
75790	S		Visualize A-V shunt	0281	7.2117	410.94	115.16	82.19
75801	X		Lymph vessel x-ray, arm/leg	0264	3.4194	194.85	79.41	38.97
75803	X		Lymph vessel x-ray,arms/legs	0264	3.4194	194.85	79.41	38.97
75805	X		Lymph vessel x-ray, trunk	0264	3.4194	194.85	79.41	38.97
75807	X		Lymph vessel x-ray, trunk	0264	3.4194	194.85	79.41	38.97
75809	X		Nonvascular shunt, x-ray	0263	1.8514	105.50	38.51	21.10
75810	S		Vein x-ray, spleen/liver	0279	8.8113	502.09	150.03	100.42
75820	S		Vein x-ray, arm/leg	0281	7.2117	410.94	115.16	82.19
75822	S		Vein x-ray, arms/legs	0281	7.2117	410.94	115.16	82.19
75825	S		Vein x-ray, trunk	0279	8.8113	502.09	150.03	100.42
75827	S		Vein x-ray, chest	0279	8.8113	502.09	150.03	100.42
75831	S		Vein x-ray, kidney	0287	8.3130	473.70	111.33	94.74
75833	S		Vein x-ray, kidneys	0279	8.8113	502.09	150.03	100.42
75840	S		Vein x-ray, adrenal gland	0287	8.3130	473.70	111.33	94.74
75842	S		Vein x-ray, adrenal glands	0287	8.3130	473.70	111.33	94.74
75860	S		Vein x-ray, neck	0287	8.3130	473.70	111.33	94.74
75870	S		Vein x-ray, skull	0287	8.3130	473.70	111.33	94.74
75872	S		Vein x-ray, skull	0287	8.3130	473.70	111.33	94.74
75880	S		Vein x-ray, eye socket	0287	8.3130	473.70	111.33	94.74
75885	S		Vein x-ray, liver	0280	20.1741	1149.58	353.85	229.92
75887	S		Vein x-ray, liver	0279	8.8113	502.09	150.03	100.42
75889	S		Vein x-ray, liver	0280	20.1741	1149.58	353.85	229.92
75891	S		Vein x-ray, liver	0279	8.8113	502.09	150.03	100.42
75893	N		Venous sampling by catheter					
75894	S		X-rays, transcath therapy	0297	5.2294	297.99	122.13	59.60
75896	S		X-rays, transcath therapy	0297	5.2294	297.99	122.13	59.60
75898	X		Follow-up angiography	0263	1.8514	105.50	38.51	21.10
75900	C		Arterial catheter exchange					
75901	X		Remove cva device obstruct	0263	1.8514	105.50	38.51	21.10
75902	X		Remove cva lumen obstruct	0263	1.8514	105.50	38.51	21.10
75940	T		X-ray placement, vein filter	0187	3.8526	219.53		43.91
75945	S		Intravascular us	0267	2.4250	138.18	62.18	27.64
75946	S		Intravascular us add-on	0267	2.4250	138.18	62.18	27.64
75952	C		Endovasc repair abdom aorta					
75953	C		Abdom aneurysm endovas rpr					
75954	C		Iliac aneurysm endovas rpr					
75960	S		Transcath iv stent rs&i	0668	6.7346	383.76	114.67	76.75
75961	S		Retrieval, broken catheter	0668	6.7346	383.76	114.67	76.75
75962	S		Repair arterial blockage	0668	6.7346	383.76	114.67	76.75
75964	S		Repair artery blockage, each	0668	6.7346	383.76	114.67	76.75
75966	S		Repair arterial blockage	0668	6.7346	383.76	114.67	76.75
75968	S		Repair artery blockage, each	0668	6.7346	383.76	114.67	76.75
75970	S		Vascular biopsy	0668	6.7346	383.76	114.67	76.75

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
75978	S		Repair venous blockage	0668	6.7346	383.76	114.67	76.75
75980	S		Contrast xray exam bile duct	0297	5.2294	297.99	122.13	59.60
75982	S		Contrast xray exam bile duct	0297	5.2294	297.99	122.13	59.60
75984	X		Xray control catheter change	0263	1.8514	105.50	38.51	21.10
75989	N		Abscess drainage under x-ray					
75992	S		Atherectomy, x-ray exam	0279	8.8113	502.09	150.03	100.42
75993	S		Atherectomy, x-ray exam	0279	8.8113	502.09	150.03	100.42
75994	S		Atherectomy, x-ray exam	0279	8.8113	502.09	150.03	100.42
75995	S		Atherectomy, x-ray exam	0279	8.8113	502.09	150.03	100.42
75996	S		Atherectomy, x-ray exam	0279	8.8113	502.09	150.03	100.42
75998	N		Fluoroguide for vein device					
76000	X		Fluoroscope examination	0272	1.3880	79.09	35.59	15.82
76001	N		Fluoroscope exam, extensive					
76003	N		Needle localization by x-ray					
76005	N		Fluoroguide for spine inject					
76006	X		X-ray stress view	0260	0.7698	43.87	19.74	8.77
76010	X		X-ray, nose to rectum	0260	0.7698	43.87	19.74	8.77
76012	S		Percut vertebroplasty fluor	0274	3.2901	187.48	84.36	37.50
76013	S		Percut vertebroplasty, ct	0274	3.2901	187.48	84.36	37.50
76020	X		X-rays for bone age	0260	0.7698	43.87	19.74	8.77
76040	X		X-rays, bone evaluation	0260	0.7698	43.87	19.74	8.77
76061	X		X-rays, bone survey	0261	1.3351	76.08		15.22
76062	X		X-rays, bone survey	0261	1.3351	76.08		15.22
76065	X		X-rays, bone evaluation	0261	1.3351	76.08		15.22
76066	X		Joint survey, single view	0260	0.7698	43.87	19.74	8.77
76070	S		Ct bone density, axial	0288	1.2735	72.57		14.51
76071	S		Ct bone density, peripheral	0282	1.7145	97.70	43.96	19.54
76075	S		Dxa bone density, axial	0288	1.2735	72.57		14.51
76076	S		Dxa bone density/peripheral	0665	0.7707	43.92		8.78
76077	X	NI	Dxa bone density/v-fracture	0260	0.7698	43.87	19.74	8.77
76078	X		Radiographic absorptiometry	0261	1.3351	76.08		15.22
76080	X		X-ray exam of fistula	0263	1.8514	105.50	38.51	21.10
76082	A		Computer mammogram add-on					
76083	A		Computer mammogram add-on					
76086	X		X-ray of mammary duct	0263	1.8514	105.50	38.51	21.10
76088	X		X-ray of mammary ducts	0263	1.8514	105.50	38.51	21.10
76090	A		Mammogram, one breast					
76091	A		Mammogram, both breasts					
76092	A		Mammogram, screening					
76093	E		Magnetic image, breast					
76094	E		Magnetic image, both breasts					
76095	T		Stereotactic breast biopsy	0187	3.8526	219.53		43.91
76096	X		X-ray of needle wire, breast	0289	1.5701	89.47	21.05	17.89

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
76098	X		X-ray exam, breast specimen	0260	0.7698	43.87	19.74	8.77
76100	X		X-ray exam of body section	0261	1.3351	76.08		15.22
76101	X		Complex body section x-ray	0263	1.8514	105.50	38.51	21.10
76102	X		Complex body section x-rays	0264	3.4194	194.85	79.41	38.97
76120	X		Cine/video x-rays	0272	1.3880	79.09	35.59	15.82
76125	X		Cine/video x-rays add-on	0260	0.7698	43.87	19.74	8.77
76140	E		X-ray consultation					
76150	X		X-ray exam, dry process	0260	0.7698	43.87	19.74	8.77
76350	N		Special x-ray contrast study					
76355	S		Ct scan for localization	0283	4.7485	270.58	121.76	54.12
76360	S		Ct scan for needle biopsy	0283	4.7485	270.58	121.76	54.12
76362	S		Ct guide for tissue ablation	0332	3.3910	193.23	86.95	38.65
76370	S		Ct scan for therapy guide	0282	1.7145	97.70	43.96	19.54
76375	S		3d/holograph reconstr add-on	0282	1.7145	97.70	43.96	19.54
76380	S		CAT scan follow-up study	0282	1.7145	97.70	43.96	19.54
76390	E		Mr spectroscopy					
76393	S		Mr guidance for needle place	0335	6.0472	344.59	150.64	68.92
76394	S		Mri for tissue ablation	0335	6.0472	344.59	150.64	68.92
76400	S		Magnetic image, bone marrow	0335	6.0472	344.59	150.64	68.92
76496	X		Fluoroscopic procedure	0272	1.3880	79.09	35.59	15.82
76497	S		Ct procedure	0282	1.7145	97.70	43.96	19.54
76498	S		Mri procedure	0335	6.0472	344.59	150.64	68.92
76499	X		Radiographic procedure	0260	0.7698	43.87	19.74	8.77
76506	S		Echo exam of head	0266	1.6275	92.74	41.73	18.55
76510	S	NI	Ophth us, b & quant a	0266	1.6275	92.74	41.73	18.55
76511	S		Ophth us, quant a only	0266	1.6275	92.74	41.73	18.55
76512	S		Ophth us, b w/non-quant a	0266	1.6275	92.74	41.73	18.55
76513	S		Echo exam of eye, water bath	0266	1.6275	92.74	41.73	18.55
76514	X		Echo exam of eye, thickness	0340	0.6328	36.06		7.21
76516	S		Echo exam of eye	0266	1.6275	92.74	41.73	18.55
76519	S		Echo exam of eye	0266	1.6275	92.74	41.73	18.55
76529	S		Echo exam of eye	0266	1.6275	92.74	41.73	18.55
76536	S		Us exam of head and neck	0266	1.6275	92.74	41.73	18.55
76604	S		Us exam, chest, b-scan	0266	1.6275	92.74	41.73	18.55
76645	S		Us exam, breast(s)	0265	1.0473	59.68	26.85	11.94
76700	S		Us exam, abdom, complete	0266	1.6275	92.74	41.73	18.55
76705	S		Echo exam of abdomen	0266	1.6275	92.74	41.73	18.55
76770	S		Us exam abdo back wall, comp	0266	1.6275	92.74	41.73	18.55
76775	S		Us exam abdo back wall, lim	0266	1.6275	92.74	41.73	18.55
76778	S		Us exam kidney transplant	0266	1.6275	92.74	41.73	18.55
76800	S		Us exam, spinal canal	0266	1.6275	92.74	41.73	18.55
76801	S		Ob us < 14 wks, single fetus	0266	1.6275	92.74	41.73	18.55
76802	S		Ob us < 14 wks, add'l fetus	0265	1.0473	59.68	26.85	11.94

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
76805	S		Ob us >/= 14 wks, sngl fetus	0266	1.6275	92.74	41.73	18.55
76810	S		Ob us >/= 14 wks, addl fetus	0266	1.6275	92.74	41.73	18.55
76811	S		Ob us, detailed, sngl fetus	0267	2.4250	138.18	62.18	27.64
76812	S		Ob us, detailed, addl fetus	0266	1.6275	92.74	41.73	18.55
76815	S		Ob us, limited, fetus(s)	0265	1.0473	59.68	26.85	11.94
76816	S		Ob us, follow-up, per fetus	0265	1.0473	59.68	26.85	11.94
76817	S		Transvaginal us, obstetric	0266	1.6275	92.74	41.73	18.55
76818	S		Fetal biophys profile w/nst	0266	1.6275	92.74	41.73	18.55
76819	S		Fetal biophys profil w/o nst	0266	1.6275	92.74	41.73	18.55
76820	S	NI	Umbilical artery echo	0096	1.7035	97.07	43.68	19.41
76821	S	NI	Middle cerebral artery echo	0096	1.7035	97.07	43.68	19.41
76825	S		Echo exam of fetal heart	0671	1.7087	97.37	43.81	19.47
76826	S		Echo exam of fetal heart	0697	1.5184	86.52	38.93	17.30
76827	S		Echo exam of fetal heart	0671	1.7087	97.37	43.81	19.47
76828	S		Echo exam of fetal heart	0697	1.5184	86.52	38.93	17.30
76830	S		Transvaginal us, non-ob	0266	1.6275	92.74	41.73	18.55
76831	S		Echo exam, uterus	0266	1.6275	92.74	41.73	18.55
76856	S		Us exam, pelvic, complete	0266	1.6275	92.74	41.73	18.55
76857	S		Us exam, pelvic, limited	0265	1.0473	59.68	26.85	11.94
76870	S		Us exam, scrotum	0266	1.6275	92.74	41.73	18.55
76872	S		Us, transrectal	0266	1.6275	92.74	41.73	18.55
76873	S		Echograp trans r, pros study	0266	1.6275	92.74	41.73	18.55
76880	S		Us exam, extremity	0266	1.6275	92.74	41.73	18.55
76885	S		Us exam infant hips, dynamic	0266	1.6275	92.74	41.73	18.55
76886	S		Us exam infant hips, static	0266	1.6275	92.74	41.73	18.55
76930	S		Echo guide, cardiocentesis	0268	1.1835	67.44		13.49
76932	S		Echo guide for heart biopsy	0268	1.1835	67.44		13.49
76936	S		Echo guide for artery repair	0268	1.1835	67.44		13.49
76937	N		Us guide, vascular access					
76940	S		Us guide, tissue ablation	0268	1.1835	67.44		13.49
76941	S		Echo guide for transfusion	0268	1.1835	67.44		13.49
76942	S		Echo guide for biopsy	0268	1.1835	67.44		13.49
76945	S		Echo guide, villus sampling	0268	1.1835	67.44		13.49
76946	S		Echo guide for amniocentesis	0268	1.1835	67.44		13.49
76948	S		Echo guide, ova aspiration	0268	1.1835	67.44		13.49
76950	S		Echo guidance radiotherapy	0268	1.1835	67.44		13.49
76965	S		Echo guidance radiotherapy	0268	1.1835	67.44		13.49
76970	S		Ultrasound exam follow-up	0265	1.0473	59.68	26.85	11.94
76975	S		GI endoscopic ultrasound	0266	1.6275	92.74	41.73	18.55
76977	X		Us bone density measure	0340	0.6328	36.06		7.21
76986	S		Ultrasound guide intraoper	0266	1.6275	92.74	41.73	18.55
76999	S		Echo examination procedure	0265	1.0473	59.68	26.85	11.94
77261	E		Radiation therapy planning					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
77262	E		Radiation therapy planning					
77263	E		Radiation therapy planning					
77280	X		Set radiation therapy field	0304	1.7107	97.48	41.52	19.50
77285	X		Set radiation therapy field	0305	3.9322	224.07	91.38	44.81
77290	X		Set radiation therapy field	0305	3.9322	224.07	91.38	44.81
77295	X		Set radiation therapy field	0310	14.2774	813.57	325.27	162.71
77299	E		Radiation therapy planning					
77300	X		Radiation therapy dose plan	0304	1.7107	97.48	41.52	19.50
77301	X		Radiotherapy dose plan, imrt	0310	14.2774	813.57	325.27	162.71
77305	X		Teletx isodose plan simple	0304	1.7107	97.48	41.52	19.50
77310	X		Teletx isodose plan intermed	0304	1.7107	97.48	41.52	19.50
77315	X		Teletx isodose plan complex	0305	3.9322	224.07	91.38	44.81
77321	X		Special teletx port plan	0305	3.9322	224.07	91.38	44.81
77326	X		Brachytx isodose calc simp	0304	1.7107	97.48	41.52	19.50
77327	X		Brachytx isodose calc interm	0305	3.9322	224.07	91.38	44.81
77328	X		Brachytx isodose plan compl	0305	3.9322	224.07	91.38	44.81
77331	X		Special radiation dosimetry	0304	1.7107	97.48	41.52	19.50
77332	X		Radiation treatment aid(s)	0303	2.8722	163.67	66.95	32.73
77333	X		Radiation treatment aid(s)	0303	2.8722	163.67	66.95	32.73
77334	X		Radiation treatment aid(s)	0303	2.8722	163.67	66.95	32.73
77336	X		Radiation physics consult	0304	1.7107	97.48	41.52	19.50
77370	X		Radiation physics consult	0304	1.7107	97.48	41.52	19.50
77399	X		External radiation dosimetry	0304	1.7107	97.48	41.52	19.50
77401	S		Radiation treatment delivery	0300	1.5279	87.06		17.41
77402	S		Radiation treatment delivery	0300	1.5279	87.06		17.41
77403	S		Radiation treatment delivery	0300	1.5279	87.06		17.41
77404	S		Radiation treatment delivery	0300	1.5279	87.06		17.41
77406	S		Radiation treatment delivery	0300	1.5279	87.06		17.41
77407	S		Radiation treatment delivery	0300	1.5279	87.06		17.41
77408	S		Radiation treatment delivery	0300	1.5279	87.06		17.41
77409	S		Radiation treatment delivery	0300	1.5279	87.06		17.41
77411	S		Radiation treatment delivery	0300	1.5279	87.06		17.41
77412	S		Radiation treatment delivery	0301	2.1782	124.12		24.82
77413	S		Radiation treatment delivery	0301	2.1782	124.12		24.82
77414	S		Radiation treatment delivery	0301	2.1782	124.12		24.82
77416	S		Radiation treatment delivery	0301	2.1782	124.12		24.82
77417	X		Radiology port film(s)	0260	0.7698	43.87	19.74	8.77
77418	S		Radiation tx delivery, imrt	0412	5.4261	309.20		61.84
77427	E		Radiation tx management, x5					
77431	E		Radiation therapy management					
77432	E		Stereotactic radiation trmt					
77470	S		Special radiation treatment	0299	5.8368	332.60		66.52
77499	E		Radiation therapy management					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
77520	S		Proton trmt, simple w/o comp	0664	9.8560	561.62		112.32
77522	S		Proton trmt, simple w/comp	0664	9.8560	561.62		112.32
77523	S		Proton trmt, intermediate	1510		850.00		170.00
77525	S		Proton treatment, complex	1510		850.00		170.00
77600	S		Hyperthermia treatment	0314	4.2608	242.79	98.36	48.56
77605	S		Hyperthermia treatment	0314	4.2608	242.79	98.36	48.56
77610	S		Hyperthermia treatment	0314	4.2608	242.79	98.36	48.56
77615	S		Hyperthermia treatment	0314	4.2608	242.79	98.36	48.56
77620	S		Hyperthermia treatment	0314	4.2608	242.79	98.36	48.56
77750	S		Infuse radioactive materials	0300	1.5279	87.06		17.41
77761	S		Apply intrcav radiat simple	0312	5.5783	317.87		63.57
77762	S		Apply intrcav radiat interm	0312	5.5783	317.87		63.57
77763	S		Apply intrcav radiat compl	0312	5.5783	317.87		63.57
77776	S		Apply interstit radiat simpl	0312	5.5783	317.87		63.57
77777	S		Apply interstit radiat inter	0312	5.5783	317.87		63.57
77778	S		Apply interstit radiat compl	0651	21.9176	1248.93		249.79
77781	S		High intensity brachytherapy	0313	13.8770	790.75		158.15
77782	S		High intensity brachytherapy	0313	13.8770	790.75		158.15
77783	S		High intensity brachytherapy	0313	13.8770	790.75		158.15
77784	S		High intensity brachytherapy	0313	13.8770	790.75		158.15
77789	S		Apply surface radiation	0300	1.5279	87.06		17.41
77790	N		Radiation handling					
77799	S		Radium/radioisotope therapy	0313	13.8770	790.75		158.15
78000	S		Thyroid, single uptake	0389	1.7805	101.46	44.54	20.29
78001	S		Thyroid, multiple uptakes	0389	1.7805	101.46	44.54	20.29
78003	S		Thyroid suppress/stimul	0389	1.7805	101.46	44.54	20.29
78006	S		Thyroid imaging with uptake	0390	2.8999	165.25	74.36	33.05
78007	S		Thyroid image, mult uptakes	0391	3.3043	188.29	84.73	37.66
78010	S		Thyroid imaging	0390	2.8999	165.25	74.36	33.05
78011	S		Thyroid imaging with flow	0390	2.8999	165.25	74.36	33.05
78015	S		Thyroid met imaging	0406	4.5311	258.20	116.19	51.64
78016	S		Thyroid met imaging/studies	0406	4.5311	258.20	116.19	51.64
78018	S		Thyroid met imaging, body	0406	4.5311	258.20	116.19	51.64
78020	S		Thyroid met uptake	0399	1.5961	90.95	40.92	18.19
78070	S		Parathyroid nuclear imaging	0391	3.3043	188.29	84.73	37.66
78075	S		Adrenal nuclear imaging	0391	3.3043	188.29	84.73	37.66
78099	S		Endocrine nuclear procedure	0390	2.8999	165.25	74.36	33.05
78102	S		Bone marrow imaging, ltd	0400	4.1858	238.52	104.32	47.70
78103	S		Bone marrow imaging, mult	0400	4.1858	238.52	104.32	47.70
78104	S		Bone marrow imaging, body	0400	4.1858	238.52	104.32	47.70
78110	S		Plasma volume, single	0393	4.6873	267.10	120.19	53.42
78111	S		Plasma volume, multiple	0393	4.6873	267.10	120.19	53.42
78120	S		Red cell mass, single	0393	4.6873	267.10	120.19	53.42

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
78121	S		Red cell mass, multiple	0393	4.6873	267.10	120.19	53.42
78122	S		Blood volume	0393	4.6873	267.10	120.19	53.42
78130	S		Red cell survival study	0393	4.6873	267.10	120.19	53.42
78135	S		Red cell survival kinetics	0393	4.6873	267.10	120.19	53.42
78140	S		Red cell sequestration	0393	4.6873	267.10	120.19	53.42
78160	S		Plasma iron turnover	0393	4.6873	267.10	120.19	53.42
78162	S		Radioiron absorption exam	0393	4.6873	267.10	120.19	53.42
78170	S		Red cell iron utilization	0393	4.6873	267.10	120.19	53.42
78172	S		Total body iron estimation	0393	4.6873	267.10	120.19	53.42
78185	S		Spleen imaging	0400	4.1858	238.52	104.32	47.70
78190	S		Platelet survival, kinetics	0389	1.7805	101.46	44.54	20.29
78191	S		Platelet survival	0389	1.7805	101.46	44.54	20.29
78195	S		Lymph system imaging	0400	4.1858	238.52	104.32	47.70
78199	S		Blood/lymph nuclear exam	0400	4.1858	238.52	104.32	47.70
78201	S		Liver imaging	0394	4.5876	261.42	117.63	52.28
78202	S		Liver imaging with flow	0394	4.5876	261.42	117.63	52.28
78205	S		Liver imaging (3D)	0394	4.5876	261.42	117.63	52.28
78206	S		Liver image (3d) with flow	0394	4.5876	261.42	117.63	52.28
78215	S		Liver and spleen imaging	0394	4.5876	261.42	117.63	52.28
78216	S		Liver & spleen image/flow	0394	4.5876	261.42	117.63	52.28
78220	S		Liver function study	0394	4.5876	261.42	117.63	52.28
78223	S		Hepatobiliary imaging	0394	4.5876	261.42	117.63	52.28
78230	S		Salivary gland imaging	0395	3.9819	226.90	102.10	45.38
78231	S		Serial salivary imaging	0395	3.9819	226.90	102.10	45.38
78232	S		Salivary gland function exam	0395	3.9819	226.90	102.10	45.38
78258	S		Esophageal motility study	0395	3.9819	226.90	102.10	45.38
78261	S		Gastric mucosa imaging	0395	3.9819	226.90	102.10	45.38
78262	S		Gastroesophageal reflux exam	0395	3.9819	226.90	102.10	45.38
78264	S		Gastric emptying study	0395	3.9819	226.90	102.10	45.38
78267	A		Breath tst attain/anal c-14					
78268	A		Breath test analysis, c-14					
78270	S		Vit B-12 absorption exam	0389	1.7805	101.46	44.54	20.29
78271	S		Vit b-12 absrp exam, int fac	0389	1.7805	101.46	44.54	20.29
78272	S		Vit B-12 absorp, combined	0389	1.7805	101.46	44.54	20.29
78278	S		Acute GI blood loss imaging	0395	3.9819	226.90	102.10	45.38
78282	S		GI protein loss exam	0395	3.9819	226.90	102.10	45.38
78290	S		Meckel's divert exam	0395	3.9819	226.90	102.10	45.38
78291	S		Leveen/shunt patency exam	0395	3.9819	226.90	102.10	45.38
78299	S		GI nuclear procedure	0395	3.9819	226.90	102.10	45.38
78300	S		Bone imaging, limited area	0396	4.2024	239.47	107.76	47.89
78305	S		Bone imaging, multiple areas	0396	4.2024	239.47	107.76	47.89
78306	S		Bone imaging, whole body	0396	4.2024	239.47	107.76	47.89
78315	S		Bone imaging, 3 phase	0396	4.2024	239.47	107.76	47.89

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
78320	S		Bone imaging (3D)	0396	4.2024	239.47	107.76	47.89
78350	X		Bone mineral, single photon	0261	1.3351	76.08		15.22
78351	E		Bone mineral, dual photon					
78399	S		Musculoskeletal nuclear exam	0396	4.2024	239.47	107.76	47.89
78414	S		Non-imaging heart function	0398	4.6280	263.72	118.67	52.74
78428	S		Cardiac shunt imaging	0398	4.6280	263.72	118.67	52.74
78445	S		Vascular flow imaging	0397	2.5517	145.40	60.51	29.08
78455	S		Venous thrombosis study	0397	2.5517	145.40	60.51	29.08
78456	S		Acute venous thrombus image	0397	2.5517	145.40	60.51	29.08
78457	S		Venous thrombosis imaging	0397	2.5517	145.40	60.51	29.08
78458	S		Ven thrombosis images, bilat	0397	2.5517	145.40	60.51	29.08
78459	B		Heart muscle imaging (PET)					
78460	S		Heart muscle blood, single	0398	4.6280	263.72	118.67	52.74
78461	S		Heart muscle blood, multiple	0377	7.0532	401.91	180.85	80.38
78464	S		Heart image (3d), single	0398	4.6280	263.72	118.67	52.74
78465	S		Heart image (3d), multiple	0377	7.0532	401.91	180.85	80.38
78466	S		Heart infarct image	0398	4.6280	263.72	118.67	52.74
78468	S		Heart infarct image (ef)	0398	4.6280	263.72	118.67	52.74
78469	S		Heart infarct image (3D)	0398	4.6280	263.72	118.67	52.74
78472	S		Gated heart, planar, single	0398	4.6280	263.72	118.67	52.74
78473	S		Gated heart, multiple	0376	4.9171	280.19	121.42	56.04
78478	S		Heart wall motion add-on	0399	1.5961	90.95	40.92	18.19
78480	S		Heart function add-on	0399	1.5961	90.95	40.92	18.19
78481	S		Heart first pass, single	0398	4.6280	263.72	118.67	52.74
78483	S		Heart first pass, multiple	0376	4.9171	280.19	121.42	56.04
78491	E		Heart image (pet), single					
78492	E		Heart image (pet), multiple					
78494	S		Heart image, spect	0398	4.6280	263.72	118.67	52.74
78496	S		Heart first pass add-on	0399	1.5961	90.95	40.92	18.19
78499	S		Cardiovascular nuclear exam	0398	4.6280	263.72	118.67	52.74
78580	S		Lung perfusion imaging	0401	3.3594	191.43	86.14	38.29
78584	S		Lung V/Q image single breath	0378	5.5820	318.08	143.13	63.62
78585	S		Lung V/Q imaging	0378	5.5820	318.08	143.13	63.62
78586	S		Aerosol lung image, single	0401	3.3594	191.43	86.14	38.29
78587	S		Aerosol lung image, multiple	0401	3.3594	191.43	86.14	38.29
78588	S		Perfusion lung image	0378	5.5820	318.08	143.13	63.62
78591	S		Vent image, 1 breath, 1 proj	0401	3.3594	191.43	86.14	38.29
78593	S		Vent image, 1 proj, gas	0401	3.3594	191.43	86.14	38.29
78594	S		Vent image, mult proj, gas	0401	3.3594	191.43	86.14	38.29
78596	S		Lung differential function	0378	5.5820	318.08	143.13	63.62
78599	S		Respiratory nuclear exam	0401	3.3594	191.43	86.14	38.29
78600	S		Brain imaging, ltd static	0402	5.2120	297.00	133.65	59.40
78601	S		Brain imaging, ltd w/flow	0402	5.2120	297.00	133.65	59.40

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
78605	S		Brain imaging, complete	0402	5.2120	297.00	133.65	59.40
78606	S		Brain imaging, compl w/flow	0402	5.2120	297.00	133.65	59.40
78607	S		Brain imaging (3D)	0402	5.2120	297.00	133.65	59.40
78608	E		Brain imaging (PET)					
78609	E		Brain imaging (PET)					
78610	S		Brain flow imaging only	0402	5.2120	297.00	133.65	59.40
78615	S		Cerebral vascular flow image	0402	5.2120	297.00	133.65	59.40
78630	S		Cerebrospinal fluid scan	0403	3.6801	209.70	94.36	41.94
78635	S		CSF ventriculography	0403	3.6801	209.70	94.36	41.94
78645	S		CSF shunt evaluation	0403	3.6801	209.70	94.36	41.94
78647	S		Cerebrospinal fluid scan	0403	3.6801	209.70	94.36	41.94
78650	S		CSF leakage imaging	0403	3.6801	209.70	94.36	41.94
78660	S		Nuclear exam of tear flow	0403	3.6801	209.70	94.36	41.94
78699	S		Nervous system nuclear exam	0402	5.2120	297.00	133.65	59.40
78700	S		Kidney imaging, static	0404	3.9496	225.06	101.27	45.01
78701	S		Kidney imaging with flow	0404	3.9496	225.06	101.27	45.01
78704	S		Imaging renogram	0404	3.9496	225.06	101.27	45.01
78707	S		Kidney flow/function image	0404	3.9496	225.06	101.27	45.01
78708	S		Kidney flow/function image	0405	4.4571	253.98	114.29	50.80
78709	S		Kidney flow/function image	0405	4.4571	253.98	114.29	50.80
78710	S		Kidney imaging (3D)	0404	3.9496	225.06	101.27	45.01
78715	S		Renal vascular flow exam	0404	3.9496	225.06	101.27	45.01
78725	S		Kidney function study	0389	1.7805	101.46	44.54	20.29
78730	X		Urinary bladder retention	0340	0.6328	36.06		7.21
78740	S		Ureteral reflux study	0404	3.9496	225.06	101.27	45.01
78760	S		Testicular imaging	0404	3.9496	225.06	101.27	45.01
78761	S		Testicular imaging/flow	0404	3.9496	225.06	101.27	45.01
78799	S		Genitourinary nuclear exam	0404	3.9496	225.06	101.27	45.01
78800	S		Tumor imaging, limited area	0406	4.5311	258.20	116.19	51.64
78801	S		Tumor imaging, mult areas	0406	4.5311	258.20	116.19	51.64
78802	S		Tumor imaging, whole body	0406	4.5311	258.20	116.19	51.64
78803	S		Tumor imaging (3D)	0406	4.5311	258.20	116.19	51.64
78804	S		Tumor imaging, whole body	1508		650.00		130.00
78805	S		Abscess imaging, ltd area	0406	4.5311	258.20	116.19	51.64
78806	S		Abscess imaging, whole body	0406	4.5311	258.20	116.19	51.64
78807	S		Nuclear localization/abscess	0406	4.5311	258.20	116.19	51.64
78810	D		Tumor imaging (PET)					
78811	E	NI	Tumor imaging (pet), limited					
78812	E	NI	Tumor image (pet)/skul-thigh					
78813	E	NI	Tumor image (pet) full body					
78814	E	NI	Tumor image pet/ct, limited					
78815	E	NI	Tumorimage pet/ct skul-thigh					
78816	E	NI	Tumor image pet/ct full body					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
78890	N		Nuclear medicine data proc					
78891	N		Nuclear med data proc					
78990	D		Provide diag radionuclide(s)					
78999	S		Nuclear diagnostic exam	0389	1.7805	101.46	44.54	20.29
79000	D		Init hyperthyroid therapy					
79001	D		Repeat hyperthyroid therapy					
79005	S	NI	Nuclear rx, oral admin	0407	4.0836	232.70	97.77	46.54
79020	D		Thyroid ablation					
79030	D		Thyroid ablation, carcinoma					
79035	D		Thyroid metastatic therapy					
79100	D		Hematopoetic nuclear therapy					
79101	S	NI	Nuclear rx, iv admin	0407	4.0836	232.70	97.77	46.54
79200	S		Nuclear rx, intracav admin	0407	4.0836	232.70	97.77	46.54
79300	S		Nuclr rx, interstit colloid	0407	4.0836	232.70	97.77	46.54
79400	D		Nonhemato nuclear therapy					
79403	S		Hematopoietic nuclear tx	1507		550.00		110.00
79420	D		Intravascular nuclear ther					
79440	S		Nuclear rx, intra-articular	0407	4.0836	232.70	97.77	46.54
79445	S	NI	Nuclear rx, intra-arterial	0407	4.0836	232.70	97.77	46.54
79900	D		Provide ther radiopharm(s)					
79999	S		Nuclear medicine therapy	0407	4.0836	232.70	97.77	46.54
80048	A		Basic metabolic panel					
80050	E		General health panel					
80051	A		Electrolyte panel					
80053	A		Comprehen metabolic panel					
80055	E		Obstetric panel					
80061	A		Lipid panel					
80069	A		Renal function panel					
80074	A		Acute hepatitis panel					
80076	A		Hepatic function panel					
80100	A		Drug screen, qualitate/multi					
80101	A		Drug screen, single					
80102	A		Drug confirmation					
80103	N		Drug analysis, tissue prep					
80150	A		Assay of amikacin					
80152	A		Assay of amitriptyline					
80154	A		Assay of benzodiazepines					
80156	A		Assay, carbamazepine, total					
80157	A		Assay, carbamazepine, free					
80158	A		Assay of cyclosporine					
80160	A		Assay of desipramine					
80162	A		Assay of digoxin					
80164	A		Assay, dipropylacetic acid					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
80166	A		Assay of doxepin					
80168	A		Assay of ethosuximide					
80170	A		Assay of gentamicin					
80172	A		Assay of gold					
80173	A		Assay of haloperidol					
80174	A		Assay of imipramine					
80176	A		Assay of lidocaine					
80178	A		Assay of lithium					
80182	A		Assay of nortriptyline					
80184	A		Assay of phenobarbital					
80185	A		Assay of phenytoin, total					
80186	A		Assay of phenytoin, free					
80188	A		Assay of primidone					
80190	A		Assay of procainamide					
80192	A		Assay of procainamide					
80194	A		Assay of quinidine					
80196	A		Assay of salicylate					
80197	A		Assay of tacrolimus					
80198	A		Assay of theophylline					
80200	A		Assay of tobramycin					
80201	A		Assay of topiramate					
80202	A		Assay of vancomycin					
80299	A		Quantitative assay, drug					
80400	A		Acth stimulation panel					
80402	A		Acth stimulation panel					
80406	A		Acth stimulation panel					
80408	A		Aldosterone suppression eval					
80410	A		Calcitonin stimul panel					
80412	A		CRH stimulation panel					
80414	A		Testosterone response					
80415	A		Estradiol response panel					
80416	A		Renin stimulation panel					
80417	A		Renin stimulation panel					
80418	A		Pituitary evaluation panel					
80420	A		Dexamethasone panel					
80422	A		Glucagon tolerance panel					
80424	A		Glucagon tolerance panel					
80426	A		Gonadotropin hormone panel					
80428	A		Growth hormone panel					
80430	A		Growth hormone panel					
80432	A		Insulin suppression panel					
80434	A		Insulin tolerance panel					
80435	A		Insulin tolerance panel					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
80436	A		Metyrapone panel					
80438	A		TRH stimulation panel					
80439	A		TRH stimulation panel					
80440	A		TRH stimulation panel					
80500	X		Lab pathology consultation	0342	0.2068	11.78	5.30	2.36
80502	X		Lab pathology consultation	0342	0.2068	11.78	5.30	2.36
81000	A		Urinalysis, nonauto w/scope					
81001	A		Urinalysis, auto w/scope					
81002	A		Urinalysis nonauto w/o scope					
81003	A		Urinalysis, auto, w/o scope					
81005	A		Urinalysis					
81007	A		Urine screen for bacteria					
81015	A		Microscopic exam of urine					
81020	A		Urinalysis, glass test					
81025	A		Urine pregnancy test					
81050	A		Urinalysis, volume measure					
81099	A		Urinalysis test procedure					
82000	A		Assay of blood acetaldehyde					
82003	A		Assay of acetaminophen					
82009	A		Test for acetone/ketones					
82010	A		Acetone assay					
82013	A		Acetylcholinesterase assay					
82016	A		Acylcarnitines, qual					
82017	A		Acylcarnitines, quant					
82024	A		Assay of acth					
82030	A		Assay of adp & amp					
82040	A		Assay of serum albumin					
82042	A		Assay of urine albumin					
82043	A		Microalbumin, quantitative					
82044	A		Microalbumin, semiquant					
82045	A	NI	Albumin, ischemia modified					
82055	A		Assay of ethanol					
82075	A		Assay of breath ethanol					
82085	A		Assay of aldolase					
82088	A		Assay of aldosterone					
82101	A		Assay of urine alkaloids					
82103	A		Alpha-1-antitrypsin, total					
82104	A		Alpha-1-antitrypsin, pheno					
82105	A		Alpha-fetoprotein, serum					
82106	A		Alpha-fetoprotein, amniotic					
82108	A		Assay of aluminum					
82120	A		Amines, vaginal fluid qual					
82127	A		Amino acid, single qual					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
82128	A		Amino acids, mult qual					
82131	A		Amino acids, single quant					
82135	A		Assay, aminolevulinic acid					
82136	A		Amino acids, quant, 2-5					
82139	A		Amino acids, quan, 6 or more					
82140	A		Assay of ammonia					
82143	A		Amniotic fluid scan					
82145	A		Assay of amphetamines					
82150	A		Assay of amylase					
82154	A		Androstanediol glucuronide					
82157	A		Assay of androstenedione					
82160	A		Assay of androsterone					
82163	A		Assay of angiotensin II					
82164	A		Angiotensin I enzyme test					
82172	A		Assay of apolipoprotein					
82175	A		Assay of arsenic					
82180	A		Assay of ascorbic acid					
82190	A		Atomic absorption					
82205	A		Assay of barbiturates					
82232	A		Assay of beta-2 protein					
82239	A		Bile acids, total					
82240	A		Bile acids, cholylglycine					
82247	A		Bilirubin, total					
82248	A		Bilirubin, direct					
82252	A		Fecal bilirubin test					
82261	A		Assay of biotinidase					
82270	A		Test for blood, feces					
82273	A		Test for blood, other source					
82274	A		Assay test for blood, fecal					
82286	A		Assay of bradykinin					
82300	A		Assay of cadmium					
82306	A		Assay of vitamin D					
82307	A		Assay of vitamin D					
82308	A		Assay of calcitonin					
82310	A		Assay of calcium					
82330	A		Assay of calcium					
82331	A		Calcium infusion test					
82340	A		Assay of calcium in urine					
82355	A		Calculus analysis, qual					
82360	A		Calculus assay, quant					
82365	A		Calculus spectroscopy					
82370	A		X-ray assay, calculus					
82373	A		Assay, c-d transfer measure					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
82374	A		Assay, blood carbon dioxide					
82375	A		Assay, blood carbon monoxide					
82376	A		Test for carbon monoxide					
82378	A		Carcinoembryonic antigen					
82379	A		Assay of carnitine					
82380	A		Assay of carotene					
82382	A		Assay, urine catecholamines					
82383	A		Assay, blood catecholamines					
82384	A		Assay, three catecholamines					
82387	A		Assay of cathepsin-d					
82390	A		Assay of ceruloplasmin					
82397	A		Chemiluminescent assay					
82415	A		Assay of chloramphenicol					
82435	A		Assay of blood chloride					
82436	A		Assay of urine chloride					
82438	A		Assay, other fluid chlorides					
82441	A		Test for chlorohydrocarbons					
82465	A		Assay, bld/serum cholesterol					
82480	A		Assay, serum cholinesterase					
82482	A		Assay, rbc cholinesterase					
82485	A		Assay, chondroitin sulfate					
82486	A		Gas/liquid chromatography					
82487	A		Paper chromatography					
82488	A		Paper chromatography					
82489	A		Thin layer chromatography					
82491	A		Chromotography, quant, sing					
82492	A		Chromotography, quant, mult					
82495	A		Assay of chromium					
82507	A		Assay of citrate					
82520	A		Assay of cocaine					
82523	A		Collagen crosslinks					
82525	A		Assay of copper					
82528	A		Assay of corticosterone					
82530	A		Cortisol, free					
82533	A		Total cortisol					
82540	A		Assay of creatine					
82541	A		Column chromotography, qual					
82542	A		Column chromotography, quant					
82543	A		Column chromotograph/isotope					
82544	A		Column chromotograph/isotope					
82550	A		Assay of ck (cpk)					
82552	A		Assay of cpk in blood					
82553	A		Creatine, MB fraction					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
82554	A		Creatine, isoforms					
82565	A		Assay of creatinine					
82570	A		Assay of urine creatinine					
82575	A		Creatinine clearance test					
82585	A		Assay of cryofibrinogen					
82595	A		Assay of cryoglobulin					
82600	A		Assay of cyanide					
82607	A		Vitamin B-12					
82608	A		B-12 binding capacity					
82615	A		Test for urine cystines					
82626	A		Dehydroepiandrosterone					
82627	A		Dehydroepiandrosterone					
82633	A		Desoxycorticosterone					
82634	A		Deoxycortisol					
82638	A		Assay of dibucaine number					
82646	A		Assay of dihydrocodeinone					
82649	A		Assay of dihydromorphinone					
82651	A		Assay of dihydrotestosterone					
82652	A		Assay of dihydroxyvitamin d					
82654	A		Assay of dimethadione					
82656	A	NI	Pancreatic elastase, fecal					
82657	A		Enzyme cell activity					
82658	A		Enzyme cell activity, ra					
82664	A		Electrophoretic test					
82666	A		Assay of epiandrosterone					
82668	A		Assay of erythropoietin					
82670	A		Assay of estradiol					
82671	A		Assay of estrogens					
82672	A		Assay of estrogen					
82677	A		Assay of estriol					
82679	A		Assay of estrone					
82690	A		Assay of ethchlorvynol					
82693	A		Assay of ethylene glycol					
82696	A		Assay of etiocholanolone					
82705	A		Fats/lipids, feces, qual					
82710	A		Fats/lipids, feces, quant					
82715	A		Assay of fecal fat					
82725	A		Assay of blood fatty acids					
82726	A		Long chain fatty acids					
82728	A		Assay of ferritin					
82731	A		Assay of fetal fibronectin					
82735	A		Assay of fluoride					
82742	A		Assay of flurazepam					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
82746	A		Blood folic acid serum					
82747	A		Assay of folic acid, rbc					
82757	A		Assay of semen fructose					
82759	A		Assay of rbc galactokinase					
82760	A		Assay of galactose					
82775	A		Assay galactose transferase					
82776	A		Galactose transferase test					
82784	A		Assay of gammaglobulin igm					
82785	A		Assay of gammaglobulin ige					
82787	A		Igg 1, 2, 3 or 4, each					
82800	A		Blood pH					
82803	A		Blood gases: pH, pO2 & pCO2					
82805	A		Blood gases W/02 saturation					
82810	A		Blood gases, O2 sat only					
82820	A		Hemoglobin-oxygen affinity					
82926	A		Assay of gastric acid					
82928	A		Assay of gastric acid					
82938	A		Gastrin test					
82941	A		Assay of gastrin					
82943	A		Assay of glucagon					
82945	A		Glucose other fluid					
82946	A		Glucagon tolerance test					
82947	A		Assay, glucose, blood quant					
82948	A		Reagent strip/blood glucose					
82950	A		Glucose test					
82951	A		Glucose tolerance test (GTT)					
82952	A		GTT-added samples					
82953	A		Glucose-tolbutamide test					
82955	A		Assay of g6pd enzyme					
82960	A		Test for G6PD enzyme					
82962	A		Glucose blood test					
82963	A		Assay of glucosidase					
82965	A		Assay of gdh enzyme					
82975	A		Assay of glutamine					
82977	A		Assay of GGT					
82978	A		Assay of glutathione					
82979	A		Assay, rbc glutathione					
82980	A		Assay of glutethimide					
82985	A		Glycated protein					
83001	A		Gonadotropin (FSH)					
83002	A		Gonadotropin (LH)					
83003	A		Assay, growth hormone (hgh)					
83008	A		Assay of guanosine					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
83009	A	NI	H pylori (c-13), blood					
83010	A		Assay of haptoglobin, quant					
83012	A		Assay of haptoglobins					
83013	A		H pylori (c-13), breath					
83014	A		H pylori drug admin					
83015	A		Heavy metal screen					
83018	A		Quantitative screen, metals					
83020	A		Hemoglobin electrophoresis					
83021	A		Hemoglobin chromotography					
83026	A		Hemoglobin, copper sulfate					
83030	A		Fetal hemoglobin, chemical					
83033	A		Fetal hemoglobin assay, qual					
83036	A		Glycated hemoglobin test					
83045	A		Blood methemoglobin test					
83050	A		Blood methemoglobin assay					
83051	A		Assay of plasma hemoglobin					
83055	A		Blood sulfhemoglobin test					
83060	A		Blood sulfhemoglobin assay					
83065	A		Assay of hemoglobin heat					
83068	A		Hemoglobin stability screen					
83069	A		Assay of urine hemoglobin					
83070	A		Assay of hemosiderin, qual					
83071	A		Assay of hemosiderin, quant					
83080	A		Assay of b hexosaminidase					
83088	A		Assay of histamine					
83090	A		Assay of homocystine					
83150	A		Assay of for hva					
83491	A		Assay of corticosteroids					
83497	A		Assay of 5-hiaa					
83498	A		Assay of progesterone					
83499	A		Assay of progesterone					
83500	A		Assay, free hydroxyproline					
83505	A		Assay, total hydroxyproline					
83516	A		Immunoassay, nonantibody					
83518	A		Immunoassay, dipstick					
83519	A		Immunoassay, nonantibody					
83520	A		Immunoassay, RIA					
83525	A		Assay of insulin					
83527	A		Assay of insulin					
83528	A		Assay of intrinsic factor					
83540	A		Assay of iron					
83550	A		Iron binding test					
83570	A		Assay of idh enzyme					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
83582	A		Assay of ketogenic steroids					
83586	A		Assay 17- ketosteroids					
83593	A		Fractionation, ketosteroids					
83605	A		Assay of lactic acid					
83615	A		Lactate (LD) (LDH) enzyme					
83625	A		Assay of ldh enzymes					
83630	A	NI	Lactoferrin, fecal (qual)					
83632	A		Placental lactogen					
83633	A		Test urine for lactose					
83634	A		Assay of urine for lactose					
83655	A		Assay of lead					
83661	A		L/s ratio, fetal lung					
83662	A		Foam stability, fetal lung					
83663	A		Fluoro polarize, fetal lung					
83664	A		Lamellar bdy, fetal lung					
83670	A		Assay of lap enzyme					
83690	A		Assay of lipase					
83715	A		Assay of blood lipoproteins					
83716	A		Assay of blood lipoproteins					
83718	A		Assay of lipoprotein					
83719	A		Assay of blood lipoprotein					
83721	A		Assay of blood lipoprotein					
83727	A		Assay of lrh hormone					
83735	A		Assay of magnesium					
83775	A		Assay of md enzyme					
83785	A		Assay of manganese					
83788	A		Mass spectrometry qual					
83789	A		Mass spectrometry quant					
83805	A		Assay of meprobamate					
83825	A		Assay of mercury					
83835	A		Assay of metanephrines					
83840	A		Assay of methadone					
83857	A		Assay of methemalbumin					
83858	A		Assay of methsuximide					
83864	A		Mucopolysaccharides					
83866	A		Mucopolysaccharides screen					
83872	A		Assay synovial fluid mucin					
83873	A		Assay of csf protein					
83874	A		Assay of myoglobin					
83880	A		Natriuretic peptide					
83883	A		Assay, nephelometry not spec					
83885	A		Assay of nickel					
83887	A		Assay of nicotine					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
83890	A		Molecule isolate					
83891	A		Molecule isolate nucleic					
83892	A		Molecular diagnostics					
83893	A		Molecule dot/slot/blot					
83894	A		Molecule gel electrophor					
83896	A		Molecular diagnostics					
83897	A		Molecule nucleic transfer					
83898	A		Molecule nucleic ampli					
83901	A		Molecule nucleic ampli					
83902	A		Molecular diagnostics					
83903	A		Molecule mutation scan					
83904	A		Molecule mutation identify					
83905	A		Molecule mutation identify					
83906	A		Molecule mutation identify					
83912	A		Genetic examination					
83915	A		Assay of nucleotidase					
83916	A		Oligoclonal bands					
83918	A		Organic acids, total, quant					
83919	A		Organic acids, qual, each					
83921	A		Organic acid, single, quant					
83925	A		Assay of opiates					
83930	A		Assay of blood osmolality					
83935	A		Assay of urine osmolality					
83937	A		Assay of osteocalcin					
83945	A		Assay of oxalate					
83950	A		Oncoprotein, her-2/neu					
83970	A		Assay of parathormone					
83986	A		Assay of body fluid acidity					
83992	A		Assay for phencyclidine					
84022	A		Assay of phenothiazine					
84030	A		Assay of blood pku					
84035	A		Assay of phenylketones					
84060	A		Assay acid phosphatase					
84061	A		Phosphatase, forensic exam					
84066	A		Assay prostate phosphatase					
84075	A		Assay alkaline phosphatase					
84078	A		Assay alkaline phosphatase					
84080	A		Assay alkaline phosphatases					
84081	A		Amniotic fluid enzyme test					
84085	A		Assay of rbc pg6d enzyme					
84087	A		Assay phosphohexose enzymes					
84100	A		Assay of phosphorus					
84105	A		Assay of urine phosphorus					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
84106	A		Test for porphobilinogen					
84110	A		Assay of porphobilinogen					
84119	A		Test urine for porphyrins					
84120	A		Assay of urine porphyrins					
84126	A		Assay of feces porphyrins					
84127	A		Assay of feces porphyrins					
84132	A		Assay of serum potassium					
84133	A		Assay of urine potassium					
84134	A		Assay of prealbumin					
84135	A		Assay of pregnanediol					
84138	A		Assay of pregnanetriol					
84140	A		Assay of pregnenolone					
84143	A		Assay of 17-hydroxypregneno					
84144	A		Assay of progesterone					
84146	A		Assay of prolactin					
84150	A		Assay of prostaglandin					
84152	A		Assay of psa, complexed					
84153	A		Assay of psa, total					
84154	A		Assay of psa, free					
84155	A		Assay of protein, serum					
84156	A		Assay of protein, urine					
84157	A		Assay of protein, other					
84160	A		Assay of protein, any source					
84163	A	NI	Pappa, serum					
84165	A		Protein e-phoresis, serum					
84166	A	NI	Protein e-phoresis/urine/csf					
84181	A		Western blot test					
84182	A		Protein, western blot test					
84202	A		Assay RBC protoporphyrin					
84203	A		Test RBC protoporphyrin					
84206	A		Assay of proinsulin					
84207	A		Assay of vitamin b-6					
84210	A		Assay of pyruvate					
84220	A		Assay of pyruvate kinase					
84228	A		Assay of quinine					
84233	A		Assay of estrogen					
84234	A		Assay of progesterone					
84235	A		Assay of endocrine hormone					
84238	A		Assay, nonendocrine receptor					
84244	A		Assay of renin					
84252	A		Assay of vitamin b-2					
84255	A		Assay of selenium					
84260	A		Assay of serotonin					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
84270	A		Assay of sex hormone globul					
84275	A		Assay of sialic acid					
84285	A		Assay of silica					
84295	A		Assay of serum sodium					
84300	A		Assay of urine sodium					
84302	A		Assay of sweat sodium					
84305	A		Assay of somatomedin					
84307	A		Assay of somatostatin					
84311	A		Spectrophotometry					
84315	A		Body fluid specific gravity					
84375	A		Chromatogram assay, sugars					
84376	A		Sugars, single, qual					
84377	A		Sugars, multiple, qual					
84378	A		Sugars, single, quant					
84379	A		Sugars multiple quant					
84392	A		Assay of urine sulfate					
84402	A		Assay of testosterone					
84403	A		Assay of total testosterone					
84425	A		Assay of vitamin b-1					
84430	A		Assay of thiocyanate					
84432	A		Assay of thyroglobulin					
84436	A		Assay of total thyroxine					
84437	A		Assay of neonatal thyroxine					
84439	A		Assay of free thyroxine					
84442	A		Assay of thyroid activity					
84443	A		Assay thyroid stim hormone					
84445	A		Assay of tsi					
84446	A		Assay of vitamin e					
84449	A		Assay of transcortin					
84450	A		Transferase (AST) (SGOT)					
84460	A		Alanine amino (ALT) (SGPT)					
84466	A		Assay of transferrin					
84478	A		Assay of triglycerides					
84479	A		Assay of thyroid (t3 or t4)					
84480	A		Assay, triiodothyronine (t3)					
84481	A		Free assay (FT-3)					
84482	A		T3 reverse					
84484	A		Assay of troponin, quant					
84485	A		Assay duodenal fluid trypsin					
84488	A		Test feces for trypsin					
84490	A		Assay of feces for trypsin					
84510	A		Assay of tyrosine					
84512	A		Assay of troponin, qual					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
84520	A		Assay of urea nitrogen					
84525	A		Urea nitrogen semi-quant					
84540	A		Assay of urine/urea-n					
84545	A		Urea-N clearance test					
84550	A		Assay of blood/uric acid					
84560	A		Assay of urine/uric acid					
84577	A		Assay of feces/urobilinogen					
84578	A		Test urine urobilinogen					
84580	A		Assay of urine urobilinogen					
84583	A		Assay of urine urobilinogen					
84585	A		Assay of urine vma					
84586	A		Assay of vip					
84588	A		Assay of vasopressin					
84590	A		Assay of vitamin a					
84591	A		Assay of nos vitamin					
84597	A		Assay of vitamin k					
84600	A		Assay of volatiles					
84620	A		Xylose tolerance test					
84630	A		Assay of zinc					
84681	A		Assay of c-peptide					
84702	A		Chorionic gonadotropin test					
84703	A		Chorionic gonadotropin assay					
84830	A		Ovulation tests					
84999	A		Clinical chemistry test					
85002	A		Bleeding time test					
85004	A		Automated diff wbc count					
85007	A		Bl smear w/diff wbc count					
85008	A		Bl smear w/o diff wbc count					
85009	A		Manual diff wbc count b-coat					
85013	A		Spun microhematocrit					
85014	A		Hematocrit					
85018	A		Hemoglobin					
85025	A		Complete cbc w/auto diff wbc					
85027	A		Complete cbc, automated					
85032	A		Manual cell count, each					
85041	A		Automated rbc count					
85044	A		Manual reticulocyte count					
85045	A		Automated reticulocyte count					
85046	A		Reticyte/hgb concentrate					
85048	A		Automated leukocyte count					
85049	A		Automated platelet count					
85055	A		Reticulated platelet assay					
85060	X		Blood smear interpretation	0342	0.2068	11.78	5.30	2.36

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
85097	X		Bone marrow interpretation	0343	0.4329	24.67	11.10	4.93
85130	A		Chromogenic substrate assay					
85170	A		Blood clot retraction					
85175	A		Blood clot lysis time					
85210	A		Blood clot factor II test					
85220	A		Blood clot factor V test					
85230	A		Blood clot factor VII test					
85240	A		Blood clot factor VIII test					
85244	A		Blood clot factor VIII test					
85245	A		Blood clot factor VIII test					
85246	A		Blood clot factor VIII test					
85247	A		Blood clot factor VIII test					
85250	A		Blood clot factor IX test					
85260	A		Blood clot factor X test					
85270	A		Blood clot factor XI test					
85280	A		Blood clot factor XII test					
85290	A		Blood clot factor XIII test					
85291	A		Blood clot factor XIII test					
85292	A		Blood clot factor assay					
85293	A		Blood clot factor assay					
85300	A		Antithrombin III test					
85301	A		Antithrombin III test					
85302	A		Blood clot inhibitor antigen					
85303	A		Blood clot inhibitor test					
85305	A		Blood clot inhibitor assay					
85306	A		Blood clot inhibitor test					
85307	A		Assay activated protein c					
85335	A		Factor inhibitor test					
85337	A		Thrombomodulin					
85345	A		Coagulation time					
85347	A		Coagulation time					
85348	A		Coagulation time					
85360	A		Euglobulin lysis					
85362	A		Fibrin degradation products					
85366	A		Fibrinogen test					
85370	A		Fibrinogen test					
85378	A		Fibrin degrade, semiquant					
85379	A		Fibrin degradation, quant					
85380	A		Fibrin degradation, vte					
85384	A		Fibrinogen					
85385	A		Fibrinogen					
85390	A		Fibrinolysins screen					
85396	N		Clotting assay, whole blood					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
85400	A		Fibrinolytic plasmin					
85410	A		Fibrinolytic antiplasmin					
85415	A		Fibrinolytic plasminogen					
85420	A		Fibrinolytic plasminogen					
85421	A		Fibrinolytic plasminogen					
85441	A		Heinz bodies, direct					
85445	A		Heinz bodies, induced					
85460	A		Hemoglobin, fetal					
85461	A		Hemoglobin, fetal					
85475	A		Hemolysin					
85520	A		Heparin assay					
85525	A		Heparin neutralization					
85530	A		Heparin-protamine tolerance					
85536	A		Iron stain peripheral blood					
85540	A		Wbc alkaline phosphatase					
85547	A		RBC mechanical fragility					
85549	A		Muramidase					
85555	A		RBC osmotic fragility					
85557	A		RBC osmotic fragility					
85576	A		Blood platelet aggregation					
85597	A		Platelet neutralization					
85610	A		Prothrombin time					
85611	A		Prothrombin test					
85612	A		Viper venom prothrombin time					
85613	A		Russell viper venom, diluted					
85635	A		Reptilase test					
85651	A		Rbc sed rate, nonautomated					
85652	A		Rbc sed rate, automated					
85660	A		RBC sickle cell test					
85670	A		Thrombin time, plasma					
85675	A		Thrombin time, titer					
85705	A		Thromboplastin inhibition					
85730	A		Thromboplastin time, partial					
85732	A		Thromboplastin time, partial					
85810	A		Blood viscosity examination					
85999	A		Hematology procedure					
86000	A		Agglutinins, febrile					
86001	A		Allergen specific igg					
86003	A		Allergen specific IgE					
86005	A		Allergen specific IgE					
86021	A		WBC antibody identification					
86022	A		Platelet antibodies					
86023	A		Immunoglobulin assay					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
86038	A		Antinuclear antibodies					
86039	A		Antinuclear antibodies (ANA)					
86060	A		Antistreptolysin o, titer					
86063	A		Antistreptolysin o, screen					
86064	A	NI	B cells, total count					
86077	X	NI	Physician blood bank service	0343	0.4329	24.67	11.10	4.93
86078	X	NI	Physician blood bank service	0343	0.4329	24.67	11.10	4.93
86079	X	NI	Physician blood bank service	0343	0.4329	24.67	11.10	4.93
86140	A		C-reactive protein					
86141	A		C-reactive protein, hs					
86146	A		Glycoprotein antibody					
86147	A		Cardiolipin antibody					
86148	A		Phospholipid antibody					
86155	A		Chemotaxis assay					
86156	A		Cold agglutinin, screen					
86157	A		Cold agglutinin, titer					
86160	A		Complement, antigen					
86161	A		Complement/function activity					
86162	A		Complement, total (CH50)					
86171	A		Complement fixation, each					
86185	A		Counterimmunoelectrophoresis					
86215	A		Deoxyribonuclease, antibody					
86225	A		DNA antibody					
86226	A		DNA antibody, single strand					
86235	A		Nuclear antigen antibody					
86243	A		Fc receptor					
86255	A		Fluorescent antibody, screen					
86256	A		Fluorescent antibody, titer					
86277	A		Growth hormone antibody					
86280	A		Hemagglutination inhibition					
86294	A		Immunoassay, tumor, qual					
86300	A		Immunoassay, tumor, ca 15-3					
86301	A		Immunoassay, tumor, ca 19-9					
86304	A		Immunoassay, tumor, ca 125					
86308	A		Heterophile antibodies					
86309	A		Heterophile antibodies					
86310	A		Heterophile antibodies					
86316	A		Immunoassay, tumor other					
86317	A		Immunoassay,infectious agent					
86318	A		Immunoassay,infectious agent					
86320	A		Serum immunoelectrophoresis					
86325	A		Other immunoelectrophoresis					
86327	A		Immunoelectrophoresis assay					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
86329	A		Immunodiffusion					
86331	A		Immunodiffusion ouchterlony					
86332	A		Immune complex assay					
86334	A		Immunofix e-phoresis, serum					
86335	A	NI	Immunfix e-phorsis/urine/csf					
86336	A		Inhibin A					
86337	A		Insulin antibodies					
86340	A		Intrinsic factor antibody					
86341	A		Islet cell antibody					
86343	A		Leukocyte histamine release					
86344	A		Leukocyte phagocytosis					
86353	A		Lymphocyte transformation					
86359	A		T cells, total count					
86360	A		T cell, absolute count/ratio					
86361	A		T cell, absolute count					
86376	A		Microsomal antibody					
86378	A		Migration inhibitory factor					
86379	A	NI	Nk cells, total count					
86382	A		Neutralization test, viral					
86384	A		Nitroblue tetrazolium dye					
86403	A		Particle agglutination test					
86406	A		Particle agglutination test					
86430	A		Rheumatoid factor test					
86431	A		Rheumatoid factor, quant					
86485	X		Skin test, candida	0341	0.1132	6.45	2.62	1.29
86490	X		Coccidioidomycosis skin test	0341	0.1132	6.45	2.62	1.29
86510	X		Histoplasmosis skin test	0341	0.1132	6.45	2.62	1.29
86580	X		TB intradermal test	0341	0.1132	6.45	2.62	1.29
86585	X		TB tine test	0341	0.1132	6.45	2.62	1.29
86586	X		Skin test, unlisted	0341	0.1132	6.45	2.62	1.29
86587	A	NI	Stem cells, total count					
86590	A		Streptokinase, antibody					
86592	A		Blood serology, qualitative					
86593	A		Blood serology, quantitative					
86602	A		Antinomyces antibody					
86603	A		Adenovirus antibody					
86606	A		Aspergillus antibody					
86609	A		Bacterium antibody					
86611	A		Bartonella antibody					
86612	A		Blastomyces antibody					
86615	A		Bordetella antibody					
86617	A		Lyme disease antibody					
86618	A		Lyme disease antibody					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
86619	A		Borrelia antibody					
86622	A		Brucella antibody					
86625	A		Campylobacter antibody					
86628	A		Candida antibody					
86631	A		Chlamydia antibody					
86632	A		Chlamydia igm antibody					
86635	A		Coccidioides antibody					
86638	A		Q fever antibody					
86641	A		Cryptococcus antibody					
86644	A		CMV antibody					
86645	A		CMV antibody, IgM					
86648	A		Diphtheria antibody					
86651	A		Encephalitis antibody					
86652	A		Encephalitis antibody					
86653	A		Encephalitis antibody					
86654	A		Encephalitis antibody					
86658	A		Enterovirus antibody					
86663	A		Epstein-barr antibody					
86664	A		Epstein-barr antibody					
86665	A		Epstein-barr antibody					
86666	A		Ehrlichia antibody					
86668	A		Francisella tularensis					
86671	A		Fungus antibody					
86674	A		Giardia lamblia antibody					
86677	A		Helicobacter pylori					
86682	A		Helminth antibody					
86684	A		Hemophilus influenza					
86687	A		Htlv-i antibody					
86688	A		Htlv-ii antibody					
86689	A		HTLV/HIV confirmatory test					
86692	A		Hepatitis, delta agent					
86694	A		Herpes simplex test					
86695	A		Herpes simplex test					
86696	A		Herpes simplex type 2					
86698	A		Histoplasma					
86701	A		HIV-1					
86702	A		HIV-2					
86703	A		HIV-1/HIV-2, single assay					
86704	A		Hep b core antibody, total					
86705	A		Hep b core antibody, igm					
86706	A		Hep b surface antibody					
86707	A		Hep be antibody					
86708	A		Hep a antibody, total					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
86709	A		Hep a antibody, igm					
86710	A		Influenza virus antibody					
86713	A		Legionella antibody					
86717	A		Leishmania antibody					
86720	A		Leptospira antibody					
86723	A		Listeria monocytogenes ab					
86727	A		Lymph choriomeningitis ab					
86729	A		Lympho venereum antibody					
86732	A		Mucormycosis antibody					
86735	A		Mumps antibody					
86738	A		Mycoplasma antibody					
86741	A		Neisseria meningitidis					
86744	A		Nocardia antibody					
86747	A		Parvovirus antibody					
86750	A		Malaria antibody					
86753	A		Protozoa antibody nos					
86756	A		Respiratory virus antibody					
86757	A		Rickettsia antibody					
86759	A		Rotavirus antibody					
86762	A		Rubella antibody					
86765	A		Rubeola antibody					
86768	A		Salmonella antibody					
86771	A		Shigella antibody					
86774	A		Tetanus antibody					
86777	A		Toxoplasma antibody					
86778	A		Toxoplasma antibody, igm					
86781	A		Treponema pallidum, confirm					
86784	A		Trichinella antibody					
86787	A		Varicella-zoster antibody					
86790	A		Virus antibody nos					
86793	A		Yersinia antibody					
86800	A		Thyroglobulin antibody					
86803	A		Hepatitis c ab test					
86804	A		Hep c ab test, confirm					
86805	A		Lymphocytotoxicity assay					
86806	A		Lymphocytotoxicity assay					
86807	A		Cytotoxic antibody screening					
86808	A		Cytotoxic antibody screening					
86812	A		HLA typing, A, B, or C					
86813	A		HLA typing, A, B, or C					
86816	A		HLA typing, DR/DQ					
86817	A		HLA typing, DR/DQ					
86821	A		Lymphocyte culture, mixed					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
86822	A		Lymphocyte culture, primed					
86849	A		Immunology procedure					
86850	X		RBC antibody screen	0345	0.2413	13.75	3.06	2.75
86860	X		RBC antibody elution	0346	0.3586	20.43	5.15	4.09
86870	X		RBC antibody identification	0346	0.3586	20.43	5.15	4.09
86880	X		Coombs test, direct	0409	0.1272	7.25	2.22	1.45
86885	X		Coombs test, indirect, qual	0409	0.1272	7.25	2.22	1.45
86886	X		Coombs test, indirect, titer	0409	0.1272	7.25	2.22	1.45
86890	X		Autologous blood process	0347	0.9386	53.48	13.20	10.70
86891	X		Autologous blood, op salvage	0345	0.2413	13.75	3.06	2.75
86900	X		Blood typing, ABO	0409	0.1272	7.25	2.22	1.45
86901	X		Blood typing, Rh (D)	0409	0.1272	7.25	2.22	1.45
86903	X		Blood typing, antigen screen	0345	0.2413	13.75	3.06	2.75
86904	X		Blood typing, patient serum	0345	0.2413	13.75	3.06	2.75
86905	X		Blood typing, RBC antigens	0345	0.2413	13.75	3.06	2.75
86906	X		Blood typing, Rh phenotype	0345	0.2413	13.75	3.06	2.75
86910	E		Blood typing, paternity test					
86911	E		Blood typing, antigen system					
86920	X		Compatibility test	0346	0.3586	20.43	5.15	4.09
86921	X		Compatibility test	0345	0.2413	13.75	3.06	2.75
86922	X		Compatibility test	0346	0.3586	20.43	5.15	4.09
86927	X		Plasma, fresh frozen	0346	0.3586	20.43	5.15	4.09
86930	X		Frozen blood prep	0347	0.9386	53.48	13.20	10.70
86931	X		Frozen blood thaw	0347	0.9386	53.48	13.20	10.70
86932	X		Frozen blood freeze/thaw	0347	0.9386	53.48	13.20	10.70
86940	A		Hemolysins/agglutinins, auto					
86941	A		Hemolysins/agglutinins					
86945	X		Blood product/irradiation	0346	0.3586	20.43	5.15	4.09
86950	X		Leukacyte transfusion	0347	0.9386	53.48	13.20	10.70
86965	X		Pooling blood platelets	0346	0.3586	20.43	5.15	4.09
86970	X		RBC pretreatment	0345	0.2413	13.75	3.06	2.75
86971	X		RBC pretreatment	0345	0.2413	13.75	3.06	2.75
86972	X		RBC pretreatment	0345	0.2413	13.75	3.06	2.75
86975	X		RBC pretreatment, serum	0345	0.2413	13.75	3.06	2.75
86976	X		RBC pretreatment, serum	0345	0.2413	13.75	3.06	2.75
86977	X		RBC pretreatment, serum	0345	0.2413	13.75	3.06	2.75
86978	X		RBC pretreatment, serum	0345	0.2413	13.75	3.06	2.75
86985	X		Split blood or products	0347	0.9386	53.48	13.20	10.70
86999	X		Transfusion procedure	0345	0.2413	13.75	3.06	2.75
87001	A		Small animal inoculation					
87003	A		Small animal inoculation					
87015	A		Specimen concentration					
87040	A		Blood culture for bacteria					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
87045	A		Feces culture, bacteria					
87046	A		Stool cultr, bacteria, each					
87070	A		Culture, bacteria, other					
87071	A		Culture bacteri aerobic othr					
87073	A		Culture bacteria anaerobic					
87075	A		Cultr bacteria, except blood					
87076	A		Culture anaerobe ident, each					
87077	A		Culture aerobic identify					
87081	A		Culture screen only					
87084	A		Culture of specimen by kit					
87086	A		Urine culture/colony count					
87088	A		Urine bacteria culture					
87101	A		Skin fungi culture					
87102	A		Fungus isolation culture					
87103	A		Blood fungus culture					
87106	A		Fungi identification, yeast					
87107	A		Fungi identification, mold					
87109	A		Mycoplasma					
87110	A		Chlamydia culture					
87116	A		Mycobacteria culture					
87118	A		Mycobacteric identification					
87140	A		Culture type immunofluoresc					
87143	A		Culture typing, glc/hplc					
87147	A		Culture type, immunologic					
87149	A		Culture type, nucleic acid					
87152	A		Culture type pulse field gel					
87158	A		Culture typing, added method					
87164	A		Dark field examination					
87166	A		Dark field examination					
87168	A		Macroscopic exam arthropod					
87169	A		Macroscopic exam parasite					
87172	A		Pinworm exam					
87176	A		Tissue homogenization, cultr					
87177	A		Ova and parasites smears					
87181	A		Microbe susceptible, diffuse					
87184	A		Microbe susceptible, disk					
87185	A		Microbe susceptible, enzyme					
87186	A		Microbe susceptible, mic					
87187	A		Microbe susceptible, mlc					
87188	A		Microbe suscept, macrobroth					
87190	A		Microbe suscept, mycobacteri					
87197	A		Bactericidal level, serum					
87205	A		Smear, gram stain					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
87206	A		Smear, fluorescent/acid stai					
87207	A		Smear, special stain					
87210	A		Smear, wet mount, saline/ink					
87220	A		Tissue exam for fungi					
87230	A		Assay, toxin or antitoxin					
87250	A		Virus inoculate, eggs/animal					
87252	A		Virus inoculation, tissue					
87253	A		Virus inoculate tissue, addl					
87254	A		Virus inoculation, shell via					
87255	A		Genet virus isolate, hsv					
87260	A		Adenovirus ag, if					
87265	A		Pertussis ag, if					
87267	A		Enterovirus antibody, dfa					
87269	A		Giardia ag, if					
87270	A		Chlamydia trachomatis ag, if					
87271	A		Cryptosporidum/gardia ag, if					
87272	A		Cryptosporidium ag, if					
87273	A		Herpes simplex 2, ag, if					
87274	A		Herpes simplex 1, ag, if					
87275	A		Influenza b, ag, if					
87276	A		Influenza a, ag, if					
87277	A		Legionella micdadei, ag, if					
87278	A		Legion pneumophilia ag, if					
87279	A		Parainfluenza, ag, if					
87280	A		Respiratory syncytial ag, if					
87281	A		Pneumocystis carinii, ag, if					
87283	A		Rubeola, ag, if					
87285	A		Treponema pallidum, ag, if					
87290	A		Varicella zoster, ag, if					
87299	A		Antibody detection, nos, if					
87300	A		Ag detection, polyval, if					
87301	A		Adenovirus ag, eia					
87320	A		Chylmd trach ag, eia					
87324	A		Clostridium ag, eia					
87327	A		Cryptococcus neoform ag, eia					
87328	A		Cryptosporidium ag, eia					
87329	A		Giardia ag, eia					
87332	A		Cytomegalovirus ag, eia					
87335	A		E coli 0157 ag, eia					
87336	A		Entamoeb hist dispr, ag, eia					
87337	A		Entamoeb hist group, ag, eia					
87338	A		Hpylori, stool, eia					
87339	A		H pylori ag, eia					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
87340	A		Hepatitis b surface ag, eia					
87341	A		Hepatitis b surface, ag, eia					
87350	A		Hepatitis be ag, eia					
87380	A		Hepatitis delta ag, eia					
87385	A		Histoplasma capsul ag, eia					
87390	A		Hiv-1 ag, eia					
87391	A		Hiv-2 ag, eia					
87400	A		Influenza a/b, ag, eia					
87420	A		Resp syncytial ag, eia					
87425	A		Rotavirus ag, eia					
87427	A		Shiga-like toxin ag, eia					
87430	A		Strep a ag, eia					
87449	A		Ag detect nos, eia, mult					
87450	A		Ag detect nos, eia, single					
87451	A		Ag detect polyval, eia, mult					
87470	A		Bartonella, dna, dir probe					
87471	A		Bartonella, dna, amp probe					
87472	A		Bartonella, dna, quant					
87475	A		Lyme dis, dna, dir probe					
87476	A		Lyme dis, dna, amp probe					
87477	A		Lyme dis, dna, quant					
87480	A		Candida, dna, dir probe					
87481	A		Candida, dna, amp probe					
87482	A		Candida, dna, quant					
87485	A		Chylmd pneum, dna, dir probe					
87486	A		Chylmd pneum, dna, amp probe					
87487	A		Chylmd pneum, dna, quant					
87490	A		Chylmd trach, dna, dir probe					
87491	A		Chylmd trach, dna, amp probe					
87492	A		Chylmd trach, dna, quant					
87495	A		Cytomeg, dna, dir probe					
87496	A		Cytomeg, dna, amp probe					
87497	A		Cytomeg, dna, quant					
87510	A		Gardner vag, dna, dir probe					
87511	A		Gardner vag, dna, amp probe					
87512	A		Gardner vag, dna, quant					
87515	A		Hepatitis b, dna, dir probe					
87516	A		Hepatitis b, dna, amp probe					
87517	A		Hepatitis b, dna, quant					
87520	A		Hepatitis c, rna, dir probe					
87521	A		Hepatitis c, rna, amp probe					
87522	A		Hepatitis c, rna, quant					
87525	A		Hepatitis g, dna, dir probe					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
87526	A		Hepatitis g, dna, amp probe					
87527	A		Hepatitis g, dna, quant					
87528	A		Hsv, dna, dir probe					
87529	A		Hsv, dna, amp probe					
87530	A		Hsv, dna, quant					
87531	A		Hhv-6, dna, dir probe					
87532	A		Hhv-6, dna, amp probe					
87533	A		Hhv-6, dna, quant					
87534	A		Hiv-1, dna, dir probe					
87535	A		Hiv-1, dna, amp probe					
87536	A		Hiv-1, dna, quant					
87537	A		Hiv-2, dna, dir probe					
87538	A		Hiv-2, dna, amp probe					
87539	A		Hiv-2, dna, quant					
87540	A		Legion pneumo, dna, dir prob					
87541	A		Legion pneumo, dna, amp prob					
87542	A		Legion pneumo, dna, quant					
87550	A		Mycobacteria, dna, dir probe					
87551	A		Mycobacteria, dna, amp probe					
87552	A		Mycobacteria, dna, quant					
87555	A		M.tuberculo, dna, dir probe					
87556	A		M.tuberculo, dna, amp probe					
87557	A		M.tuberculo, dna, quant					
87560	A		M.avium-intra, dna, dir prob					
87561	A		M.avium-intra, dna, amp prob					
87562	A		M.avium-intra, dna, quant					
87580	A		M.pneumon, dna, dir probe					
87581	A		M.pneumon, dna, amp probe					
87582	A		M.pneumon, dna, quant					
87590	A		N.gonorrhoeae, dna, dir prob					
87591	A		N.gonorrhoeae, dna, amp prob					
87592	A		N.gonorrhoeae, dna, quant					
87620	A		Hpv, dna, dir probe					
87621	A		Hpv, dna, amp probe					
87622	A		Hpv, dna, quant					
87650	A		Strep a, dna, dir probe					
87651	A		Strep a, dna, amp probe					
87652	A		Strep a, dna, quant					
87660	A		Trichomonas vagin, dir probe					
87797	A		Detect agent nos, dna, dir					
87798	A		Detect agent nos, dna, amp					
87799	A		Detect agent nos, dna, quant					
87800	A		Detect agnt mult, dna, direc					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
87801	A		Detect agnt mult, dna, ampli					
87802	A		Strep b assay w/optic					
87803	A		Clostridium toxin a w/optic					
87804	A		Influenza assay w/optic					
87807	A	NI	Rsv assay w/optic					
87810	A		Chylmd trach assay w/optic					
87850	A		N. gonorrhoeae assay w/optic					
87880	A		Strep a assay w/optic					
87899	A		Agent nos assay w/optic					
87901	A		Genotype, dna, hiv reverse t					
87902	A		Genotype, dna, hepatitis C					
87903	A		Phenotype, dna hiv w/culture					
87904	A		Phenotype, dna hiv w/clt add					
87999	A		Microbiology procedure					
88000	E		Autopsy (necropsy), gross					
88005	E		Autopsy (necropsy), gross					
88007	E		Autopsy (necropsy), gross					
88012	E		Autopsy (necropsy), gross					
88014	E		Autopsy (necropsy), gross					
88016	E		Autopsy (necropsy), gross					
88020	E		Autopsy (necropsy), complete					
88025	E		Autopsy (necropsy), complete					
88027	E		Autopsy (necropsy), complete					
88028	E		Autopsy (necropsy), complete					
88029	E		Autopsy (necropsy), complete					
88036	E		Limited autopsy					
88037	E		Limited autopsy					
88040	E		Forensic autopsy (necropsy)					
88045	E		Coroner's autopsy (necropsy)					
88099	E		Necropsy (autopsy) procedure					
88104	X		Cytopathology, fluids	0343	0.4329	24.67	11.10	4.93
88106	X		Cytopathology, fluids	0343	0.4329	24.67	11.10	4.93
88107	X		Cytopathology, fluids	0343	0.4329	24.67	11.10	4.93
88108	X		Cytopath, concentrate tech	0343	0.4329	24.67	11.10	4.93
88112	X		Cytopath, cell enhance tech	0343	0.4329	24.67	11.10	4.93
88125	X		Forensic cytopathology	0342	0.2068	11.78	5.30	2.36
88130	A		Sex chromatin identification					
88140	A		Sex chromatin identification					
88141	N		Cytopath, c/v, interpret					
88142	A		Cytopath, c/v, thin layer					
88143	A		Cytopath c/v thin layer redo					
88147	A		Cytopath, c/v, automated					
88148	A		Cytopath, c/v, auto rescreen					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
88150	A		Cytopath, c/v, manual		.	.	.	.
88152	A		Cytopath, c/v, auto redo		.	.	.	.
88153	A		Cytopath, c/v, redo		.	.	.	.
88154	A		Cytopath, c/v, select		.	.	.	.
88155	A		Cytopath, c/v, index add-on		.	.	.	.
88160	X		Cytopath smear, other source	0342	0.2068	11.78	5.30	2.36
88161	X		Cytopath smear, other source	0343	0.4329	24.67	11.10	4.93
88162	X		Cytopath smear, other source	0342	0.2068	11.78	5.30	2.36
88164	A		Cytopath tbs, c/v, manual		.	.	.	.
88165	A		Cytopath tbs, c/v, redo		.	.	.	.
88166	A		Cytopath tbs, c/v, auto redo		.	.	.	.
88167	A		Cytopath tbs, c/v, select		.	.		
88172	X		Cytopathology eval of fna	0343	0.4329	24.67	11.10	4.93
88173	X		Cytopath eval, fna, report	0343	0.4329	24.67	11.10	4.93
88174	A		Cytopath, c/v auto, in fluid		.	.	.	.
88175	A		Cytopath c/v auto fluid redo		.	.	.	.
88180	D		Cell marker study		.	.	.	.
88182	X		Cell marker study	0344	0.6110	34.82	15.66	6.96
88184	X	NI	Flowcytometry/ tc, 1 marker	0342	0.2068	11.78	5.30	2.36
88185	X	NI	Flowcytometry/tc, add-on	0342	0.2068	11.78	5.30	2.36
88187	X	NI	Flowcytometry/read, 2-8	0342	0.2068	11.78	5.30	2.36
88188	X	NI	Flowcytometry/read, 9-15	0342	0.2068	11.78	5.30	2.36
88189	X	NI	Flowcytometry/read, 16 & >	0344	0.6110	34.82	15.66	6.96
88199	A		Cytopathology procedure		.	.	.	.
88230	A		Tissue culture, lymphocyte		.	.	.	.
88233	A		Tissue culture, skin/biopsy		.	.	.	.
88235	A		Tissue culture, placenta		.	.	.	.
88237	A		Tissue culture, bone marrow		.	.	.	.
88239	A		Tissue culture, tumor		.	.	.	.
88240	A		Cell cryopreserve/storage		.	.	.	.
88241	A		Frozen cell preparation		.	.	.	.
88245	A		Chromosome analysis, 20-25		.	.	.	.
88248	A		Chromosome analysis, 50-100		.	.	.	.
88249	A		Chromosome analysis, 100		.	.	.	.
88261	A		Chromosome analysis, 5		.	.	.	.
88262	A		Chromosome analysis, 15-20		.	.	.	.
88263	A		Chromosome analysis, 45		.	.	.	.
88264	A		Chromosome analysis, 20-25		.	.	.	.
88267	A		Chromosome analys, placenta		.	.	.	.
88269	A		Chromosome analys, amniotic		.	.	.	.
88271	A		Cytogenetics, dna probe		.	.	.	.
88272	A		Cytogenetics, 3-5		.	.	.	.
88273	A		Cytogenetics, 10-30		.	.	.	.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
88274	A		Cytogenetics, 25-99		.	.	.	.
88275	A		Cytogenetics, 100-300		.	.	.	.
88280	A		Chromosome karyotype study		.	.	.	.
88283	A		Chromosome banding study		.	.	.	.
88285	A		Chromosome count, additional		.	.	.	.
88289	A		Chromosome study, additional		.	.	.	.
88291	A		Cyto/molecular report		.	.	.	.
88299	X		Cytogenetic study	0342	0.2068	11.78	5.30	2.36
88300	X		Surgical path, gross	0342	0.2068	11.78	5.30	2.36
88302	X		Tissue exam by pathologist	0342	0.2068	11.78	5.30	2.36
88304	X		Tissue exam by pathologist	0343	0.4329	24.67	11.10	4.93
88305	X		Tissue exam by pathologist	0343	0.4329	24.67	11.10	4.93
88307	X		Tissue exam by pathologist	0344	0.6110	34.82	15.66	6.96
88309	X		Tissue exam by pathologist	0344	0.6110	34.82	15.66	6.96
88311	X		Decalcify tissue	0342	0.2068	11.78	5.30	2.36
88312	X		Special stains	0342	0.2068	11.78	5.30	2.36
88313	X		Special stains	0342	0.2068	11.78	5.30	2.36
88314	X		Histochemical stain	0342	0.2068	11.78	5.30	2.36
88318	X		Chemical histochemistry	0342	0.2068	11.78	5.30	2.36
88319	X		Enzyme histochemistry	0342	0.2068	11.78	5.30	2.36
88321	X		Microslide consultation	0342	0.2068	11.78	5.30	2.36
88323	X		Microslide consultation	0344	0.6110	34.82	15.66	6.96
88325	X		Comprehensive review of data	0344	0.6110	34.82	15.66	6.96
88329	X		Path consult introp	0342	0.2068	11.78	5.30	2.36
88331	X		Path consult intraop, 1 bloc	0343	0.4329	24.67	11.10	4.93
88332	X		Path consult intraop, add'l	0342	0.2068	11.78	5.30	2.36
88342	X		Immunohistochemistry	0344	0.6110	34.82	15.66	6.96
88346	X		Immunofluorescent study	0344	0.6110	34.82	15.66	6.96
88347	X		Immunofluorescent study	0344	0.6110	34.82	15.66	6.96
88348	X		Electron microscopy	0661	3.5068	199.83	88.87	39.97
88349	X		Scanning electron microscopy	0661	3.5068	199.83	88.87	39.97
88355	X		Analysis, skeletal muscle	0344	0.6110	34.82	15.66	6.96
88356	X		Analysis, nerve	0344	0.6110	34.82	15.66	6.96
88358	X		Analysis, tumor	0344	0.6110	34.82	15.66	6.96
88360	X	NI	Tumor immunohistochem/manual	0344	0.6110	34.82	15.66	6.96
88361	X		Tumor immunohistochem/comput	0344	0.6110	34.82	15.66	6.96
88362	X		Nerve teasing preparations	0344	0.6110	34.82	15.66	6.96
88365	X		Insitu hybridization (fish)	0344	0.6110	34.82	15.66	6.96
88367	X	NI	Insitu hybridization, auto	0344	0.6110	34.82	15.66	6.96
88368	X	NI	Insitu hybridization, manual	0344	0.6110	34.82	15.66	6.96
88371	A		Protein, western blot tissue		.	.	.	.
88372	A		Protein analysis w/probe		.	.	.	.
88380	A		Microdissection		.	.	.	.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
88399	A		Surgical pathology procedure		.	.	.	.
88400	A		Bilirubin total transcut		.	.	.	.
89050	A		Body fluid cell count		.	.	.	.
89051	A		Body fluid cell count		.	.	.	.
89055	A		Leukocyte assessment, fecal		.	.	.	.
89060	A		Exam,synovial fluid crystals		.	.	.	.
89100	X		Sample intestinal contents	0360	1.6719	95.27	42.45	19.05
89105	X		Sample intestinal contents	0360	1.6719	95.27	42.45	19.05
89125	A		Specimen fat stain		.	.	.	.
89130	X		Sample stomach contents	0360	1.6719	95.27	42.45	19.05
89132	X		Sample stomach contents	0360	1.6719	95.27	42.45	19.05
89135	X		Sample stomach contents	0360	1.6719	95.27	42.45	19.05
89136	X		Sample stomach contents	0360	1.6719	95.27	42.45	19.05
89140	X		Sample stomach contents	0360	1.6719	95.27	42.45	19.05
89141	X		Sample stomach contents	0360	1.6719	95.27	42.45	19.05
89160	A		Exam feces for meat fibers		.	.	.	.
89190	A		Nasal smear for eosinophils		.	.	.	.
89220	X		Sputum specimen collection	0343	0.4329	24.67	11.10	4.93
89225	A		Starch granules, feces		.	.	.	.
89230	X		Collect sweat for test	0343	0.4329	24.67	11.10	4.93
89235	A		Water load test		.	.	.	.
89240	A		Pathology lab procedure		.	.	.	.
89250	X		Cultr oocyte/embryo <4 days	0348	0.7675	43.73	.	8.75
89251	X		Cultr oocyte/embryo <4 days	0348	0.7675	43.73	.	8.75
89253	X		Embryo hatching	0348	0.7675	43.73	.	8.75
89254	X		Oocyte identification	0348	0.7675	43.73	.	8.75
89255	X		Prepare embryo for transfer	0348	0.7675	43.73	.	8.75
89257	X		Sperm identification	0348	0.7675	43.73	.	8.75
89258	X		Cryopreservation; embryo(s)	0348	0.7675	43.73	.	8.75
89259	X		Cryopreservation, sperm	0348	0.7675	43.73	.	8.75
89260	X		Sperm isolation, simple	0348	0.7675	43.73	.	8.75
89261	X		Sperm isolation, complex	0348	0.7675	43.73	.	8.75
89264	X		Identify sperm tissue	0348	0.7675	43.73	.	8.75
89268	X		Insemination of oocytes	0348	0.7675	43.73	.	8.75
89272	X		Extended culture of oocytes	0348	0.7675	43.73	.	8.75
89280	X		Assist oocyte fertilization	0348	0.7675	43.73	.	8.75
89281	X		Assist oocyte fertilization	0348	0.7675	43.73	.	8.75
89290	X		Biopsy, oocyte polar body	0348	0.7675	43.73	.	8.75
89291	X		Biopsy, oocyte polar body	0348	0.7675	43.73	.	8.75
89300	A		Semen analysis w/huhner		.	.	.	.
89310	A		Semen analysis w/count		.	.	.	.
89320	A		Semen analysis, complete		.	.	.	.
89321	A		Semen analysis & motility		.	.	.	.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
89325	A		Sperm antibody test					
89329	A		Sperm evaluation test					
89330	A		Evaluation, cervical mucus					
89335	X		Cryopreserve testicular tiss	0348	0.7675	43.73		8.75
89342	X		Storage/year; embryo(s)	0348	0.7675	43.73		8.75
89343	X		Storage/year; sperm/semen	0348	0.7675	43.73		8.75
89344	X		Storage/year; reprod tissue	0348	0.7675	43.73		8.75
89346	X		Storage/year; oocyte(s)	0348	0.7675	43.73		8.75
89352	X		Thawing cryopresrved; embryo	0348	0.7675	43.73		8.75
89353	X		Thawing cryopresrved; sperm	0348	0.7675	43.73		8.75
89354	X		Thaw cryoprsvrd; reprod tiss	0348	0.7675	43.73		8.75
89356	X		Thawing cryopresrved; oocyte	0348	0.7675	43.73		8.75
90281	E		Human ig, im					
90283	E		Human ig, iv					
90287	E		Botulinum antitoxin					
90288	E		Botulism ig, iv					
90291	E		Cmv ig, iv					
90296	N		Diphtheria antitoxin					
90371	E		Hep b ig, im					
90375	N		Rabies ig, im/sc					
90376	K		Rabies ig, heat treated	0356	1.5752	89.76		17.95
90378	E		Rsv ig, im, 50mg					
90379	E		Rsv ig, iv					
90384	E		Rh ig, full-dose, im					
90385	N		Rh ig, minidose, im					
90386	E		Rh ig, iv					
90389	E		Tetanus ig, im					
90393	K		Vaccina ig, im	0356	1.5752	89.76		17.95
90396	K		Varicella-zoster ig, im	0356	1.5752	89.76		17.95
90399	E		Immune globulin					
90465	N	NI	Immune admin 1 inj, < 8 yrs					
90466	N	NI	Immune admin addl inj, < 8 y					
90467	N	NI	Immune admin o or n, < 8 yrs					
90468	N	NI	Immune admin o/n, addl < 8 y					
90471	N		Immunization admin					
90472	N		Immunization admin, each add					
90473	E		Immune admin oral/nasal					
90474	E		Immune admin oral/nasal addl					
90476	K		Adenovirus vaccine, type 4	0356	1.5752	89.76		17.95
90477	N		Adenovirus vaccine, type 7					
90581	N		Anthrax vaccine, sc					
90585	N		Bcg vaccine, percut					
90586	K		Bcg vaccine, intravesical	0356	1.5752	89.76		17.95

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
90632	N		Hep a vaccine, adult im					
90633	N		Hep a vacc, ped/adol, 2 dose					
90634	N		Hep a vacc, ped/adol, 3 dose					
90636	K		Hep a/hep b vacc, adult im	0356	1.5752	89.76		17.95
90645	N		Hib vaccine, hboc, im					
90646	N		Hib vaccine, prp-d, im					
90647	N		Hib vaccine, prp-omp, im					
90648	N		Hib vaccine, prp-t, im					
90655	L		Flu vaccine no preserv 6-35m					
90656	L	NI	Flu vaccine no preserv 3 & >					
90657	L		Flu vaccine, 3 yrs, im					
90658	L		Flu vaccine, 3 yrs & >, im					
90660	E		Flu vaccine, nasal					
90665	K		Lyme disease vaccine, im	0356	1.5752	89.76		17.95
90669	E		Pneumococcal vacc, ped <5					
90675	K		Rabies vaccine, im	0356	1.5752	89.76		17.95
90676	K		Rabies vaccine, id	0356	1.5752	89.76		17.95
90680	N		Rotovirus vaccine, oral					
90690	N		Typhoid vaccine, oral					
90691	N		Typhoid vaccine, im					
90692	N		Typhoid vaccine, h-p, sc/id					
90693	N		Typhoid vaccine, akd, sc					
90698	N	NI	Dtap-hib-ip vaccine, im					
90700	N		Dtap vaccine, < 7 yrs, im					
90701	N		Dtp vaccine, im					
90702	N		Dt vaccine < 7, im					
90703	N		Tetanus vaccine, im					
90704	N		Mumps vaccine, sc					
90705	N		Measles vaccine, sc					
90706	N		Rubella vaccine, sc					
90707	N		Mmr vaccine, sc					
90708	N		Measles-rubella vaccine, sc					
90710	K		Mmrv vaccine, sc	0355	0.3596	20.49		4.10
90712	N		Oral poliovirus vaccine					
90713	N		Poliovirus, ipv, sc					
90715	N		Tdap vaccine >7 im					
90716	N		Chicken pox vaccine, sc					
90717	N		Yellow fever vaccine, sc					
90718	N		Td vaccine > 7, im					
90719	N		Diphtheria vaccine, im					
90720	N		Dtp/hib vaccine, im					
90721	N		Dtap/hib vaccine, im					
90723	E		Dtap-hep b-ipv vaccine, im					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
90725	K		Cholera vaccine, injectable	0356	1.5752	89.76		17.95
90727	N		Plague vaccine, im					
90732	L		Pneumococcal vaccine					
90733	N		Meningococcal vaccine, sc					
90734	N	NI	Meningococcal vaccine, im					
90735	K		Encephalitis vaccine, sc	0356	1.5752	89.76		17.95
90740	K		Hepb vacc, ill pat 3 dose im	0355	0.3596	20.49		4.10
90743	K		Hep b vacc, adol, 2 dose, im	0355	0.3596	20.49		4.10
90744	K		Hepb vacc ped/adol 3 dose im	0355	0.3596	20.49		4.10
90746	K		Hep b vaccine, adult, im	0355	0.3596	20.49		4.10
90747	K		Hepb vacc, ill pat 4 dose im	0356	1.5752	89.76		17.95
90748	E		Hep b/hib vaccine, im					
90749	N		Vaccine toxoid					
90780	T		IV infusion therapy, 1 hour	0120	1.9620	111.80	28.21	22.36
90781	N		IV infusion, additional hour					
90782	X		Injection, sc/im	0353	0.3981	22.68		4.54
90783	X		Injection, ia	0359	0.8693	49.54		9.91
90784	X		Injection, iv	0359	0.8693	49.54		9.91
90788	X		Injection of antibiotic	0359	0.8693	49.54		9.91
90799	X		Ther/prophylactic/dx inject	0352	0.1197	6.82		1.36
90801	S		Psy dx interview	0323	1.7589	100.23	20.90	20.05
90802	S		Intac psy dx interview	0323	1.7589	100.23	20.90	20.05
90804	S		Psytx, office, 20-30 min	0322	1.2917	73.60		14.72
90805	S		Psytx, off, 20-30 min w/e&m	0322	1.2917	73.60		14.72
90806	S		Psytx, off, 45-50 min	0323	1.7589	100.23	20.90	20.05
90807	S		Psytx, off, 45-50 min w/e&m	0323	1.7589	100.23	20.90	20.05
90808	S		Psytx, office, 75-80 min	0323	1.7589	100.23	20.90	20.05
90809	S		Psytx, off, 75-80, w/e&m	0323	1.7589	100.23	20.90	20.05
90810	S		Intac psytx, off, 20-30 min	0322	1.2917	73.60		14.72
90811	S		Intac psytx, 20-30, w/e&m	0322	1.2917	73.60		14.72
90812	S		Intac psytx, off, 45-50 min	0323	1.7589	100.23	20.90	20.05
90813	S		Intac psytx, 45-50 min w/e&m	0323	1.7589	100.23	20.90	20.05
90814	S		Intac psytx, off, 75-80 min	0323	1.7589	100.23	20.90	20.05
90815	S		Intac psytx, 75-80 w/e&m	0323	1.7589	100.23	20.90	20.05
90816	S		Psytx, hosp, 20-30 min	0322	1.2917	73.60		14.72
90817	S		Psytx, hosp, 20-30 min w/e&m	0322	1.2917	73.60		14.72
90818	S		Psytx, hosp, 45-50 min	0323	1.7589	100.23	20.90	20.05
90819	S		Psytx, hosp, 45-50 min w/e&m	0323	1.7589	100.23	20.90	20.05
90821	S		Psytx, hosp, 75-80 min	0323	1.7589	100.23	20.90	20.05
90822	S		Psytx, hosp, 75-80 min w/e&m	0323	1.7589	100.23	20.90	20.05
90823	S		Intac psytx, hosp, 20-30 min	0322	1.2917	73.60		14.72
90824	S		Intac psytx, hsp 20-30 w/e&m	0322	1.2917	73.60		14.72
90826	S		Intac psytx, hosp, 45-50 min	0323	1.7589	100.23	20.90	20.05

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
90827	S		Intac psytx, hsp 45-50 w/e&m	0323	1.7589	100.23	20.90	20.05
90828	S		Intac psytx, hosp, 75-80 min	0323	1.7589	100.23	20.90	20.05
90829	S		Intac psytx, hsp 75-80 w/e&m	0323	1.7589	100.23	20.90	20.05
90845	S		Psychoanalysis	0323	1.7589	100.23	20.90	20.05
90846	S		Family psytx w/o patient	0324	2.8357	161.59		32.32
90847	S		Family psytx w/patient	0324	2.8357	161.59		32.32
90849	S		Multiple family group psytx	0325	1.4675	83.62	18.27	16.72
90853	S		Group psychotherapy	0325	1.4675	83.62	18.27	16.72
90857	S		Intac group psytx	0325	1.4675	83.62	18.27	16.72
90862	X		Medication management	0374	1.0880	62.00		12.40
90865	S		Narcosynthesis	0323	1.7589	100.23	20.90	20.05
90870	S		Electroconvulsive therapy	0320	5.3260	303.49	80.06	60.70
90871	E		Electroconvulsive therapy					
90875	E		Psychophysiological therapy					
90876	E		Psychophysiological therapy					
90880	S		Hypnotherapy	0323	1.7589	100.23	20.90	20.05
90882	E		Environmental manipulation					
90885	N		Psy evaluation of records					
90887	N		Consultation with family					
90889	N		Preparation of report					
90899	S		Psychiatric service/therapy	0322	1.2917	73.60		14.72
90901	A		Biofeedback train, any meth					
90911	S		Biofeedback peri/uro/rectal	0321	1.4150	80.63	21.72	16.13
90918	E		ESRD related services, month					
90919	E		ESRD related services, month					
90920	E		ESRD related services, month					
90921	E		ESRD related services, month					
90922	E		ESRD related services, day					
90923	E		Esrd related services, day					
90924	E		Esrd related services, day					
90925	E		Esrd related services, day					
90935	S		Hemodialysis, one evaluation	0170	6.2255	354.75		70.95
90937	E		Hemodialysis, repeated eval					
90939	N		Hemodialysis study, transcut					
90940	N		Hemodialysis access study					
90945	S		Dialysis, one evaluation	0170	6.2255	354.75		70.95
90947	E		Dialysis, repeated eval					
90989	B		Dialysis training, complete					
90993	B		Dialysis training, incompl					
90997	E		Hemoperfusion					
90999	B		Dialysis procedure					
91000	X		Esophageal intubation	0361	3.6408	207.46	83.23	41.49
91010	X		Esophagus motility study	0361	3.6408	207.46	83.23	41.49

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
91011	X		Esophagus motility study	0361	3.6408	207.46	83.23	41.49
91012	X		Esophagus motility study	0361	3.6408	207.46	83.23	41.49
91020	X		Gastric motility	0361	3.6408	207.46	83.23	41.49
91030	X		Acid perfusion of esophagus	0361	3.6408	207.46	83.23	41.49
91032	D		Esophagus, acid reflux test		.	.	.	.
91033	D		Prolonged acid reflux test		.	.	.	.
91034	X	NI	Gastroesophageal reflux test	0361	3.6408	207.46	83.23	41.49
91035	S	NI	G-esoph reflx tst w/electrod	1506	.	450.00	.	90.00
91037	X	NI	Esoph imped function test	0361	3.6408	207.46	83.23	41.49
91038	X	NI	Esoph imped funct test > 1h	0361	3.6408	207.46	83.23	41.49
91040	X	NI	Esoph balloon distension tst	0360	1.6719	95.27	42.45	19.05
91052	X		Gastric analysis test	0361	3.6408	207.46	83.23	41.49
91055	X		Gastric intubation for smear	0360	1.6719	95.27	42.45	19.05
91060	X		Gastric saline load test	0360	1.6719	95.27	42.45	19.05
91065	X		Breath hydrogen test	0360	1.6719	95.27	42.45	19.05
91100	X		Pass intestine bleeding tube	0360	1.6719	95.27	42.45	19.05
91105	X		Gastric intubation treatment	0360	1.6719	95.27	42.45	19.05
91110	T		Gi tract capsule endoscopy	0142	8.7069	496.15	152.78	99.23
91120	T	NI	Rectal sensation test	0156	2.4782	141.22	40.52	28.24
91122	T		Anal pressure record	0156	2.4782	141.22	40.52	28.24
91123	N		Irrigate fecal impaction		.	.	.	.
91132	X		Electrogastrography	0360	1.6719	95.27	42.45	19.05
91133	X		Electrogastrography w/test	0360	1.6719	95.27	42.45	19.05
91299	X		Gastroenterology procedure	0360	1.6719	95.27	42.45	19.05
92002	V		Eye exam, new patient	0601	0.9847	56.11	.	11.22
92004	V		Eye exam, new patient	0602	1.3977	79.65	.	15.93
92012	V		Eye exam established pat	0600	0.9033	51.47	.	10.29
92014	V		Eye exam & treatment	0602	1.3977	79.65	.	15.93
92015	E		Refraction		.	.	.	.
92018	T		New eye exam & treatment	0699	9.7041	552.97	.	110.59
92019	T		Eye exam & treatment	0699	9.7041	552.97	.	110.59
92020	S		Special eye evaluation	0230	0.8019	45.69	14.97	9.14
92060	S		Special eye evaluation	0230	0.8019	45.69	14.97	9.14
92065	S		Orthoptic/pleoptic training	0230	0.8019	45.69	14.97	9.14
92070	N		Fitting of contact lens		.	.	.	.
92081	S		Visual field examination(s)	0230	0.8019	45.69	14.97	9.14
92082	S		Visual field examination(s)	0230	0.8019	45.69	14.97	9.14
92083	S		Visual field examination(s)	0230	0.8019	45.69	14.97	9.14
92100	N		Serial tonometry exam(s)		.	.	.	.
92120	S		Tonography & eye evaluation	0230	0.8019	45.69	14.97	9.14
92130	S		Water provocation tonography	0230	0.8019	45.69	14.97	9.14
92135	S		Opthalmic dx imaging	0230	0.8019	45.69	14.97	9.14
92136	S		Ophthalmic biometry	0230	0.8019	45.69	14.97	9.14

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
92140	S		Glaucoma provocative tests	0698	1.4649	83.47	18.72	16.69
92225	S		Special eye exam, initial	0230	0.8019	45.69	14.97	9.14
92226	S		Special eye exam, subsequent	0230	0.8019	45.69	14.97	9.14
92230	T		Eye exam with photos	0699	9.7041	552.97		110.59
92235	S		Eye exam with photos	0231	2.0073	114.38	44.61	22.88
92240	S		Icg angiography	0231	2.0073	114.38	44.61	22.88
92250	S		Eye exam with photos	0230	0.8019	45.69	14.97	9.14
92260	S		Ophthalmoscopy/dynamometry	0230	0.8019	45.69	14.97	9.14
92265	S		Eye muscle evaluation	0230	0.8019	45.69	14.97	9.14
92270	S		Electro-oculography	0230	0.8019	45.69	14.97	9.14
92275	S		Electroretinography	0231	2.0073	114.38	44.61	22.88
92283	S		Color vision examination	0230	0.8019	45.69	14.97	9.14
92284	S		Dark adaptation eye exam	0698	1.4649	83.47	18.72	16.69
92285	S		Eye photography	0230	0.8019	45.69	14.97	9.14
92286	S		Internal eye photography	0698	1.4649	83.47	18.72	16.69
92287	S		Internal eye photography	0698	1.4649	83.47	18.72	16.69
92310	E		Contact lens fitting					
92311	X		Contact lens fitting	0362	1.0861	61.89		12.38
92312	X		Contact lens fitting	0362	1.0861	61.89		12.38
92313	X		Contact lens fitting	0362	1.0861	61.89		12.38
92314	E		Prescription of contact lens					
92315	X		Prescription of contact lens	0362	1.0861	61.89		12.38
92316	X		Prescription of contact lens	0362	1.0861	61.89		12.38
92317	X		Prescription of contact lens	0362	1.0861	61.89		12.38
92325	X		Modification of contact lens	0362	1.0861	61.89		12.38
92326	X		Replacement of contact lens	0362	1.0861	61.89		12.38
92330	S		Fitting of artificial eye	0230	0.8019	45.69	14.97	9.14
92335	N		Fitting of artificial eye					
92340	E		Fitting of spectacles					
92341	E		Fitting of spectacles					
92342	E		Fitting of spectacles					
92352	X		Special spectacles fitting	0362	1.0861	61.89		12.38
92353	X		Special spectacles fitting	0362	1.0861	61.89		12.38
92354	X		Special spectacles fitting	0362	1.0861	61.89		12.38
92355	X		Special spectacles fitting	0362	1.0861	61.89		12.38
92358	X		Eye prosthesis service	0362	1.0861	61.89		12.38
92370	E		Repair & adjust spectacles					
92371	X		Repair & adjust spectacles	0362	1.0861	61.89		12.38
92390	E		Supply of spectacles					
92391	E		Supply of contact lenses					
92392	E		Supply of low vision aids					
92393	E		Supply of artificial eye					
92395	E		Supply of spectacles					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
92396	E		Supply of contact lenses		.	.	.	.
92499	S		Eye service or procedure	0230	0.8019	45.69	14.97	9.14
92502	T		Ear and throat examination	0251	1.9352	110.27	.	22.05
92504	N		Ear microscopy examination		.	.	.	.
92506	A		Speech/hearing evaluation		.	.	.	.
92507	A		Speech/hearing therapy		.	.	.	.
92508	A		Speech/hearing therapy		.	.	.	.
92510	E		Rehab for ear implant		.	.	.	.
92511	T		Nasopharyngoscopy	0071	0.7396	42.14	11.31	8.43
92512	X		Nasal function studies	0363	0.8653	49.31	17.44	9.86
92516	X		Facial nerve function test	0660	1.7060	97.21	30.66	19.44
92520	X		Laryngeal function studies	0660	1.7060	97.21	30.66	19.44
92526	A		Oral function therapy		.	.	.	.
92531	N		Spontaneous nystagmus study		.	.	.	.
92532	N		Positional nystagmus test		.	.	.	.
92533	N		Caloric vestibular test		.	.	.	.
92534	N		Optokinetic nystagmus test		.	.	.	.
92541	X		Spontaneous nystagmus test	0363	0.8653	49.31	17.44	9.86
92542	X		Positional nystagmus test	0363	0.8653	49.31	17.44	9.86
92543	X		Caloric vestibular test	0660	1.7060	97.21	30.66	19.44
92544	X		Optokinetic nystagmus test	0363	0.8653	49.31	17.44	9.86
92545	X		Oscillating tracking test	0363	0.8653	49.31	17.44	9.86
92546	X		Sinusoidal rotational test	0660	1.7060	97.21	30.66	19.44
92547	X		Supplemental electrical test	0363	0.8653	49.31	17.44	9.86
92548	X		Posturography	0660	1.7060	97.21	30.66	19.44
92551	E		Pure tone hearing test, air		.	.	.	.
92552	X		Pure tone audiometry, air	0364	0.4766	27.16	9.06	5.43
92553	X		Audiometry, air & bone	0364	0.4766	27.16	9.06	5.43
92555	X		Speech threshold audiometry	0364	0.4766	27.16	9.06	5.43
92556	X		Speech audiometry, complete	0364	0.4766	27.16	9.06	5.43
92557	X		Comprehensive hearing test	0365	1.2743	72.61	18.95	14.52
92559	E		Group audiometric testing		.	.	.	.
92560	E		Bekesy audiometry, screen		.	.	.	.
92561	X		Bekesy audiometry, diagnosis	0365	1.2743	72.61	18.95	14.52
92562	X		Loudness balance test	0364	0.4766	27.16	9.06	5.43
92563	X		Tone decay hearing test	0364	0.4766	27.16	9.06	5.43
92564	X		Sisi hearing test	0364	0.4766	27.16	9.06	5.43
92565	X		Stenger test, pure tone	0364	0.4766	27.16	9.06	5.43
92567	X		Tympanometry	0364	0.4766	27.16	9.06	5.43
92568	X		Acoustic reflex testing	0364	0.4766	27.16	9.06	5.43
92569	X		Acoustic reflex decay test	0364	0.4766	27.16	9.06	5.43
92571	X		Filtered speech hearing test	0364	0.4766	27.16	9.06	5.43
92572	X		Staggered spondaic word test	0364	0.4766	27.16	9.06	5.43

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92573	X		Lombard test	0364	0.4766	27.16	9.06	5.43
92575	X		Sensorineural acuity test	0364	0.4766	27.16	9.06	5.43
92576	X		Synthetic sentence test	0364	0.4766	27.16	9.06	5.43
92577	X		Stenger test, speech	0365	1.2743	72.61	18.95	14.52
92579	X		Visual audiometry (vra)	0365	1.2743	72.61	18.95	14.52
92582	X		Conditioning play audiometry	0365	1.2743	72.61	18.95	14.52
92583	X		Select picture audiometry	0364	0.4766	27.16	9.06	5.43
92584	X		Electrocochleography	0660	1.7060	97.21	30.66	19.44
92585	S		Auditor evoke potent, compre	0216	2.6359	150.20		30.04
92586	S		Auditor evoke potent, limit	0218	1.1442	65.20		13.04
92587	X		Evoked auditory test	0363	0.8653	49.31	17.44	9.86
92588	X		Evoked auditory test	0363	0.8653	49.31	17.44	9.86
92589	D		Auditory function test(s)					
92590	E		Hearing aid exam, one ear					
92591	E		Hearing aid exam, both ears					
92592	E		Hearing aid check, one ear					
92593	E		Hearing aid check, both ears					
92594	E		Electro hearng aid test, one					
92595	E		Electro hearng aid tst, both					
92596	X		Ear protector evaluation	0364	0.4766	27.16	9.06	5.43
92597	A		Oral speech device eval					
92601	X		Cochlear implt f/up exam < 7	0366	1.8412	104.92	30.04	20.98
92602	X		Reprogram cochlear implt < 7	0366	1.8412	104.92	30.04	20.98
92603	X		Cochlear implt f/up exam 7 >	0366	1.8412	104.92	30.04	20.98
92604	X		Reprogram cochlear implt 7 >	0366	1.8412	104.92	30.04	20.98
92605	A		Eval for nonspeech device rx					
92606	A		Non-speech device service					
92607	A		Ex for speech device rx, 1hr					
92608	A		Ex for speech device rx addl					
92609	A		Use of speech device service					
92610	A		Evaluate swallowing function					
92611	A		Motion fluoroscopy/swallow					
92612	A		Endoscopy swallow tst (fees)					
92613	E		Endoscopy swallow tst (fees)					
92614	A		Laryngoscopic sensory test					
92615	E		Eval laryngoscopy sense tst					
92616	A		Fees w/laryngeal sense test					
92617	E		Interprt fees/laryngeal test					
92620	X	NI	Auditory function, 60 min	0364	0.4766	27.16	9.06	5.43
92621	N	NI	Auditory function, + 15 min					
92625	X	NI	Tinnitus assessment	0364	0.4766	27.16	9.06	5.43
92700	X		Ent procedure/service	0364	0.4766	27.16	9.06	5.43
92950	S		Heart/lung resuscitation cpr	0094	2.6945	153.54	48.58	30.71

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
92953	S		Temporary external pacing	0094	2.6945	153.54	48.58	30.71
92960	S		Cardioversion electric, ext	0679	5.5971	318.94	95.30	63.79
92961	S		Cardioversion, electric, int	0679	5.5971	318.94	95.30	63.79
92970	C		Cardioassist, internal					
92971	C		Cardioassist, external					
92973	T		Percut coronary thrombectomy	0676	4.2729	243.48		48.70
92974	T		Cath place, cardio brachytx	1559		2250.00		450.00
92975	C		Dissolve clot, heart vessel					
92977	T		Dissolve clot, heart vessel	0677	2.5535	145.51		29.10
92978	S		Intravasc us, heart add-on	0670	30.3817	1731.24	542.37	346.25
92979	S		Intravasc us, heart add-on	0416	4.8182	274.56	99.43	54.91
92980	T		Insert intracoronary stent	0104	81.1177	4622.33		924.47
92981	T		Insert intracoronary stent	0104	81.1177	4622.33		924.47
92982	T		Coronary artery dilation	0083	55.3618	3154.68		630.94
92984	T		Coronary artery dilation	0083	55.3618	3154.68		630.94
92986	T		Revision of aortic valve	0083	55.3618	3154.68		630.94
92987	T		Revision of mitral valve	0083	55.3618	3154.68		630.94
92990	T		Revision of pulmonary valve	0083	55.3618	3154.68		630.94
92992	C		Revision of heart chamber					
92993	C		Revision of heart chamber					
92995	T		Coronary atherectomy	0082	103.0652	5872.96	1263.32	1174.59
92996	T		Coronary atherectomy add-on	0082	103.0652	5872.96	1263.32	1174.59
92997	T		Pul art balloon repr, percut	0081	32.7548	1866.47		373.29
92998	T		Pul art balloon repr, percut	0081	32.7548	1866.47		373.29
93000	B		Electrocardiogram, complete					
93005	S		Electrocardiogram, tracing	0099	0.3812	21.72		4.34
93010	A		Electrocardiogram report					
93012	N		Transmission of ecg					
93014	B		Report on transmitted ecg					
93015	B		Cardiovascular stress test					
93016	B		Cardiovascular stress test					
93017	X		Cardiovascular stress test	0100	2.4975	142.32	41.44	28.46
93018	B		Cardiovascular stress test					
93024	X		Cardiac drug stress test	0100	2.4975	142.32	41.44	28.46
93025	X		Microvolt t-wave assess	0100	2.4975	142.32	41.44	28.46
93040	B		Rhythm ECG with report					
93041	S		Rhythm ECG, tracing	0099	0.3812	21.72		4.34
93042	B		Rhythm ECG, report					
93224	B		ECG monitor/report, 24 hrs					
93225	X		ECG monitor/record, 24 hrs	0097	1.0180	58.01	23.79	11.60
93226	X		ECG monitor/report, 24 hrs	0097	1.0180	58.01	23.79	11.60
93227	B		ECG monitor/review, 24 hrs					
93230	B		ECG monitor/report, 24 hrs					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
93231	X		Ecg monitor/record, 24 hrs	0097	1.0180	58.01	23.79	11.60
93232	X		ECG monitor/report, 24 hrs	0097	1.0180	58.01	23.79	11.60
93233	B		ECG monitor/review, 24 hrs					
93235	B		ECG monitor/report, 24 hrs					
93236	X		ECG monitor/report, 24 hrs	0097	1.0180	58.01	23.79	11.60
93237	B		ECG monitor/review, 24 hrs					
93268	B		ECG record/review					
93270	X		ECG recording	0097	1.0180	58.01	23.79	11.60
93271	X		Ecg/monitoring and analysis	0097	1.0180	58.01	23.79	11.60
93272	B		Ecg/review, interpret only					
93278	S		ECG/signal-averaged	0099	0.3812	21.72		4.34
93303	S		Echo transthoracic	0269	3.2554	185.50	83.47	37.10
93304	S		Echo transthoracic	0697	1.5184	86.52	38.93	17.30
93307	S		Echo exam of heart	0269	3.2554	185.50	83.47	37.10
93308	S		Echo exam of heart	0697	1.5184	86.52	38.93	17.30
93312	S		Echo transesophageal	0270	6.1046	347.86	146.79	69.57
93313	S		Echo transesophageal	0270	6.1046	347.86	146.79	69.57
93314	N		Echo transesophageal					
93315	S		Echo transesophageal	0270	6.1046	347.86	146.79	69.57
93316	S		Echo transesophageal	0270	6.1046	347.86	146.79	69.57
93317	N		Echo transesophageal					
93318	S		Echo transesophageal intraop	0270	6.1046	347.86	146.79	69.57
93320	S		Doppler echo exam, heart	0671	1.7087	97.37	43.81	19.47
93321	S		Doppler echo exam, heart	0697	1.5184	86.52	38.93	17.30
93325	S		Doppler color flow add-on	0697	1.5184	86.52	38.93	17.30
93350	S		Echo transthoracic	0269	3.2554	185.50	83.47	37.10
93501	T		Right heart catheterization	0080	36.2660	2066.55	838.92	413.31
93503	T		Insert/place heart catheter	0103	13.1337	748.40	223.63	149.68
93505	T		Biopsy of heart lining	0103	13.1337	748.40	223.63	149.68
93508	T		Cath placement, angiography	0080	36.2660	2066.55	838.92	413.31
93510	T		Left heart catheterization	0080	36.2660	2066.55	838.92	413.31
93511	T		Left heart catheterization	0080	36.2660	2066.55	838.92	413.31
93514	T		Left heart catheterization	0080	36.2660	2066.55	838.92	413.31
93524	T		Left heart catheterization	0080	36.2660	2066.55	838.92	413.31
93526	T		Rt & Lt heart catheters	0080	36.2660	2066.55	838.92	413.31
93527	T		Rt & Lt heart catheters	0080	36.2660	2066.55	838.92	413.31
93528	T		Rt & Lt heart catheters	0080	36.2660	2066.55	838.92	413.31
93529	T		Rt, lt heart catheterization	0080	36.2660	2066.55	838.92	413.31
93530	T		Rt heart cath, congenital	0080	36.2660	2066.55	838.92	413.31
93531	T		R & l heart cath, congenital	0080	36.2660	2066.55	838.92	413.31
93532	T		R & l heart cath, congenital	0080	36.2660	2066.55	838.92	413.31
93533	T		R & l heart cath, congenital	0080	36.2660	2066.55	838.92	413.31
93539	N		Injection, cardiac cath					

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93540	N		Injection, cardiac cath					
93541	N		Injection for lung angiogram					
93542	N		Injection for heart x-rays					
93543	N		Injection for heart x-rays					
93544	N		Injection for aortography					
93545	N		Inject for coronary x-rays					
93555	N		Imaging, cardiac cath					
93556	N		Imaging, cardiac cath					
93561	N		Cardiac output measurement					
93562	N		Cardiac output measurement					
93571	S	NI	Heart flow reserve measure	0670	30.3817	1731.24	542.37	346.25
93572	S	NI	Heart flow reserve measure	0416	4.8182	274.56	99.43	54.91
93580	T		Transcath closure of asd	1559		2250.00		450.00
93581	T		Transcath closure of vsd	1559		2250.00		450.00
93600	T		Bundle of His recording	0087	37.2315	2121.56		424.31
93602	T		Intra-atrial recording	0087	37.2315	2121.56		424.31
93603	T		Right ventricular recording	0087	37.2315	2121.56		424.31
93609	T		Map tachycardia, add-on	0087	37.2315	2121.56		424.31
93610	T		Intra-atrial pacing	0087	37.2315	2121.56		424.31
93612	T		Intraventricular pacing	0087	37.2315	2121.56		424.31
93613	T		Electrophys map 3d, add-on	0087	37.2315	2121.56		424.31
93615	T		Esophageal recording	0087	37.2315	2121.56		424.31
93616	T		Esophageal recording	0087	37.2315	2121.56		424.31
93618	T		Heart rhythm pacing	0087	37.2315	2121.56		424.31
93619	T		Electrophysiology evaluation	0085	34.7491	1980.11	426.25	396.02
93620	T		Electrophysiology evaluation	0085	34.7491	1980.11	426.25	396.02
93621	T		Electrophysiology evaluation	0085	34.7491	1980.11	426.25	396.02
93622	T		Electrophysiology evaluation	0085	34.7491	1980.11	426.25	396.02
93623	T		Stimulation, pacing heart	0087	37.2315	2121.56		424.31
93624	S		Electrophysiologic study	0084	10.6370	606.13		121.23
93631	T		Heart pacing, mapping	0087	37.2315	2121.56		424.31
93640	S		Evaluation heart device	0084	10.6370	606.13		121.23
93641	S		Electrophysiology evaluation	0084	10.6370	606.13		121.23
93642	S		Electrophysiology evaluation	0084	10.6370	606.13		121.23
93650	T		Ablate heart dysrhythm focus	0086	45.0490	2567.03	833.33	513.41
93651	T		Ablate heart dysrhythm focus	0086	45.0490	2567.03	833.33	513.41
93652	T		Ablate heart dysrhythm focus	0086	45.0490	2567.03	833.33	513.41
93660	S		Tilt table evaluation	0101	4.3954	250.46	105.27	50.09
93662	S		Intracardiac ecg (ice)	0670	30.3817	1731.24	542.37	346.25
93668	E		Peripheral vascular rehab					
93701	S		Bioimpedance, thoracic	0099	0.3812	21.72		4.34
93720	B		Total body plethysmography					
93721	X		Plethysmography tracing	0368	0.9465	53.93	24.26	10.79

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
93722	B		Plethysmography report					
93724	S		Analyze pacemaker system	0690	0.3963	22.58	10.16	4.52
93727	S		Analyze ilr system	0690	0.3963	22.58	10.16	4.52
93731	S		Analyze pacemaker system	0690	0.3963	22.58	10.16	4.52
93732	S		Analyze pacemaker system	0690	0.3963	22.58	10.16	4.52
93733	S		Telephone analy, pacemaker	0690	0.3963	22.58	10.16	4.52
93734	S		Analyze pacemaker system	0690	0.3963	22.58	10.16	4.52
93735	S		Analyze pacemaker system	0690	0.3963	22.58	10.16	4.52
93736	S		Telephonic analy, pacemaker	0690	0.3963	22.58	10.16	4.52
93740	X		Temperature gradient studies	0368	0.9465	53.93	24.26	10.79
93741	S		Analyze ht pace device sngl	0689	0.5852	33.35		6.67
93742	S		Analyze ht pace device sngl	0689	0.5852	33.35		6.67
93743	S		Analyze ht pace device dual	0689	0.5852	33.35		6.67
93744	S		Analyze ht pace device dual	0689	0.5852	33.35		6.67
93745	S	NI	Set-up cardiovert-defibrill	0689	0.5852	33.35		6.67
93760	E		Cephalic thermogram					
93762	E		Peripheral thermogram					
93770	N		Measure venous pressure					
93784	E		Ambulatory BP monitoring					
93786	X		Ambulatory BP recording	0097	1.0180	58.01	23.79	11.60
93788	X		Ambulatory BP analysis	0097	1.0180	58.01	23.79	11.60
93790	B		Review/report BP recording					
93797	S		Cardiac rehab	0095	0.6044	34.44	15.49	6.89
93798	S		Cardiac rehab/monitor	0095	0.6044	34.44	15.49	6.89
93799	S		Cardiovascular procedure	0096	1.7035	97.07	43.68	19.41
93875	S		Extracranial study	0096	1.7035	97.07	43.68	19.41
93880	S		Extracranial study	0267	2.4250	138.18	62.18	27.64
93882	S		Extracranial study	0267	2.4250	138.18	62.18	27.64
93886	S		Intracranial study	0267	2.4250	138.18	62.18	27.64
93888	S		Intracranial study	0266	1.6275	92.74	41.73	18.55
93890	S	NI	Tcd, vasoreactivity study	0266	1.6275	92.74	41.73	18.55
93892	S	NI	Tcd, emboli detect w/o inj	0266	1.6275	92.74	41.73	18.55
93893	S	NI	Tcd, emboli detect w/inj	0266	1.6275	92.74	41.73	18.55
93922	S		Extremity study	0096	1.7035	97.07	43.68	19.41
93923	S		Extremity study	0096	1.7035	97.07	43.68	19.41
93924	S		Extremity study	0096	1.7035	97.07	43.68	19.41
93925	S		Lower extremity study	0267	2.4250	138.18	62.18	27.64
93926	S		Lower extremity study	0267	2.4250	138.18	62.18	27.64
93930	S		Upper extremity study	0267	2.4250	138.18	62.18	27.64
93931	S		Upper extremity study	0266	1.6275	92.74	41.73	18.55
93965	S		Extremity study	0096	1.7035	97.07	43.68	19.41
93970	S		Extremity study	0267	2.4250	138.18	62.18	27.64
93971	S		Extremity study	0267	2.4250	138.18	62.18	27.64

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
93975	S		Vascular study	0267	2.4250	138.18	62.18	27.64
93976	S		Vascular study	0267	2.4250	138.18	62.18	27.64
93978	S		Vascular study	0267	2.4250	138.18	62.18	27.64
93979	S		Vascular study	0267	2.4250	138.18	62.18	27.64
93980	S		Penile vascular study	0267	2.4250	138.18	62.18	27.64
93981	S		Penile vascular study	0267	2.4250	138.18	62.18	27.64
93990	S		Doppler flow testing	0267	2.4250	138.18	62.18	27.64
94010	X		Breathing capacity test	0368	0.9465	53.93	24.26	10.79
94014	X		Patient recorded spirometry	0368	0.9465	53.93	24.26	10.79
94015	X		Patient recorded spirometry	0367	0.5775	32.91	14.80	6.58
94016	A		Review patient spirometry					
94060	X		Evaluation of wheezing	0368	0.9465	53.93	24.26	10.79
94070	X		Evaluation of wheezing	0369	2.7431	156.31	44.18	31.26
94150	X		Vital capacity test	0367	0.5775	32.91	14.80	6.58
94200	X		Lung function test (MBC/MVV)	0367	0.5775	32.91	14.80	6.58
94240	X		Residual lung capacity	0368	0.9465	53.93	24.26	10.79
94250	X		Expired gas collection	0367	0.5775	32.91	14.80	6.58
94260	X		Thoracic gas volume	0368	0.9465	53.93	24.26	10.79
94350	X		Lung nitrogen washout curve	0368	0.9465	53.93	24.26	10.79
94360	X		Measure airflow resistance	0367	0.5775	32.91	14.80	6.58
94370	X		Breath airway closing volume	0367	0.5775	32.91	14.80	6.58
94375	X		Respiratory flow volume loop	0368	0.9465	53.93	24.26	10.79
94400	X		CO2 breathing response curve	0367	0.5775	32.91	14.80	6.58
94450	X		Hypoxia response curve	0368	0.9465	53.93	24.26	10.79
94452	X	NI	Hast w/report	0368	0.9465	53.93	24.26	10.79
94453	X	NI	Hast w/oxygen titrate	0368	0.9465	53.93	24.26	10.79
94620	X		Pulmonary stress test/simple	0368	0.9465	53.93	24.26	10.79
94621	X		Pulm stress test/complex	0369	2.7431	156.31	44.18	31.26
94640	S		Airway inhalation treatment	0077	0.3228	18.39	7.74	3.68
94642	S		Aerosol inhalation treatment	0078	0.8315	47.38	14.55	9.48
94656	S		Initial ventilator mgmt	0079	2.4268	138.29		27.66
94657	S		Continued ventilator mgmt	0079	2.4268	138.29		27.66
94660	S		Pos airway pressure, CPAP	0068	1.1546	65.79	29.48	13.16
94662	S		Neg press ventilation, cnp	0079	2.4268	138.29		27.66
94664	S		Evaluate pt use of inhaler	0077	0.3228	18.39	7.74	3.68
94667	S		Chest wall manipulation	0077	0.3228	18.39	7.74	3.68
94668	S		Chest wall manipulation	0077	0.3228	18.39	7.74	3.68
94680	X		Exhaled air analysis, o2	0367	0.5775	32.91	14.80	6.58
94681	X		Exhaled air analysis, o2/co2	0368	0.9465	53.93	24.26	10.79
94690	X		Exhaled air analysis	0368	0.9465	53.93	24.26	10.79
94720	X		Monoxide diffusing capacity	0368	0.9465	53.93	24.26	10.79
94725	X		Membrane diffusion capacity	0368	0.9465	53.93	24.26	10.79
94750	X		Pulmonary compliance study	0368	0.9465	53.93	24.26	10.79

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
94760	N		Measure blood oxygen level					
94761	N		Measure blood oxygen level					
94762	N		Measure blood oxygen level					
94770	X		Exhaled carbon dioxide test	0367	0.5775	32.91	14.80	6.58
94772	X		Breath recording, infant	0369	2.7431	156.31	44.18	31.26
94799	X		Pulmonary service/procedure	0367	0.5775	32.91	14.80	6.58
95004	X		Percut allergy skin tests	0370	0.9661	55.05	11.58	11.01
95010	X		Percut allergy titrate test	0370	0.9661	55.05	11.58	11.01
95015	X		Id allergy titrate-drug/bug	0370	0.9661	55.05	11.58	11.01
95024	X		Id allergy test, drug/bug	0370	0.9661	55.05	11.58	11.01
95027	X		Id allergy titrate-airborne	0370	0.9661	55.05	11.58	11.01
95028	X		Id allergy test-delayed type	0370	0.9661	55.05	11.58	11.01
95044	X		Allergy patch tests	0370	0.9661	55.05	11.58	11.01
95052	X		Photo patch test	0370	0.9661	55.05	11.58	11.01
95056	X		Photosensitivity tests	0370	0.9661	55.05	11.58	11.01
95060	X		Eye allergy tests	0370	0.9661	55.05	11.58	11.01
95065	X		Nose allergy test	0370	0.9661	55.05	11.58	11.01
95070	X		Bronchial allergy tests	0369	2.7431	156.31	44.18	31.26
95071	X		Bronchial allergy tests	0369	2.7431	156.31	44.18	31.26
95075	X		Ingestion challenge test	0361	3.6408	207.46	83.23	41.49
95078	X		Provocative testing	0370	0.9661	55.05	11.58	11.01
95115	X		Immunotherapy, one injection	0352	0.1197	6.82		1.36
95117	X		Immunotherapy injections	0353	0.3981	22.68		4.54
95120	B		Immunotherapy, one injection					
95125	B		Immunotherapy, many antigens					
95130	B		Immunotherapy, insect venom					
95131	B		Immunotherapy, insect venoms					
95132	B		Immunotherapy, insect venoms					
95133	B		Immunotherapy, insect venoms					
95134	B		Immunotherapy, insect venoms					
95144	X		Antigen therapy services	0371	0.4310	24.56		4.91
95145	X		Antigen therapy services	0371	0.4310	24.56		4.91
95146	X		Antigen therapy services	0371	0.4310	24.56		4.91
95147	X		Antigen therapy services	0371	0.4310	24.56		4.91
95148	X		Antigen therapy services	0371	0.4310	24.56		4.91
95149	X		Antigen therapy services	0371	0.4310	24.56		4.91
95165	X		Antigen therapy services	0371	0.4310	24.56		4.91
95170	X		Antigen therapy services	0371	0.4310	24.56		4.91
95180	X		Rapid desensitization	0370	0.9661	55.05	11.58	11.01
95199	X		Allergy immunology services	0370	0.9661	55.05	11.58	11.01
95250	X		Glucose monitoring, cont	0421	1.8691	106.51		21.30
95805	S		Multiple sleep latency test	0209	11.6170	661.97	280.58	132.39
95806	S		Sleep study, unattended	0213	2.7461	156.48	64.89	31.30

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
95807	S		Sleep study, attended	0209	11.6170	661.97	280.58	132.39
95808	S		Polysomnography, 1-3	0209	11.6170	661.97	280.58	132.39
95810	S		Polysomnography, 4 or more	0209	11.6170	661.97	280.58	132.39
95811	S		Polysomnography w/cpap	0209	11.6170	661.97	280.58	132.39
95812	S		Eeg, 41-60 minutes	0213	2.7461	156.48	64.89	31.30
95813	S		Eeg, over 1 hour	0213	2.7461	156.48	64.89	31.30
95816	S		Eeg, awake and drowsy	0214	2.2788	129.85	58.12	25.97
95819	S		Eeg, awake and asleep	0214	2.2788	129.85	58.12	25.97
95822	S		Eeg, coma or sleep only	0214	2.2788	129.85	58.12	25.97
95824	S		Eeg, cerebral death only	0214	2.2788	129.85	58.12	25.97
95827	S		Eeg, all night recording	0213	2.7461	156.48	64.89	31.30
95829	S		Surgery electrocorticogram	0214	2.2788	129.85	58.12	25.97
95830	B		Insert electrodes for EEG					
95831	A		Limb muscle testing, manual					
95832	A		Hand muscle testing, manual					
95833	A		Body muscle testing, manual					
95834	A		Body muscle testing, manual					
95851	A		Range of motion measurements					
95852	A		Range of motion measurements					
95857	S		Tensilon test	0218	1.1442	65.20		13.04
95858	S		Tensilon test & myogram	0215	0.6600	37.61	15.76	7.52
95860	S		Muscle test, one limb	0218	1.1442	65.20		13.04
95861	S		Muscle test, 2 limbs	0218	1.1442	65.20		13.04
95863	S		Muscle test, 3 limbs	0218	1.1442	65.20		13.04
95864	S		Muscle test, 4 limbs	0218	1.1442	65.20		13.04
95867	S		Muscle test cran nerv unilat	0218	1.1442	65.20		13.04
95868	S		Muscle test cran nerve bilat	0218	1.1442	65.20		13.04
95869	S		Muscle test, thor paraspinal	0215	0.6600	37.61	15.76	7.52
95870	S		Muscle test, nonparaspinal	0215	0.6600	37.61	15.76	7.52
95872	S		Muscle test, one fiber	0218	1.1442	65.20		13.04
95875	S		Limb exercise test	0215	0.6600	37.61	15.76	7.52
95900	S		Motor nerve conduction test	0215	0.6600	37.61	15.76	7.52
95903	S		Motor nerve conduction test	0215	0.6600	37.61	15.76	7.52
95904	S		Sense nerve conduction test	0215	0.6600	37.61	15.76	7.52
95920	S		Intraop nerve test add-on	0216	2.6359	150.20		30.04
95921	S		Autonomic nerv function test	0218	1.1442	65.20		13.04
95922	S		Autonomic nerv function test	0218	1.1442	65.20		13.04
95923	S		Autonomic nerv function test	0218	1.1442	65.20		13.04
95925	S		Somatosensory testing	0216	2.6359	150.20		30.04
95926	S		Somatosensory testing	0216	2.6359	150.20		30.04
95927	S		Somatosensory testing	0216	2.6359	150.20		30.04
95928	S	NI	C motor evoked, uppr limbs	0218	1.1442	65.20		13.04
95929	S	NI	C motor evoked, lwr limbs	0218	1.1442	65.20		13.04

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
95930	S		Visual evoked potential test	0216	2.6359	150.20		30.04
95933	S		Blink reflex test	0215	0.6600	37.61	15.76	7.52
95934	S		H-reflex test	0215	0.6600	37.61	15.76	7.52
95936	S		H-reflex test	0215	0.6600	37.61	15.76	7.52
95937	S		Neuromuscular junction test	0218	1.1442	65.20		13.04
95950	S		Ambulatory eeg monitoring	0209	11.6170	661.97	280.58	132.39
95951	S		EEG monitoring/videorecord	0209	11.6170	661.97	280.58	132.39
95953	S		EEG monitoring/computer	0209	11.6170	661.97	280.58	132.39
95954	S		EEG monitoring/giving drugs	0214	2.2788	129.85	58.12	25.97
95955	S		EEG during surgery	0213	2.7461	156.48	64.89	31.30
95956	S		Eeg monitoring, cable/radio	0209	11.6170	661.97	280.58	132.39
95957	S		EEG digital analysis	0214	2.2788	129.85	58.12	25.97
95958	S		EEG monitoring/function test	0213	2.7461	156.48	64.89	31.30
95961	S		Electrode stimulation, brain	0216	2.6359	150.20		30.04
95962	S		Electrode stim, brain add-on	0216	2.6359	150.20		30.04
95965	S		Meg, spontaneous	1528		5250.00		1050.00
95966	S		Meg, evoked, single	1516		1450.00		290.00
95967	S		Meg, evoked, each add'l	1511		950.00		190.00
95970	S		Analyze neurostim, no prog	0218	1.1442	65.20		13.04
95971	S		Analyze neurostim, simple	0692	2.0584	117.29	30.16	23.46
95972	S		Analyze neurostim, complex	0692	2.0584	117.29	30.16	23.46
95973	S		Analyze neurostim, complex	0692	2.0584	117.29	30.16	23.46
95974	S		Cranial neurostim, complex	0692	2.0584	117.29	30.16	23.46
95975	S		Cranial neurostim, complex	0692	2.0584	117.29	30.16	23.46
95978	S	NI	Analyze neurostim brain/1h	0692	2.0584	117.29	30.16	23.46
95979	S	NI	Analyz neurostim brain addon	0692	2.0584	117.29	30.16	23.46
95990	T		Spin/brain pump refil & main	0125	2.1652	123.38		24.68
95991	T		Spin/brain pump refil & main	0125	2.1652	123.38		24.68
95999	S		Neurological procedure	0215	0.6600	37.61	15.76	7.52
96000	S		Motion analysis, video/3d	0216	2.6359	150.20		30.04
96001	S		Motion test w/ft press meas	0216	2.6359	150.20		30.04
96002	S		Dynamic surface emg	0218	1.1442	65.20		13.04
96003	S		Dynamic fine wire emg	0215	0.6600	37.61	15.76	7.52
96004	E		Phys review of motion tests					
96100	X		Psychological testing	0373	2.3347	133.04		26.61
96105	A		Assessment of aphasia					
96110	X		Developmental test, lim	0373	2.3347	133.04		26.61
96111	X		Developmental test, extend	0373	2.3347	133.04		26.61
96115	X		Neurobehavior status exam	0373	2.3347	133.04		26.61
96117	X		Neuropsych test battery	0373	2.3347	133.04		26.61
96150	S		Assess hlth/behave, init	0322	1.2917	73.60		14.72
96151	S		Assess hlth/behave, subseq	0322	1.2917	73.60		14.72
96152	S		Intervene hlth/behave, indiv	0322	1.2917	73.60		14.72

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
96153	S		Intervene hlth/behave, group	0322	1.2917	73.60		14.72
96154	S		Interv hlth/behav, fam w/pt	0322	1.2917	73.60		14.72
96155	E		Interv hlth/behav fam no pt					
96400	S		Chemotherapy, sc/im	0116	1.1117	63.35		12.67
96405	S		Intralesional chemo admin	0116	1.1117	63.35		12.67
96406	S		Intralesional chemo admin	0116	1.1117	63.35		12.67
96408	S		Chemotherapy, push technique	0116	1.1117	63.35		12.67
96410	S		Chemotherapy,infusion method	0117	2.9533	168.29	42.54	33.66
96412	N		Chemo, infuse method add-on					
96414	S		Chemo, infuse method add-on	0117	2.9533	168.29	42.54	33.66
96420	S		Chemotherapy, push technique	0116	1.1117	63.35		12.67
96422	S		Chemotherapy,infusion method	0117	2.9533	168.29	42.54	33.66
96423	N		Chemo, infuse method add-on					
96425	S		Chemotherapy,infusion method	0117	2.9533	168.29	42.54	33.66
96440	S		Chemotherapy, intracavitary	0116	1.1117	63.35		12.67
96445	S		Chemotherapy, intracavitary	0116	1.1117	63.35		12.67
96450	S		Chemotherapy, into CNS	0116	1.1117	63.35		12.67
96520	T		Port pump refill & main	0125	2.1652	123.38		24.68
96530	T		Syst pump refill & main	0125	2.1652	123.38		24.68
96542	S		Chemotherapy injection	0116	1.1117	63.35		12.67
96545	N		Provide chemotherapy agent					
96549	S		Chemotherapy, unspecified	0116	1.1117	63.35		12.67
96567	T		Photodynamic tx, skin	0013	1.1380	64.85	14.20	12.97
96570	T		Photodynamic tx, 30 min	0015	1.7248	98.28	20.35	19.66
96571	T		Photodynamic tx, addl 15 min	0015	1.7248	98.28	20.35	19.66
96900	S		Ultraviolet light therapy	0001	0.4007	22.83	7.00	4.57
96902	N		Trichogram					
96910	S		Photochemotherapy with UV-B	0001	0.4007	22.83	7.00	4.57
96912	S		Photochemotherapy with UV-A	0001	0.4007	22.83	7.00	4.57
96913	S		Photochemotherapy, UV-A or B	0683	2.3761	135.40	30.42	27.08
96920	T		Laser tx, skin < 250 sq cm	0013	1.1380	64.85	14.20	12.97
96921	T		Laser tx, skin 250-500 sq cm	0013	1.1380	64.85	14.20	12.97
96922	T		Laser tx, skin > 500 sq cm	0013	1.1380	64.85	14.20	12.97
96999	T		Dermatological procedure	0010	0.5940	33.85	9.65	6.77
97001	A		Pt evaluation					
97002	A		Pt re-evaluation					
97003	A		Ot evaluation					
97004	A		Ot re-evaluation					
97005	E		Athletic train eval					
97006	E		Athletic train reeval					
97010	A		Hot or cold packs therapy					
97012	A		Mechanical traction therapy					
97014	E		Electric stimulation therapy					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
97016	A		Vasopneumatic device therapy					
97018	A		Paraffin bath therapy					
97020	A		Microwave therapy					
97022	A		Whirlpool therapy					
97024	A		Diathermy treatment					
97026	A		Infrared therapy					
97028	A		Ultraviolet therapy					
97032	A		Electrical stimulation					
97033	A		Electric current therapy					
97034	A		Contrast bath therapy					
97035	A		Ultrasound therapy					
97036	A		Hydrotherapy					
97039	A		Physical therapy treatment					
97110	A		Therapeutic exercises					
97112	A		Neuromuscular reeducation					
97113	A		Aquatic therapy/exercises					
97116	A		Gait training therapy					
97124	A		Massage therapy					
97139	A		Physical medicine procedure					
97140	A		Manual therapy					
97150	A		Group therapeutic procedures					
97504	A		Orthotic training					
97520	A		Prosthetic training					
97530	A		Therapeutic activities					
97532	A		Cognitive skills development					
97533	A		Sensory integration					
97535	A		Self care mngment training					
97537	A		Community/work reintegration					
97542	A		Wheelchair mngment training					
97545	A		Work hardening					
97546	A		Work hardening add-on					
97597	A	NI	Active wound care/20 cm or <					
97598	A	NI	Active wound care > 20 cm					
97601	D		Wound(s) care, selective					
97602	A		Wound(s) care non-selective					
97605	A	NI	Neg press wound tx, < 50 cm					
97606	A	NI	Neg press wound tx, > 50 cm					
97703	A		Prosthetic checkout					
97750	A		Physical performance test					
97755	A		Assistive technology assess					
97780	D		Acupuncture w/o stimul					
97781	D		Acupuncture w/stimul					
97799	A		Physical medicine procedure					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
97802	A		Medical nutrition, indiv, in					
97803	A		Med nutrition, indiv, subseq					
97804	A		Medical nutrition, group					
97810	B	NI	Acupunct w/o stimul 15 min					
97811	B	NI	Acupunct w/o stimul addl 15m					
97813	B	NI	Acupunct w/stimul 15 min					
97814	B	NI	Acupunct w/stimul addl 15m					
98925	S		Osteopathic manipulation	0060	0.4737	26.99		5.40
98926	S		Osteopathic manipulation	0060	0.4737	26.99		5.40
98927	S		Osteopathic manipulation	0060	0.4737	26.99		5.40
98928	S		Osteopathic manipulation	0060	0.4737	26.99		5.40
98929	S		Osteopathic manipulation	0060	0.4737	26.99		5.40
98940	S		Chiropractic manipulation	0060	0.4737	26.99		5.40
98941	S		Chiropractic manipulation	0060	0.4737	26.99		5.40
98942	S		Chiropractic manipulation	0060	0.4737	26.99		5.40
98943	E		Chiropractic manipulation					
99000	B		Specimen handling					
99001	B		Specimen handling					
99002	B		Device handling					
99024	B		Postop follow-up visit					
99026	E		In-hospital on call service					
99027	E		Out-of-hosp on call service					
99050	B		Medical services after hrs					
99052	B		Medical services at night					
99054	B		Medical servcs, unusual hrs					
99056	B		Non-office medical services					
99058	B		Office emergency care					
99070	B		Special supplies					
99071	B		Patient education materials					
99075	E		Medical testimony					
99078	N		Group health education					
99080	B		Special reports or forms					
99082	B		Unusual physician travel					
99090	B		Computer data analysis					
99091	E		Collect/review data from pt					
99100	B		Special anesthesia service					
99116	B		Anesthesia with hypothermia					
99135	B		Special anesthesia procedure					
99140	B		Emergency anesthesia					
99141	N		Sedation, iv/im or inhalant					
99142	N		Sedation, oral/rectal/nasal					
99170	T		Anogenital exam, child	0191	0.1831	10.43	2.93	2.09
99172	E		Ocular function screen					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
99173	E		Visual acuity screen					
99175	N		Induction of vomiting					
99183	B		Hyperbaric oxygen therapy					
99185	N		Regional hypothermia					
99186	N		Total body hypothermia					
99190	C		Special pump services					
99191	C		Special pump services					
99192	C		Special pump services					
99195	X		Phlebotomy	0372	0.5656	32.23	10.09	6.45
99199	B		Special service/proc/report					
99201	V		Office/outpatient visit, new	0600	0.9033	51.47		10.29
99202	V		Office/outpatient visit, new	0600	0.9033	51.47		10.29
99203	V		Office/outpatient visit, new	0601	0.9847	56.11		11.22
99204	V		Office/outpatient visit, new	0602	1.3977	79.65		15.93
99205	V		Office/outpatient visit, new	0602	1.3977	79.65		15.93
99211	V		Office/outpatient visit, est	0600	0.9033	51.47		10.29
99212	V		Office/outpatient visit, est	0600	0.9033	51.47		10.29
99213	V		Office/outpatient visit, est	0601	0.9847	56.11		11.22
99214	V		Office/outpatient visit, est	0602	1.3977	79.65		15.93
99215	V		Office/outpatient visit, est	0602	1.3977	79.65		15.93
99217	N		Observation care discharge					
99218	N		Observation care					
99219	N		Observation care					
99220	N		Observation care					
99221	E		Initial hospital care					
99222	E		Initial hospital care					
99223	E		Initial hospital care					
99231	E		Subsequent hospital care					
99232	E		Subsequent hospital care					
99233	E		Subsequent hospital care					
99234	N		Observ/hosp same date					
99235	N		Observ/hosp same date					
99236	N		Observ/hosp same date					
99238	E		Hospital discharge day					
99239	E		Hospital discharge day					
99241	V		Office consultation	0600	0.9033	51.47		10.29
99242	V		Office consultation	0600	0.9033	51.47		10.29
99243	V		Office consultation	0601	0.9847	56.11		11.22
99244	V		Office consultation	0602	1.3977	79.65		15.93
99245	V		Office consultation	0602	1.3977	79.65		15.93
99251	C		Initial inpatient consult					
99252	C		Initial inpatient consult					
99253	C		Initial inpatient consult					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
99254	C		Initial inpatient consult		.	.	.	.
99255	C		Initial inpatient consult		.	.	.	.
99261	C		Follow-up inpatient consult		.	.	.	.
99262	C		Follow-up inpatient consult		.	.	.	.
99263	C		Follow-up inpatient consult		.	.	.	.
99271	V		Confirmatory consultation	0600	0.9033	51.47	.	10.29
99272	V		Confirmatory consultation	0600	0.9033	51.47	.	10.29
99273	V		Confirmatory consultation	0601	0.9847	56.11	.	11.22
99274	V		Confirmatory consultation	0602	1.3977	79.65	.	15.93
99275	V		Confirmatory consultation	0602	1.3977	79.65	.	15.93
99281	V		Emergency dept visit	0610	1.3544	77.18	19.57	15.44
99282	V		Emergency dept visit	0610	1.3544	77.18	19.57	15.44
99283	V		Emergency dept visit	0611	2.3926	136.34	36.16	27.27
99284	V		Emergency dept visit	0612	4.1139	234.42	54.12	46.88
99285	V		Emergency dept visit	0612	4.1139	234.42	54.12	46.88
99288	B		Direct advanced life support		.	.	.	.
99289	N		Ped crit care transport		.	.	.	.
99290	N		Ped crit care transport addl		.	.	.	.
99291	S		Critical care, first hour	0620	9.0648	516.54	142.30	103.31
99292	N		Critical care, add'l 30 min		.	.	.	.
99293	C		Ped critical care, initial		.	.	.	.
99294	C		Ped critical care, subseq		.	.	.	.
99295	C		Neonate crit care, initial		.	.	.	.
99296	C		Neonate critical care subseq		.	.	.	.
99298	C		Ic for lbw infant < 1500 gm		.	.	.	.
99299	C		Ic, lbw infant 1500-2500 gm		.	.	.	.
99301	B		Nursing facility care		.	.	.	.
99302	B		Nursing facility care		.	.	.	.
99303	B		Nursing facility care		.	.	.	.
99311	B		Nursing fac care, subseq		.	.	.	.
99312	B		Nursing fac care, subseq		.	.	.	.
99313	B		Nursing fac care, subseq		.	.	.	.
99315	B		Nursing fac discharge day		.	.	.	.
99316	B		Nursing fac discharge day		.	.	.	.
99321	B		Rest home visit, new patient		.	.	.	.
99322	B		Rest home visit, new patient		.	.	.	.
99323	B		Rest home visit, new patient		.	.	.	.
99331	B		Rest home visit, est pat		.	.	.	.
99332	B		Rest home visit, est pat		.	.	.	.
99333	B		Rest home visit, est pat		.	.	.	.
99341	B		Home visit, new patient		.	.	.	.
99342	B		Home visit, new patient		.	.	.	.
99343	B		Home visit, new patient		.	.	.	.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
99344	B		Home visit, new patient					
99345	B		Home visit, new patient					
99347	B		Home visit, est patient					
99348	B		Home visit, est patient					
99349	B		Home visit, est patient					
99350	B		Home visit, est patient					
99354	N		Prolonged service, office					
99355	N		Prolonged service, office					
99356	C		Prolonged service, inpatient					
99357	C		Prolonged service, inpatient					
99358	N		Prolonged serv, w/o contact					
99359	N		Prolonged serv, w/o contact					
99360	B		Physician standby services					
99361	E		Physician/team conference					
99362	E		Physician/team conference					
99371	B		Physician phone consultation					
99372	B		Physician phone consultation					
99373	B		Physician phone consultation					
99374	B		Home health care supervision					
99375	E		Home health care supervision					
99377	B		Hospice care supervision					
99378	E		Hospice care supervision					
99379	B		Nursing fac care supervision					
99380	B		Nursing fac care supervision					
99381	E		Prev visit, new, infant					
99382	E		Prev visit, new, age 1-4					
99383	E		Prev visit, new, age 5-11					
99384	E		Prev visit, new, age 12-17					
99385	E		Prev visit, new, age 18-39					
99386	E		Prev visit, new, age 40-64					
99387	E		Prev visit, new, 65 & over					
99391	E		Prev visit, est, infant					
99392	E		Prev visit, est, age 1-4					
99393	E		Prev visit, est, age 5-11					
99394	E		Prev visit, est, age 12-17					
99395	E		Prev visit, est, age 18-39					
99396	E		Prev visit, est, age 40-64					
99397	E		Prev visit, est, 65 & over					
99401	E		Preventive counseling, indiv					
99402	E		Preventive counseling, indiv					
99403	E		Preventive counseling, indiv					
99404	E		Preventive counseling, indiv					
99411	E		Preventive counseling, group					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
99412	E		Preventive counseling, group					
99420	E		Health risk assessment test					
99429	E		Unlisted preventive service					
99431	V		Initial care, normal newborn	0600	0.9033	51.47		10.29
99432	N		Newborn care, not in hosp					
99433	C		Normal newborn care/hospital					
99435	E		Newborn discharge day hosp					
99436	N		Attendance, birth					
99440	S		Newborn resuscitation	0094	2.6945	153.54	48.58	30.71
99450	E		Life/disability evaluation					
99455	B		Disability examination					
99456	B		Disability examination					
99499	B		Unlisted e&m service					
99500	E		Home visit, prenatal					
99501	E		Home visit, postnatal					
99502	E		Home visit, nb care					
99503	E		Home visit, resp therapy					
99504	E		Home visit mech ventilator					
99505	E		Home visit, stoma care					
99506	E		Home visit, im injection					
99507	E		Home visit, cath maintain					
99509	E		Home visit day life activity					
99510	E		Home visit, sing/m/fam couns					
99511	E		Home visit, fecal/enema mgmt					
99512	E		Home visit for hemodialysis					
99600	E		Home visit nos					
99601	E		Home infusion/visit, 2 hrs					
99602	E		Home infusion, each addtl hr					
A0021	E		Outside state ambulance serv					
A0080	E		Noninterest escort in non er					
A0090	E		Interest escort in non er					
A0100	E		Nonemergency transport taxi					
A0110	E		Nonemergency transport bus					
A0120	E		Noner transport mini-bus					
A0130	E		Noner transport wheelch van					
A0140	E		Nonemergency transport air					
A0160	E		Noner transport case worker					
A0170	E		Transport parking fees/tolls					
A0180	E		Noner transport lodgng recip					
A0190	E		Noner transport meals recip					
A0200	E		Noner transport lodgng escrt					
A0210	E		Noner transport meals escort					
A0225	A		Neonatal emergency transport					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A0380	A		Basic life support mileage					
A0382	A		Basic support routine suppls					
A0384	A		Bls defibrillation supplies					
A0390	A		Advanced life support mileag					
A0392	A		Als defibrillation supplies					
A0394	A		Als IV drug therapy supplies					
A0396	A		Als esophageal intub suppls					
A0398	A		Als routine disposble suppls					
A0420	A		Ambulance waiting 1/2 hr					
A0422	A		Ambulance 02 life sustaining					
A0424	A		Extra ambulance attendant					
A0425	A		Ground mileage					
A0426	A		Als 1					
A0427	A		ALS1-emergency					
A0428	A		bls					
A0429	A		BLS-emergency					
A0430	A		Fixed wing air transport					
A0431	A		Rotary wing air transport					
A0432	A		PI volunteer ambulance co					
A0433	A		als 2					
A0434	A		Specialty care transport					
A0435	A		Fixed wing air mileage					
A0436	A		Rotary wing air mileage					
A0800	B		Amb trans 7pm-7am					
A0888	E		Noncovered ambulance mileage					
A0999	A		Unlisted ambulance service					
A4206	E		1 CC sterile syringe&needle					
A4207	E		2 CC sterile syringe&needle					
A4208	E		3 CC sterile syringe&needle					
A4209	E		5+ CC sterile syringe&needle					
A4210	E		Nonneedle injection device					
A4211	B		Supp for self-adm injections					
A4212	B		Non coring needle or stylet					
A4213	E		20+ CC syringe only					
A4215	E		Sterile needle					
A4216	A		Sterile water/saline, 10 ml					
A4217	A		Sterile water/saline, 500 ml					
A4220	N		Infusion pump refill kit					
A4221	Y		Maint drug infus cath per wk					
A4222	Y		Infusion supplies with pump					
A4223	E	NI	Infusion supplies w/o pump					
A4230	Y		Infus insulin pump non needl					
A4231	Y		Infusion insulin pump needle					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4232	Y		Syringe w/needle insulin 3cc					
A4244	E		Alcohol or peroxide per pint					
A4245	E		Alcohol wipes per box					
A4246	E		Betadine/phisohex solution					
A4247	E		Betadine/iodine swabs/wipes					
A4248	N		Chlorhexidine antisept					
A4250	E		Urine reagent strips/tablets					
A4253	Y		Blood glucose/reagent strips					
A4254	Y		Battery for glucose monitor					
A4255	Y		Glucose monitor platforms					
A4256	Y		Calibrator solution/chips					
A4257	Y		Replace Lensshield Cartridge					
A4258	Y		Lancet device each					
A4259	Y		Lancets per box					
A4260	E		Levonorgestrel implant					
A4261	E		Cervical cap contraceptive					
A4262	N		Temporary tear duct plug					
A4263	N		Permanent tear duct plug					
A4265	Y		Paraffin					
A4266	E		Diaphragm					
A4267	E		Male condom					
A4268	E		Female condom					
A4269	E		Spermicide					
A4270	A		Disposable endoscope sheath					
A4280	A		Brst prsths adhsv attchmnt					
A4281	E		Replacement breastpump tube					
A4282	E		Replacement breastpump adpt					
A4283	E		Replacement breastpump cap					
A4284	E		Replcmnt breast pump shield					
A4285	E		Replcmnt breast pump bottle					
A4286	E		Replcmnt breastpump lok ring					
A4290	B		Sacral nerve stim test lead					
A4300	N		Cath impl vasc access portal					
A4301	N		Implantable access syst perc					
A4305	A		Drug delivery system >=50 ML					
A4306	A		Drug delivery system <=5 ML					
A4310	A		Insert tray w/o bag/cath					
A4311	A		Catheter w/o bag 2-way latex					
A4312	A		Cath w/o bag 2-way silicone					
A4313	A		Catheter w/bag 3-way					
A4314	A		Cath w/drainage 2-way latex					
A4315	A		Cath w/drainage 2-way silcne					
A4316	A		Cath w/drainage 3-way					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4320	A		Irrigation tray					
A4321	A		Cath therapeutic irrig agent					
A4322	A		Irrigation syringe					
A4324	D		Male ext cath w/adh coating					
A4325	D		Male ext cath w/adh strip					
A4326	A		Male external catheter					
A4327	A		Fem urinary collect dev cup					
A4328	A		Fem urinary collect pouch					
A4330	A		Stool collection pouch					
A4331	A		Extension drainage tubing					
A4332	A		Lube sterile packet					
A4333	A		Urinary cath anchor device					
A4334	A		Urinary cath leg strap					
A4335	A		Incontinence supply					
A4338	A		Indwelling catheter latex					
A4340	A		Indwelling catheter special					
A4344	A		Cath indw foley 2 way silicn					
A4346	A		Cath indw foley 3 way					
A4347	D		Male external catheter					
A4348	A		Male ext cath extended wear					
A4349	Y	NI	Disposable male external cat					
A4351	A		Straight tip urine catheter					
A4352	A		Coude tip urinary catheter					
A4353	A		Intermittent urinary cath					
A4354	A		Cath insertion tray w/bag					
A4355	A		Bladder irrigation tubing					
A4356	A		Ext ureth clmp or compr dvc					
A4357	A		Bedside drainage bag					
A4358	A		Urinary leg or abdomen bag					
A4359	A		Urinary suspensory w/o leg b					
A4361	A		Ostomy face plate					
A4362	A		Solid skin barrier					
A4364	A		Adhesive, liquid or equal					
A4365	A		Adhesive remover wipes					
A4366	A		Ostomy vent					
A4367	A		Ostomy belt					
A4368	A		Ostomy filter					
A4369	A		Skin barrier liquid per oz					
A4371	A		Skin barrier powder per oz					
A4372	A		Skin barrier solid 4x4 equiv					
A4373	A		Skin barrier with flange					
A4375	A		Drainable plastic pch w fcpl					
A4376	A		Drainable rubber pch w fcplt					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4377	A		Drainable plstic pch w/o fp					
A4378	A		Drainable rubber pch w/o fp					
A4379	A		Urinary plastic pouch w fcpl					
A4380	A		Urinary rubber pouch w fcplt					
A4381	A		Urinary plastic pouch w/o fp					
A4382	A		Urinary hvy plstc pch w/o fp					
A4383	A		Urinary rubber pouch w/o fp					
A4384	A		Ostomy faceplt/silicone ring					
A4385	A		Ost skn barrier sld ext wear					
A4387	A		Ost clsd pouch w att st barr					
A4388	A		Drainable pch w ex wear barr					
A4389	A		Drainable pch w st wear barr					
A4390	A		Drainable pch ex wear convex					
A4391	A		Urinary pouch w ex wear barr					
A4392	A		Urinary pouch w st wear barr					
A4393	A		Urine pch w ex wear bar conv					
A4394	A		Ostomy pouch liq deodorant					
A4395	A		Ostomy pouch solid deodorant					
A4396	A		Peristomal hernia supprt blt					
A4397	A		Irrigation supply sleeve					
A4398	A		Ostomy irrigation bag					
A4399	A		Ostomy irrig cone/cath w brs					
A4400	A		Ostomy irrigation set					
A4402	A		Lubricant per ounce					
A4404	A		Ostomy ring each					
A4405	A		Nonpectin based ostomy paste					
A4406	A		Pectin based ostomy paste					
A4407	A		Ext wear ost skn barr <=4sq"					
A4408	A		Ext wear ost skn barr >4sq"					
A4409	A		Ost skn barr w flng <=4 sq"					
A4410	A		Ost skn barr w flng >4sq"					
A4413	A		2 pc drainable ost pouch					
A4414	A		Ostomy sknbarr w flng <=4sq"					
A4415	A		Ostomy skn barr w flng >4sq"					
A4416	A		Ost pch clsd w barrier/filtr					
A4417	A		Ost pch w bar/bltinconv/fltr					
A4418	A		Ost pch clsd w/o bar w filtr					
A4419	A		Ost pch for bar w flange/flt					
A4420	A		Ost pch clsd for bar w lk fl					
A4421	E		Ostomy supply misc					
A4422	A		Ost pouch absorbent material					
A4423	A		Ost pch for bar w lk fl/fltr					
A4424	A		Ost pch drain w bar & filter					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4425	A		Ost pch drain for barrier fl					
A4426	A		Ost pch drain 2 piece system					
A4427	A		Ost pch drain/barr lk flng/f					
A4428	A		Urine ost pouch w faucet/tap					
A4429	A		Urine ost pouch w bltinconv					
A4430	A		Ost urine pch w b/bltin conv					
A4431	A		Ost pch urine w barrier/tapv					
A4432	A		Os pch urine w bar/fange/tap					
A4433	A		Urine ost pch bar w lock fln					
A4434	A		Ost pch urine w lock flng/ft					
A4450	A		Non-waterproof tape					
A4452	A		Waterproof tape					
A4455	A		Adhesive remover per ounce					
A4458	E		Reusable enema bag					
A4462	A		Abdmnl drssng holder/binder					
A4465	A		Non-elastic extremity binder					
A4470	A		Gravlee jet washer					
A4480	A		Vabra aspirator					
A4481	A		Tracheostoma filter					
A4483	A		Moisture exchanger					
A4490	E		Above knee surgical stocking					
A4495	E		Thigh length surg stocking					
A4500	E		Below knee surgical stocking					
A4510	E		Full length surg stocking					
A4520	E	NI	Incontinence garment anytype					
A4521	D		Adult size diaper sm each					
A4522	D		Adult size diaper med each					
A4523	D		Adult size diaper lg each					
A4524	D		Adult size diaper xl each					
A4525	D		Adult size brief sm each					
A4526	D		Adult size brief med each					
A4527	D		Adult size brief lg each					
A4528	D		Adult size brief xl each					
A4529	D		Child size diaper sm/med ea					
A4530	D		Child size diaper lg each					
A4531	D		Child size brief sm/med each					
A4532	D		Child size brief lg each					
A4533	D		Youth size diaper each					
A4534	E		Youth size brief each					
A4535	D		Disp incont liner/shield ea					
A4536	D		Prot underwr wshbl any sz ea					
A4537	D		Under pad reusable any sz ea					
A4538	D		Reusable diaper from dpr svc					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4550	B		Surgical trays					
A4554	E		Disposable underpads					
A4556	Y		Electrodes, pair					
A4557	Y		Lead wires, pair					
A4558	Y		Conductive paste or gel					
A4561	N		Pessary rubber, any type					
A4562	N		Pessary, non rubber,any type					
A4565	A		Slings					
A4570	E		Splint					
A4575	E		Hyperbaric o2 chamber disps					
A4580	E		Cast supplies (plaster)					
A4590	E		Special casting material					
A4595	Y		TENS suppl 2 lead per month					
A4605	Y	NI	Trach suction cath close sys					
A4606	A		Oxygen probe used w oximeter					
A4608	Y		Transtracheal oxygen cath					
A4609	D		Trach suction cath clsed sys					
A4610	D		Trach sctn cath 72h clsedsys					
A4611	Y		Heavy duty battery					
A4612	Y		Battery cables					
A4613	Y		Battery charger					
A4614	A		Hand-held PEFR meter					
A4615	Y		Cannula nasal					
A4616	Y		Tubing (oxygen) per foot					
A4617	Y		Mouth piece					
A4618	Y		Breathing circuits					
A4619	Y		Face tent					
A4620	Y		Variable concentration mask					
A4623	A		Tracheostomy inner cannula					
A4624	Y		Tracheal suction tube					
A4625	A		Trach care kit for new trach					
A4626	A		Tracheostomy cleaning brush					
A4627	E		Spacer bag/reservoir					
A4628	Y		Oropharyngeal suction cath					
A4629	A		Tracheostomy care kit					
A4630	Y		Repl bat t.e.n.s. own by pt					
A4632	Y		Infus pump rplcemnt battery					
A4633	Y		Uvl replacement bulb					
A4634	A		Replacement bulb th lightbox					
A4635	Y		Underarm crutch pad					
A4636	Y		Handgrip for cane etc					
A4637	Y		Repl tip cane/crutch/walker					
A4638	Y		Repl batt pulse gen sys					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4639	Y		Infrared ht sys replcmnt pad					
A4640	Y		Alternating pressure pad					
A4641	N		Diagnostic imaging agent					
A4642	K		Satumomab pendetide per dose	0704		1390.25		278.05
A4643	K		High dose contrast MRI	9026	0.4605	26.24		5.25
A4644	N		Contrast 100-199 MGs iodine					
A4645	N		Contrast 200-299 MGs iodine					
A4646	N		Contrast 300-399 MGs iodine					
A4647	K		Supp- paramagnetic contr mat	9027	0.6245	35.59		7.12
A4649	A		Surgical supplies					
A4651	A		Calibrated microcap tube					
A4652	A		Microcapillary tube sealant					
A4653	A		PD catheter anchor belt					
A4656	A		Needle any size					
A4657	A		Syringe w/wo needle					
A4660	A		Sphyg/bp app w cuff and stet					
A4663	A		Dialysis blood pressure cuff					
A4670	E		Automatic bp monitor, dial					
A4671	B		Disposable cycler set					
A4672	B		Drainage ext line, dialysis					
A4673	B		Ext line w easy lock connect					
A4674	B		Chem/antisept solution, 8oz					
A4680	A		Activated carbon filter, ea					
A4690	A		Dialyzer, each					
A4706	A		Bicarbonate conc sol per gal					
A4707	A		Bicarbonate conc pow per pac					
A4708	A		Acetate conc sol per gallon					
A4709	A		Acid conc sol per gallon					
A4714	A		Treated water per gallon					
A4719	A		"Y set" tubing					
A4720	A		Dialysat sol fld vol > 249cc					
A4721	A		Dialysat sol fld vol > 999cc					
A4722	A		Dialys sol fld vol > 1999cc					
A4723	A		Dialys sol fld vol > 2999cc					
A4724	A		Dialys sol fld vol > 3999cc					
A4725	A		Dialys sol fld vol > 4999cc					
A4726	A		Dialys sol fld vol > 5999cc					
A4728	B		Dialysate solution, non-dex					
A4730	A		Fistula cannulation set, ea					
A4736	A		Topical anesthetic, per gram					
A4737	A		Inj anesthetic per 10 ml					
A4740	A		Shunt accessory					
A4750	A		Art or venous blood tubing					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4755	A		Comb art/venous blood tubing					
A4760	A		Dialysate sol test kit, each					
A4765	A		Dialysate conc pow per pack					
A4766	A		Dialysate conc sol add 10 ml					
A4770	A		Blood collection tube/vacuum					
A4771	A		Serum clotting time tube					
A4772	A		Blood glucose test strips					
A4773	A		Occult blood test strips					
A4774	A		Ammonia test strips					
A4802	A		Protamine sulfate per 50 mg					
A4860	A		Disposable catheter tips					
A4870	A		Plumb/elec wk hm hemo equip					
A4890	A		Repair/maint cont hemo equip					
A4911	A		Drain bag/bottle					
A4913	A		Misc dialysis supplies noc					
A4918	A		Venous pressure clamp					
A4927	A		Non-sterile gloves					
A4928	A		Surgical mask					
A4929	A		Tourniquet for dialysis, ea					
A4930	A		Sterile, gloves per pair					
A4931	A		Reusable oral thermometer					
A4932	E		Reusable rectal thermometer					
A5051	A		Pouch clsd w barr attached					
A5052	A		Clsd ostomy pouch w/o barr					
A5053	A		Clsd ostomy pouch faceplate					
A5054	A		Clsd ostomy pouch w/flange					
A5055	A		Stoma cap					
A5061	A		Pouch drainable w barrier at					
A5062	A		Drnble ostomy pouch w/o barr					
A5063	A		Drain ostomy pouch w/flange					
A5071	A		Urinary pouch w/barrier					
A5072	A		Urinary pouch w/o barrier					
A5073	A		Urinary pouch on barr w/flng					
A5081	A		Continent stoma plug					
A5082	A		Continent stoma catheter					
A5093	A		Ostomy accessory convex inse					
A5102	A		Bedside drain btl w/wo tube					
A5105	A		Urinary suspensory					
A5112	A		Urinary leg bag					
A5113	A		Latex leg strap					
A5114	A		Foam/fabric leg strap					
A5119	A		Skin barrier wipes box pr 50					
A5121	A		Solid skin barrier 6x6					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A5122	A		Solid skin barrier 8x8					
A5126	A		Disk/foam pad +or- adhesive					
A5131	A		Appliance cleaner					
A5200	A		Percutaneous catheter anchor					
A5500	Y		Diab shoe for density insert					
A5501	Y		Diabetic custom molded shoe					
A5503	Y		Diabetic shoe w/roller/rockr					
A5504	Y		Diabetic shoe with wedge					
A5505	Y		Diab shoe w/metatarsal bar					
A5506	Y		Diabetic shoe w/off set heel					
A5507	Y		Modification diabetic shoe					
A5508	Y		Diabetic deluxe shoe					
A5509	B		Direct heat form shoe insert					
A5510	E		Compression form shoe insert					
A5511	B		Custom fab molded shoe inser					
A6000	E		Wound warming wound cover					
A6010	A		Collagen based wound filler					
A6011	A		Collagen gel/paste wound fil					
A6021	A		Collagen dressing <=16 sq in					
A6022	A		Collagen drsg>6<=48 sq in					
A6023	A		Collagen dressing >48 sq in					
A6024	A		Collagen dsg wound filler					
A6025	E		Silicone gel sheet, each					
A6154	A		Wound pouch each					
A6196	A		Alginate dressing <=16 sq in					
A6197	A		Alginate drsg >16 <=48 sq in					
A6198	A		alginate dressing > 48 sq in					
A6199	A		Alginate drsg wound filler					
A6200	A		Compos drsg <=16 no border					
A6201	A		Compos drsg >16<=48 no bdr					
A6202	A		Compos drsg >48 no border					
A6203	A		Composite drsg <= 16 sq in					
A6204	A		Composite drsg >16<=48 sq in					
A6205	A		Composite drsg > 48 sq in					
A6206	A		Contact layer <= 16 sq in					
A6207	A		Contact layer >16<= 48 sq in					
A6208	A		Contact layer > 48 sq in					
A6209	A		Foam drsg <=16 sq in w/o bdr					
A6210	A		Foam drg >16<=48 sq in w/o b					
A6211	A		Foam drg > 48 sq in w/o brdr					
A6212	A		Foam drg <=16 sq in w/border					
A6213	A		Foam drg >16<=48 sq in w/bdr					
A6214	A		Foam drg > 48 sq in w/border					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A6215	A		Foam dressing wound filler					
A6216	A		Non-sterile gauze<=16 sq in					
A6217	A		Non-sterile gauze>16<=48 sq					
A6218	A		Non-sterile gauze > 48 sq in					
A6219	A		Gauze <= 16 sq in w/border					
A6220	A		Gauze >16 <=48 sq in w/bordr					
A6221	A		Gauze > 48 sq in w/border					
A6222	A		Gauze <=16 in no w/sal w/o b					
A6223	A		Gauze >16<=48 no w/sal w/o b					
A6224	A		Gauze > 48 in no w/sal w/o b					
A6228	A		Gauze <= 16 sq in water/sal					
A6229	A		Gauze >16<=48 sq in watr/sal					
A6230	A		Gauze > 48 sq in water/salne					
A6231	A		Hydrogel dsg<=16 sq in					
A6232	A		Hydrogel dsg>16<=48 sq in					
A6233	A		Hydrogel dressing >48 sq in					
A6234	A		Hydrocolld drg <=16 w/o bdr					
A6235	A		Hydrocolld drg >16<=48 w/o b					
A6236	A		Hydrocolld drg > 48 in w/o b					
A6237	A		Hydrocolld drg <=16 in w/bdr					
A6238	A		Hydrocolld drg >16<=48 w/bdr					
A6239	A		Hydrocolld drg > 48 in w/bdr					
A6240	A		Hydrocolld drg filler paste					
A6241	A		Hydrocolloid drg filler dry					
A6242	A		Hydrogel drg <=16 in w/o bdr					
A6243	A		Hydrogel drg >16<=48 w/o bdr					
A6244	A		Hydrogel drg >48 in w/o bdr					
A6245	A		Hydrogel drg <= 16 in w/bdr					
A6246	A		Hydrogel drg >16<=48 in w/b					
A6247	A		Hydrogel drg > 48 sq in w/b					
A6248	A		Hydrogel drsg gel filler					
A6250	A		Skin seal protect moisturizr					
A6251	A		Absorpt drg <=16 sq in w/o b					
A6252	A		Absorpt drg >16 <=48 w/o bdr					
A6253	A		Absorpt drg > 48 sq in w/o b					
A6254	A		Absorpt drg <=16 sq in w/bdr					
A6255	A		Absorpt drg >16<=48 in w/bdr					
A6256	A		Absorpt drg > 48 sq in w/bdr					
A6257	A		Transparent film <= 16 sq in					
A6258	A		Transparent film >16<=48 in					
A6259	A		Transparent film > 48 sq in					
A6260	A		Wound cleanser any type/size					
A6261	A		Wound filler gel/paste /oz					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A6262	A		Wound filler dry form / gram					
A6266	A		Impreg gauze no h20/sal/yard					
A6402	A		Sterile gauze <= 16 sq in					
A6403	A		Sterile gauze>16 <= 48 sq in					
A6404	A		Sterile gauze > 48 sq in					
A6407	A		Packing strips, non-impreg					
A6410	A		Sterile eye pad					
A6411	A		Non-sterile eye pad					
A6412	E		Occlusive eye patch					
A6441	A		Pad band w>=3" <5"/yd					
A6442	A		Conform band n/s w<3"/yd					
A6443	A		Conform band n/s w>=3"<5"/yd					
A6444	A		Conform band n/s w>=5"/yd					
A6445	A		Conform band s w <3"/yd					
A6446	A		Conform band s w>=3" <5"/yd					
A6447	A		Conform band s w >=5"/yd					
A6448	A		Lt compres band <3"/yd					
A6449	A		Lt compres band >=3" <5"/yd					
A6450	A		Lt compres band >=5"/yd					
A6451	A		Mod compres band w>=3"<5"/yd					
A6452	A		High compres band w>=3"<5"yd					
A6453	A		Self-adher band w <3"/yd					
A6454	A		Self-adher band w>=3" <5"/yd					
A6455	A		Self-adher band >=5"/yd					
A6456	A		Zinc paste band w >=3"<5"/yd					
A6501	A		Compres burngarment bodysuit					
A6502	A		Compres burngarment chinstrp					
A6503	A		Compres burngarment facehood					
A6504	A		Cmprsburngarment glove-wrist					
A6505	A		Cmprsburngarment glove-elbow					
A6506	A		Cmprsburngrmnt glove-axilla					
A6507	A		Cmprs burngarment foot-knee					
A6508	A		Cmprs burngarment foot-thigh					
A6509	A		Compres burn garment jacket					
A6510	A		Compres burn garment leotard					
A6511	A		Compres burn garment panty					
A6512	A		Compres burn garment, noc					
A6550	Y		Neg pres wound ther drsg set					
A6551	Y		Neg press wound ther canistr					
A7000	Y		Disposable canister for pump					
A7001	Y		Nondisposable pump canister					
A7002	Y		Tubing used w suction pump					
A7003	Y		Nebulizer administration set					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A7004	Y		Disposable nebulizer sml vol					
A7005	Y		Nondisposable nebulizer set					
A7006	Y		Filtered nebulizer admin set					
A7007	Y		Lg vol nebulizer disposable					
A7008	Y		Disposable nebulizer prefill					
A7009	Y		Nebulizer reservoir bottle					
A7010	Y		Disposable corrugated tubing					
A7011	Y		Nondispos corrugated tubing					
A7012	Y		Nebulizer water collec devic					
A7013	Y		Disposable compressor filter					
A7014	Y		Compressor nondispos filter					
A7015	Y		Aerosol mask used w nebulize					
A7016	Y		Nebulizer dome & mouthpiece					
A7017	Y		Nebulizer not used w oxygen					
A7018	Y		Water distilled w/nebulizer					
A7025	Y		Replace chest compress vest					
A7026	Y		Replace chst cmprss sys hose					
A7030	Y		CPAP full face mask					
A7031	Y		Replacement facemask interfa					
A7032	Y		Replacement nasal cushion					
A7033	Y		Replacement nasal pillows					
A7034	Y		Nasal application device					
A7035	Y		Pos airway press headgear					
A7036	Y		Pos airway press chinstrap					
A7037	Y		Pos airway pressure tubing					
A7038	Y		Pos airway pressure filter					
A7039	Y		Filter, non disposable w pap					
A7040	Y	NI	One way chest drain valve					
A7041	Y	NI	Water seal drain container					
A7042	A		Implanted pleural catheter					
A7043	A		Vacuum drainagebottle/tubing					
A7044	Y		PAP oral interface					
A7045	Y	NI	Repl exhalation port for PAP					
A7046	Y		Repl water chamber, PAP dev					
A7501	A		Tracheostoma valve w diaphra					
A7502	A		Replacement diaphragm/fplate					
A7503	A		HMES filter holder or cap					
A7504	A		Tracheostoma HMES filter					
A7505	A		HMES or trach valve housing					
A7506	A		HMES/trachvalve adhesivedisk					
A7507	A		Integrated filter & holder					
A7508	A		Housing & Integrated Adhesiv					
A7509	A		Heat & moisture exchange sys					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A7520	A		Trach/laryn tube non-cuffed					
A7521	A		Trach/laryn tube cuffed					
A7522	A		Trach/laryn tube stainless					
A7523	A		Tracheostomy shower protect					
A7524	A		Tracheostoma stent/stud/bttn					
A7525	A		Tracheostomy mask					
A7526	A		Tracheostomy tube collar					
A7527	Y	NI	Trach/laryn tube plug/stop					
A9150	B		Misc/exper non-prescript dru					
A9152	E	NI	Single vitamin nos					
A9153	E	NI	Multi-vitamin nos					
A9180	E	NI	Lice treatment, topical					
A9270	E		Non-covered item or service					
A9280	E		Alert device, noc					
A9300	E		Exercise equipment					
A9500	K		Technetium TC 99m sestamibi	1600		106.32		21.26
A9502	K		Technetium TC99M tetrofosmin	0705		104.58		20.92
A9503	N		Technetium TC 99m medronate					
A9504	K		Technetium tc 99m apcitide	1602		415.00		83.00
A9505	K		Thallous chloride TL 201/mci	1603		18.29		3.66
A9507	K		Indium/111 capromab pendetid	1604		1915.23		383.05
A9508	K		Iobenguane sulfate I-131	1045		996.00		199.20
A9510	N		Technetium TC99m Disofenin					
A9511	K		Technetium TC 99m depreotide	1095	0.6631	37.79		7.56
A9512	N		Technetiumtc99mpertechnetate					
A9513	N		Technetium tc-99m mebrofenin					
A9514	N		Technetiumtc99mpyrophosphate					
A9515	N		Technetium tc-99m pentetate					
A9516	N		I-123 sodium iodide capsule					
A9517	K		Th I131 so iodide cap millic	1064	0.1153	6.57		1.31
A9519	N		Technetiumtc-99mmacroag albu					
A9520	N		Technetiumtc-99m sulfur clld					
A9521	K		Technetiumtc-99m exametazine	1096		778.13		155.63
A9522	B		Indium111ibritumomabtiuxetan					
A9523	B		Yttrium90ibritumomabtiuxetan					
A9524	N		Iodinated I-131 serumalbumin					
A9525	E		Low/iso-osmolar contrast mat					
A9526	K		Ammonia N-13, per dose	0737	1.9280	109.86		21.97
A9528	K		Dx I131 so iodide cap millic	1064	0.1153	6.57		1.31
A9529	K		Dx I131 so iodide sol millic	1065	0.1707	9.73		1.95
A9530	K		Th I131 so iodide sol millic	1065	0.1707	9.73		1.95
A9531	N		Dx I131 so iodide microcurie					
A9532	N		I-125 serum albumin micro					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A9533	B		I-131 tositumomab diagnostic					
A9534	B		I-131 tositumomab therapeut					
A9600	K		Strontium-89 chloride	0701	7.1278	406.16		81.23
A9605	K		Samarium sm153 lexidronamm	0702	15.9228	907.33		181.47
A9699	N		Noc therapeutic radiopharm					
A9700	B		Echocardiography Contrast					
A9900	A		Supply/accessory/service					
A9901	A		Delivery/set up/dispensing					
A9999	Y		DME supply or accessory, nos					
B4034	A		Enter feed supkit syr by day					
B4035	A		Enteral feed supp pump per d					
B4036	A		Enteral feed sup kit grav by					
B4081	A		Enteral ng tubing w/ stylet					
B4082	A		Enteral ng tubing w/o stylet					
B4083	A		Enteral stomach tube levine					
B4086	A		Gastrostomy/jejunostomy tube					
B4100	E		Food thickener oral					
B4102	Y	NI	EF adult fluids and electro					
B4103	Y	NI	EF ped fluid and electrolyte					
B4104	B	NI	Additive for enteral formula					
B4149	Y	NI	EF blenderized foods					
B4150	A		EF complet w/intact nutrient					
B4151	D		Enteral formulae cat1natural					
B4152	A		EF calorie dense>/=1.5Kcal					
B4153	A		EF hydrolyzed/amino acids					
B4154	A		EF spec metabolic noninherit					
B4155	A		EF incomplete/modular					
B4156	D		Enteral formulae category vi					
B4157	Y	NI	EF special metabolic inherit					
B4158	Y	NI	EF ped complete intact nut					
B4159	Y	NI	EF ped complete soy based					
B4160	Y	NI	EF ped caloric dense>/=0.7kc					
B4161	Y	NI	EF ped hydrolyzed/amino acid					
B4162	Y	NI	EF ped specmetabolic inherit					
B4164	A		Parenteral 50% dextrose solu					
B4168	A		Parenteral sol amino acid 3.					
B4172	A		Parenteral sol amino acid 5.					
B4176	A		Parenteral sol amino acid 7-					
B4178	A		Parenteral sol amino acid >					
B4180	A		Parenteral sol carb > 50%					
B4184	A		Parenteral sol lipids 10%					
B4186	A		Parenteral sol lipids 20%					
B4189	A		Parenteral sol amino acid &					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
B4193	A		Parenteral sol 52-73 gm prot					
B4197	A		Parenteral sol 74-100 gm pro					
B4199	A		Parenteral sol > 100gm prote					
B4216	A		Parenteral nutrition additiv					
B4220	A		Parenteral supply kit premix					
B4222	A		Parenteral supply kit homemi					
B4224	A		Parenteral administration ki					
B5000	A		Parenteral sol renal-amirosy					
B5100	A		Parenteral sol hepatic-fream					
B5200	A		Parenteral sol stres-brnch c					
B9000	A		Enter infusion pump w/o alrm					
B9002	A		Enteral infusion pump w/ ala					
B9004	A		Parenteral infus pump portab					
B9006	A		Parenteral infus pump statio					
B9998	A		Enteral supp not otherwise c					
B9999	A		Parenteral supp not othrws c					
C1079	K		CO 57/58 per 0.5 uCi	1079		221.78		44.36
C1080	K		I-131 tositumomab, dx	1080		2241.00		448.20
C1081	K		I-131 tositumomab, tx	1081		19422.00		3884.40
C1082	K		In-111 ibritumomab tiuxetan	9118		2419.78		483.96
C1083	K		Yttrium 90 ibritumomab tiuxe	9117		20948.25		4189.65
C1091	K		IN111 oxyquinoline,per0.5mCi	1091		373.50		74.70
C1092	K		IN 111 pentetate per 0.5 mCi	1092		224.10		44.82
C1093	K	NI	TC99M fanolesomab	1093		1045.80		209.16
C1122	K		Tc 99M ARCITUMOMAB PER VIAL	1122		1079.00		215.80
C1178	K		BUSULFAN IV, 6 Mg	1178		24.35		4.87
C1200	N		TC 99M Sodium Glucoheptonat					
C1201	K		TC 99M SUCCIMER, PER Vial	1201		118.52		23.70
C1300	S		HYPERBARIC Oxygen	0659	1.5926	90.75		18.15
C1305	K		Apligraf	1305		1130.88		226.18
C1713	N		Anchor/screw bn/bn,tis/bn					
C1714	N		Cath, trans atherectomy, dir					
C1715	N		Brachytherapy needle					
C1716	H		Brachytx source, Gold 198	1716				
C1717	H		Brachytx source, HDR Ir-192	1717				
C1718	H		Brachytx source, Iodine 125	1718				
C1719	H		Brachytx sour,Non-HDR Ir-192	1719				
C1720	H		Brachytx sour, Palladium 103	1720				
C1721	N		AICD, dual chamber					
C1722	N		AICD, single chamber					
C1724	N		Cath, trans atherec,rotation					
C1725	N		Cath, translumin non-laser					
C1726	N		Cath, bal dil, non-vascular					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
C1727	N		Cath, bal tis dis, non-vas					
C1728	N		Cath, brachytx seed adm					
C1729	N		Cath, drainage					
C1730	N		Cath, EP, 19 or few elect					
C1731	N		Cath, EP, 20 or more elec					
C1732	N		Cath, EP, diag/abl, 3D/vect					
C1733	N		Cath, EP, othr than cool-tip					
C1750	N		Cath, hemodialysis,long-term					
C1751	N		Cath, inf, per/cent/midline					
C1752	N		Cath,hemodialysis,short-term					
C1753	N		Cath, intravas ultrasound					
C1754	N		Catheter, intradiscal					
C1755	N		Catheter, intraspinal					
C1756	N		Cath, pacing, transesoph					
C1757	N		Cath, thrombectomy/embolect					
C1758	N		Catheter, ureteral					
C1759	N		Cath, intra echocardiography					
C1760	N		Closure dev, vasc					
C1762	N		Conn tiss, human(inc fascia)					
C1763	N		Conn tiss, non-human					
C1764	N		Event recorder, cardiac					
C1765	N		Adhesion barrier					
C1766	N		Intro/sheath,strble,non-peel					
C1767	N		Generator, neurostim, imp					
C1768	N		Graft, vascular					
C1769	N		Guide wire					
C1770	N		Imaging coil, MR, insertable					
C1771	N		Rep dev, urinary, w/sling					
C1772	N		Infusion pump, programmable					
C1773	N		Ret dev, insertable					
C1775	K		FDG, per dose (4-40 mCi/ml)	1775	3.8803	221.11		44.22
C1776	N		Joint device (implantable)					
C1777	N		Lead, AICD, endo single coil					
C1778	N		Lead, neurostimulator					
C1779	N		Lead, pmkr, transvenous VDD					
C1780	N		Lens, intraocular (new tech)					
C1781	N		Mesh (implantable)					
C1782	N		Morcellator					
C1783	N		Ocular imp, aqueous drain de					
C1784	N		Ocular dev, intraop, det ret					
C1785	N		Pmkr, dual, rate-resp					
C1786	N		Pmkr, single, rate-resp					
C1787	N		Patient progr, neurostim					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
C1788	N		Port, indwelling, imp					
C1789	N		Prosthesis, breast, imp					
C1813	N		Prosthesis, penile, inflatab					
C1814	H		Retinal tamp, silicone oil	1814				
C1815	N		Pros, urinary sph, imp					
C1816	N		Receiver/transmitter, neuro					
C1817	N		Septal defect imp sys					
C1818	H		Integrated keratoprosthesis	1818				
C1819	H		Tissue localization-excision	1819				
C1874	N		Stent, coated/cov w/del sys					
C1875	N		Stent, coated/cov w/o del sy					
C1876	N		Stent, non-coa/non-cov w/del					
C1877	N		Stent, non-coat/cov w/o del					
C1878	N		Matrl for vocal cord					
C1879	N		Tissue marker, implantable					
C1880	N		Vena cava filter					
C1881	N		Dialysis access system					
C1882	N		AICD, other than sing/dual					
C1883	N		Adapt/ext, pacing/neuro lead					
C1884	N		Embolization Protect syst					
C1885	N		Cath, translumin angio laser					
C1887	N		Catheter, guiding					
C1888	N		Endovas non-cardiac abl cath					
C1891	N		Infusion pump,non-prog, perm					
C1892	N		Intro/sheath,fixed,peel-away					
C1893	N		Intro/sheath, fixed,non-peel					
C1894	N		Intro/sheath, non-laser					
C1895	N		Lead, AICD, endo dual coil					
C1896	N		Lead, AICD, non sing/dual					
C1897	N		Lead, neurostim test kit					
C1898	N		Lead, pmkr, other than trans					
C1899	N		Lead, pmkr/AICD combination					
C1900	N		Lead, coronary venous					
C2614	N		Probe, perc lumb disc					
C2615	N		Sealant, pulmonary, liquid					
C2616	H		Brachytx source, Yttrium-90	2616				
C2617	N		Stent, non-cor, tem w/o del					
C2618	N		Probe, cryoablation					
C2619	N		Pmkr, dual, non rate-resp					
C2620	N		Pmkr, single, non rate-resp					
C2621	N		Pmkr, other than sing/dual					
C2622	N		Prosthesis, penile, non-inf					
C2625	N		Stent, non-cor, tem w/del sy					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
C2626	N		Infusion pump, non-prog,temp					
C2627	N		Cath, suprapubic/cystoscopic					
C2628	N		Catheter, occlusion					
C2629	N		Intro/sheath, laser					
C2630	N		Cath, EP, cool-tip					
C2631	N		Rep dev, urinary, w/o sling					
C2632	H		Brachytx sol, I-125, per mCi	2632				
C2633	H		Brachytx source, Cesium-131	2633				
C2634	H	NI	Brachytx source, HA, I-125	2634				
C2635	H	NI	Brachytx source, HA, P-103	2635				
C2636	H	NI	Brachytx linear source, P-10	2636				
C8900	S		MRA w/cont, abd	0284	6.7851	386.64	173.98	77.33
C8901	S		MRA w/o cont, abd	0336	6.3150	359.85	161.93	71.97
C8902	S		MRA w/o fol w/cont, abd	0337	9.1701	522.54	235.14	104.51
C8903	S		MRI w/cont, breast, uni	0284	6.7851	386.64	173.98	77.33
C8904	S		MRI w/o cont, breast, uni	0336	6.3150	359.85	161.93	71.97
C8905	S		MRI w/o fol w/cont, brst, un	0337	9.1701	522.54	235.14	104.51
C8906	S		MRI w/cont, breast, bi	0284	6.7851	386.64	173.98	77.33
C8907	S		MRI w/o cont, breast, bi	0336	6.3150	359.85	161.93	71.97
C8908	S		MRI w/o fol w/cont, breast,	0337	9.1701	522.54	235.14	104.51
C8909	S		MRA w/cont, chest	0284	6.7851	386.64	173.98	77.33
C8910	S		MRA w/o cont, chest	0336	6.3150	359.85	161.93	71.97
C8911	S		MRA w/o fol w/cont, chest	0337	9.1701	522.54	235.14	104.51
C8912	S		MRA w/cont, lwr ext	0284	6.7851	386.64	173.98	77.33
C8913	S		MRA w/o cont, lwr ext	0336	6.3150	359.85	161.93	71.97
C8914	S		MRA w/o fol w/cont, lwr ext	0337	9.1701	522.54	235.14	104.51
C8918	S		MRA w/cont, pelvis	0284	6.7851	386.64	173.98	77.33
C8919	S		MRA w/o cont, pelvis	0336	6.3150	359.85	161.93	71.97
C8920	S		MRA w/o fol w/cont, pelvis	0337	9.1701	522.54	235.14	104.51
C9000	N		Na chromateCr51, per 0.25mCi					
C9003	K		Palivizumab, per 50 mg	9003		576.51		115.30
C9007	N		Baclofen Intrathecal kit-1am					
C9008	K		Baclofen Refill Kit-500mcg	9008		10.21		2.04
C9009	K		Baclofen Refill Kit-2000mcg	9009		37.64		7.53
C9013	K		Co 57 cobaltous chloride	9013	2.4999	142.45		28.49
C9102	N		51 Na Chromate, 50mCi					
C9103	N		Na Iothalamate I-125, 10 uCi					
C9105	K		Hep B imm glob, per 1 ml	9105		118.32		23.66
C9109	D		Tirofiban hcl, 6.25 mg					
C9112	K		Perflutren lipid micro, 2ml	9112		129.69		25.94
C9113	N		Inj pantoprazole sodium, via					
C9121	K		Injection, argatroban	9121		12.45		2.49
C9123	G	NF	Transcyte, per 247 sq cm	9123		707.97		141.59

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
C9124	D		Injection, daptomycin					
C9125	D		Injection, risperidone					
C9200	K		Orcel, per 36 cm2	9200		991.85		198.37
C9201	K		Dermagraft, per 37.5 sq cm	9201		529.54		105.91
C9202	K		Octafluoropropane	9202		129.48		25.90
C9203	G		Perflexane lipid micro	9203		142.20		28.50
C9205	G		Oxaliplatin	9205		81.61		16.32
C9206	K	NI	Integra, per cm2	9206		6.60		1.32
C9207	D		Injection, bortezomib					
C9208	D		Injection, agalsidase beta					
C9209	D		Injection, laronidase					
C9210	D		Injection, palonosetron HCl					
C9211	G		Inj, alefacept, IV	9211		560.00		112.00
C9212	G		Inj, alefacept, IM	9212		398.49		79.70
C9213	D		Injection, pemetrexed					
C9214	D		Injection, bevacizumab					
C9215	D		Injection, cetuximab					
C9216	D		Abarelix, inject suspension					
C9217	D		Injection, omalizumab					
C9218	G	NI	Injection, azacitidine	9218		3.81		0.76
C9219	D		Mycophenolic acid, oral					
C9220	G	NI	Sodium hyaluronate	9220		238.36		47.67
C9221	G	NI	Graftjacket Reg Matrix	9221		1068.75		213.75
C9222	G	NI	Graftjacket SftTis	9222		743.38		148.68
C9399	A	NF	Unclassified drugs or biolog					
C9400	K	NF	Thallous chloride, brand	9400		21.19		4.24
C9401	K	NF	Strontium-89 chloride,brand	9401		406.16		81.23
C9402	K	NF	Th I131 so iodide cap, brand	9402		6.57		1.31
C9403	K	NF	Dx I131 so iodide cap, brand	9403		6.57		1.31
C9404	K	NF	Dx I131 so iodide sol, brand	9404		9.73		1.95
C9405	K	NF	Th I131 so iodide sol, brand	9405		9.73		1.95
C9410	K	NF	Dexrazoxane HCl inj, brand	9410		123.93		24.79
C9411	K	NF	Pamidronate disodium, brand	9411		160.65		32.13
C9413	K	NF	Sodium hyaluronate inj, bran	9413		53.94		10.79
C9414	K	NF	Etoposide oral, brand	9414		25.71		5.14
C9415	K	NF	Doxorubic hcl chemo, brand	9415		6.94		1.39
C9417	K	NF	Bleomycin sulfate inj, brand	9417		130.56		26.11
C9418	K	NF	Cisplatin inj, brand	9418		11.42		2.28
C9419	K	NF	Inj cladribine, brand	9419		36.72		7.34
C9420	K	NF	Cyclophosphamide inj, brand	9420		4.10		0.82
C9421	K	NF	Cyclophosphamide lyo, brand	9421		3.50		0.70
C9422	K	NF	Cytarabine hcl inj, brand	9422		2.28		0.46
C9423	K	NF	Dacarbazine inj, brand	9423		8.15		1.63

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
C9424	K	NF	Daunorubicin, brand	9424		53.14		10.63
C9425	K	NF	Etoposide inj, brand	9425		1.22		0.24
C9426	K	NF	Floxuridine inj, brand	9426		97.92		19.58
C9427	K	NF	Ifosfomide inj, brand	9427		90.80		18.16
C9428	K	NF	Mesna injection, brand	9428		23.79		4.76
C9429	K	NF	Idarubicin hcl inj, brand	9429		66.58		13.32
C9430	K	NF	Leuprolide acetate inj, bran	9430		21.41		4.28
C9431	K	NF	Paclitaxel inj, brand	9431		93.50		18.70
C9432	K	NF	Mitomycin inj, brand	9432		45.70		9.14
C9433	K	NF	Thiotepa inj, brand	9433		66.98		13.40
C9435	K	NF	Gonadorelin hydroch, brand	9435		17.08		3.42
C9436	K	NF	Azathioprine parenteral,brnd	9436		44.61		8.92
C9437	K	NI	Carmus bischl nitro inj	9437		79.42		15.88
C9438	K	NF	Cyclosporine oral, brand	9438		1.78		0.36
C9439	K	NI	Diethylstilbestrol injection	9439		10.32		2.06
C9701	D		Stretta System					
C9703	D		Bard Endoscopic Suturing Sys					
C9704	T		Inj inert subs upper GI	1556		1750.00		350.00
C9712	D		Insert pH capsule, GERD					
C9713	S	NF	Non-contact laser vap prosta	1525		3750.00		750.00
C9714	D		Breast inters rad tx, immed					
C9715	D		Breast inters rad tx, delay					
C9716	S	NF	Radiofrequency energy to anu	1519		1750.00		350.00
C9717	D		Stapled hemorrhoidopexy					
C9718	T	NI	Kyphoplasty, first vertebra	0051	35.8607	2043.45		408.69
C9719	T	NI	Kyphoplasty, each addl	0051	35.8607	2043.45		408.69
C9720	T	NI	HE ESW tx, tennis elbow	1547		850.00		170.00
C9721	T	NI	HE ESW tx, plantar fasciitis	1547		850.00		170.00
C9722	S	NI	KV imaging w/IR tracking	1502		75.00		15.00
D0120	E		Periodic oral evaluation					
D0140	E		Limit oral eval problm focus					
D0150	S		Comprehensve oral evaluation	0330	14.0629	801.35		160.27
D0160	E		Extensv oral eval prob focus					
D0170	E		Re-eval,est pt,problem focus					
D0180	E		Comp periodontal evaluation					
D0210	E		Intraor complete film series					
D0220	E		Intraoral periapical first f					
D0230	E		Intraoral periapical ea add					
D0240	S		Intraoral occlusal film	0330	14.0629	801.35		160.27
D0250	S		Extraoral first film	0330	14.0629	801.35		160.27
D0260	S		Extraoral ea additional film	0330	14.0629	801.35		160.27
D0270	S		Dental bitewing single film	0330	14.0629	801.35		160.27
D0272	S		Dental bitewings two films	0330	14.0629	801.35		160.27

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D0274	S		Dental bitewings four films	0330	14.0629	801.35		160.27
D0277	S		Vert bitewings-sev to eight	0330	14.0629	801.35		160.27
D0290	E		Dental film skull/facial bon					
D0310	E		Dental saliography					
D0320	E		Dental tmj arthrogram incl i					
D0321	E		Dental other tmj films					
D0322	E		Dental tomographic survey					
D0330	E		Dental panoramic film					
D0340	E		Dental cephalometric film					
D0350	E		Oral/facial photo images					
D0415	E		Collection of microorganisms					
D0416	B	NI	Viral culture					
D0421	B	NI	Gen tst suscept oral disease					
D0425	E		Caries susceptibility test					
D0431	B	NI	Diag tst detect mucos abnorm					
D0460	S		Pulp vitality test	0330	14.0629	801.35		160.27
D0470	E		Diagnostic casts					
D0472	S		Gross exam, prep & report	0330	14.0629	801.35		160.27
D0473	S		Micro exam, prep & report	0330	14.0629	801.35		160.27
D0474	S		Micro w exam of surg margins	0330	14.0629	801.35		160.27
D0475	B	NI	Decalcification procedure					
D0476	B	NI	Spec stains for microorganis					
D0477	B	NI	Spec stains not for microorg					
D0478	B	NI	Immunohistochemical stains					
D0479	B	NI	Tissue in-situ hybridization					
D0480	S		Cytopath smear prep & report	0330	14.0629	801.35		160.27
D0481	B	NI	Electron microscopy diagnost					
D0482	B	NI	Direct immunofluorescence					
D0483	B	NI	Indirect immunofluorescence					
D0484	B	NI	Consult slides prep elsewher					
D0485	B	NI	Consult inc prep of slides					
D0502	S		Other oral pathology procedu	0330	14.0629	801.35		160.27
D0999	S		Unspecified diagnostic proce	0330	14.0629	801.35		160.27
D1110	E		Dental prophylaxis adult					
D1120	E		Dental prophylaxis child					
D1201	E		Topical fluor w prophy child					
D1203	E		Topical fluor w/o prophy chi					
D1204	E		Topical fluor w/o prophy adu					
D1205	E		Topical fluoride w/ prophy a					
D1310	E		Nutri counsel-control caries					
D1320	E		Tobacco counseling					
D1330	E		Oral hygiene instruction					
D1351	E		Dental sealant per tooth					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D1510	S		Space maintainer fxd unilat	0330	14.0629	801.35		160.27
D1515	S		Fixed bilat space maintainer	0330	14.0629	801.35		160.27
D1520	S		Remove unilat space maintain	0330	14.0629	801.35		160.27
D1525	S		Remove bilat space maintain	0330	14.0629	801.35		160.27
D1550	S		Recement space maintainer	0330	14.0629	801.35		160.27
D2140	E		Amalgam one surface permanen					
D2150	E		Amalgam two surfaces permane					
D2160	E		Amalgam three surfaces perma					
D2161	E		Amalgam 4 or > surfaces perm					
D2330	E		Resin one surface-anterior					
D2331	E		Resin two surfaces-anterior					
D2332	E		Resin three surfaces-anterio					
D2335	E		Resin 4/> surf or w incis an					
D2390	E		Ant resin-based cmpst crown					
D2391	E		Post 1 srfc resinbased cmpst					
D2392	E		Post 2 srfc resinbased cmpst					
D2393	E		Post 3 srfc resinbased cmpst					
D2394	E		Post >=4srfc resinbase cmpst					
D2410	E		Dental gold foil one surface					
D2420	E		Dental gold foil two surface					
D2430	E		Dental gold foil three surfa					
D2510	E		Dental inlay metalic 1 surf					
D2520	E		Dental inlay metallic 2 surf					
D2530	E		Dental inlay metl 3/more sur					
D2542	E		Dental onlay metallic 2 surf					
D2543	E		Dental onlay metallic 3 surf					
D2544	E		Dental onlay metl 4/more sur					
D2610	E		Inlay porcelain/ceramic 1 su					
D2620	E		Inlay porcelain/ceramic 2 su					
D2630	E		Dental onlay porc 3/more sur					
D2642	E		Dental onlay porcelin 2 surf					
D2643	E		Dental onlay porcelin 3 surf					
D2644	E		Dental onlay porc 4/more sur					
D2650	E		Inlay composite/resin one su					
D2651	E		Inlay composite/resin two su					
D2652	E		Dental inlay resin 3/mre sur					
D2662	E		Dental onlay resin 2 surface					
D2663	E		Dental onlay resin 3 surface					
D2664	E		Dental onlay resin 4/mre sur					
D2710	E		Crown resin-based indirect					
D2712	E	NI	Crown 3/4 resin-based compos					
D2720	E		Crown resin w/ high noble me					
D2721	E		Crown resin w/ base metal					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D2722	E		Crown resin w/ noble metal					
D2740	E		Crown porcelain/ceramic subs					
D2750	E		Crown porcelain w/ h noble m					
D2751	E		Crown porcelain fused base m					
D2752	E		Crown porcelain w/ noble met					
D2780	E		Crown 3/4 cast hi noble met					
D2781	E		Crown 3/4 cast base metal					
D2782	E		Crown 3/4 cast noble metal					
D2783	E		Crown 3/4 porcelain/ceramic					
D2790	E		Crown full cast high noble m					
D2791	E		Crown full cast base metal					
D2792	E		Crown full cast noble metal					
D2794	E	NI	Crown-titanium					
D2799	E		Provisional crown					
D2910	E		Recement inlay onlay or part					
D2915	E	NI	Recement cast or prefab post					
D2920	E		Dental recement crown					
D2930	E		Prefab stnlss steel crwn pri					
D2931	E		Prefab stnlss steel crown pe					
D2932	E		Prefabricated resin crown					
D2933	E		Prefab stainless steel crown					
D2934	E	NI	Prefab steel crown primary					
D2940	E		Dental sedative filling					
D2950	E		Core build-up incl any pins					
D2951	E		Tooth pin retention					
D2952	E		Post and core cast + crown					
D2953	E		Each addtnl cast post					
D2954	E		Prefab post/core + crown					
D2955	E		Post removal					
D2957	E		Each addtnl prefab post					
D2960	E		Laminate labial veneer					
D2961	E		Lab labial veneer resin					
D2962	E		Lab labial veneer porcelain					
D2970	D		Temporary- fractured tooth					
D2971	E	NI	Add proc construct new crown					
D2975	E	NI	Coping					
D2980	E		Crown repair					
D2999	S		Dental unspec restorative pr	0330	14.0629	801.35		160.27
D3110	E		Pulp cap direct					
D3120	E		Pulp cap indirect					
D3220	E		Therapeutic pulpotomy					
D3221	E		Gross pulpal debridement					
D3230	E		Pulpal therapy anterior prim					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D3240	E		Pulpal therapy posterior pri					
D3310	E		Anterior					
D3320	E		Root canal therapy 2 canals					
D3330	E		Root canal therapy 3 canals					
D3331	E		Non-surg tx root canal obs					
D3332	E		Incomplete endodontic tx					
D3333	E		Internal root repair					
D3346	E		Retreat root canal anterior					
D3347	E		Retreat root canal bicuspid					
D3348	E		Retreat root canal molar					
D3351	E		Apexification/recalc initial					
D3352	E		Apexification/recalc interim					
D3353	E		Apexification/recalc final					
D3410	E		Apicoect/perirad surg anter					
D3421	E		Root surgery bicuspid					
D3425	E		Root surgery molar					
D3426	E		Root surgery ea add root					
D3430	E		Retrograde filling					
D3450	E		Root amputation					
D3460	S		Endodontic endosseous implan	0330	14.0629	801.35		160.27
D3470	E		Intentional replantation					
D3910	E		Isolation- tooth w rubb dam					
D3920	E		Tooth splitting					
D3950	E		Canal prep/fitting of dowel					
D3999	S		Endodontic procedure	0330	14.0629	801.35		160.27
D4210	E		Gingivectomy/plasty per quad					
D4211	E		Gingivectomy/plasty per toot					
D4240	E		Gingival flap proc w/ planin					
D4241	E		Gngvl flap w rootplan 1-3 th					
D4245	E		Apically positioned flap					
D4249	E		Crown lengthen hard tissue					
D4260	S		Osseous surgery per quadrant	0330	14.0629	801.35		160.27
D4261	E		Osseous surgl-3teethperquad					
D4263	S		Bone replce graft first site	0330	14.0629	801.35		160.27
D4264	S		Bone replce graft each add	0330	14.0629	801.35		160.27
D4265	E		Bio mtrls to aid soft/os reg					
D4266	E		Guided tiss regen resorble					
D4267	E		Guided tiss regen nonresorb					
D4268	S		Surgical revision procedure	0330	14.0629	801.35		160.27
D4270	S		Pedicle soft tissue graft pr	0330	14.0629	801.35		160.27
D4271	S		Free soft tissue graft proc	0330	14.0629	801.35		160.27
D4273	S		Subepithelial tissue graft	0330	14.0629	801.35		160.27
D4274	E		Distal/proximal wedge proc					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D4275	E		Soft tissue allograft					
D4276	E		Con tissue w dble ped graft					
D4320	E		Provision splnt intracoronal					
D4321	E		Provisional splint extracoro					
D4341	E		Periodontal scaling & root					
D4342	E		Periodontal scaling 1-3teeth					
D4355	S		Full mouth debridement	0330	14.0629	801.35		160.27
D4381	S		Localized delivery antimicro	0330	14.0629	801.35		160.27
D4910	E		Periodontal maint procedures					
D4920	E		Unscheduled dressing change					
D4999	E		Unspecified periodontal proc					
D5110	E		Dentures complete maxillary					
D5120	E		Dentures complete mandible					
D5130	E		Dentures immediat maxillary					
D5140	E		Dentures immediat mandible					
D5211	E		Dentures maxill part resin					
D5212	E		Dentures mand part resin					
D5213	E		Dentures maxill part metal					
D5214	E		Dentures mandibl part metal					
D5225	E	NI	Maxillary part denture flex					
D5226	E	NI	Mandibular part denture flex					
D5281	E		Removable partial denture					
D5410	E		Dentures adjust cmplt maxil					
D5411	E		Dentures adjust cmplt mand					
D5421	E		Dentures adjust part maxill					
D5422	E		Dentures adjust part mandbl					
D5510	E		Dentur repr broken compl bas					
D5520	E		Replace denture teeth complt					
D5610	E		Dentures repair resin base					
D5620	E		Rep part denture cast frame					
D5630	E		Rep partial denture clasp					
D5640	E		Replace part denture teeth					
D5650	E		Add tooth to partial denture					
D5660	E		Add clasp to partial denture					
D5670	E		Replc tth&acrlc on mtl frmwk					
D5671	E		Replc tth&acrlc mandibular					
D5710	E		Dentures rebase cmplt maxil					
D5711	E		Dentures rebase cmplt mand					
D5720	E		Dentures rebase part maxill					
D5721	E		Dentures rebase part mandbl					
D5730	E		Denture reln cmplt maxil ch					
D5731	E		Denture reln cmplt mand chr					
D5740	E		Denture reln part maxil chr					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D5741	E		Denture reln part mand chr					
D5750	E		Denture reln cmplt max lab					
D5751	E		Denture reln cmplt mand lab					
D5760	E		Denture reln part maxil lab					
D5761	E		Denture reln part mand lab					
D5810	E		Denture interm cmplt maxill					
D5811	E		Denture interm cmplt mandbl					
D5820	E		Denture interm part maxill					
D5821	E		Denture interm part mandbl					
D5850	E		Denture tiss conditn maxill					
D5851	E		Denture tiss condtin mandbl					
D5860	E		Overdenture complete					
D5861	E		Overdenture partial					
D5862	E		Precision attachment					
D5867	E		Replacement of precision att					
D5875	E		Prosthesis modification					
D5899	E		Removable prosthodontic proc					
D5911	S		Facial moulage sectional	0330	14.0629	801.35		160.27
D5912	S		Facial moulage complete	0330	14.0629	801.35		160.27
D5913	E		Nasal prosthesis					
D5914	E		Auricular prosthesis					
D5915	E		Orbital prosthesis					
D5916	E		Ocular prosthesis					
D5919	E		Facial prosthesis					
D5922	E		Nasal septal prosthesis					
D5923	E		Ocular prosthesis interim					
D5924	E		Cranial prosthesis					
D5925	E		Facial augmentation implant					
D5926	E		Replacement nasal prosthesis					
D5927	E		Auricular replacement					
D5928	E		Orbital replacement					
D5929	E		Facial replacement					
D5931	E		Surgical obturator					
D5932	E		Postsurgical obturator					
D5933	E		Refitting of obturator					
D5934	E		Mandibular flange prosthesis					
D5935	E		Mandibular denture prosth					
D5936	E		Temp obturator prosthesis					
D5937	E		Trismus appliance					
D5951	E		Feeding aid					
D5952	E		Pediatric speech aid					
D5953	E		Adult speech aid					
D5954	E		Superimposed prosthesis					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D5955	E		Palatal lift prosthesis					
D5958	E		Intraoral con def inter plt					
D5959	E		Intraoral con def mod palat					
D5960	E		Modify speech aid prosthesis					
D5982	E		Surgical stent					
D5983	S		Radiation applicator	0330	14.0629	801.35		160.27
D5984	S		Radiation shield	0330	14.0629	801.35		160.27
D5985	S		Radiation cone locator	0330	14.0629	801.35		160.27
D5986	E		Fluoride applicator					
D5987	S		Commissure splint	0330	14.0629	801.35		160.27
D5988	E		Surgical splint					
D5999	E		Maxillofacial prosthesis					
D6010	E		Odontics endosteal implant					
D6020	D		Odontics abutment placement					
D6040	E		Odontics eposteal implant					
D6050	E		Odontics transosteal implnt					
D6053	E		Implnt/abtmnt spprt remv dnt					
D6054	E		Implnt/abtmnt spprt remvprtl					
D6055	E		Implant connecting bar					
D6056	E		Prefabricated abutment					
D6057	E		Custom abutment					
D6058	E		Abutment supported crown					
D6059	E		Abutment supported mtl crown					
D6060	E		Abutment supported mtl crown					
D6061	E		Abutment supported mtl crown					
D6062	E		Abutment supported mtl crown					
D6063	E		Abutment supported mtl crown					
D6064	E		Abutment supported mtl crown					
D6065	E		Implant supported crown					
D6066	E		Implant supported mtl crown					
D6067	E		Implant supported mtl crown					
D6068	E		Abutment supported retainer					
D6069	E		Abutment supported retainer					
D6070	E		Abutment supported retainer					
D6071	E		Abutment supported retainer					
D6072	E		Abutment supported retainer					
D6073	E		Abutment supported retainer					
D6074	E		Abutment supported retainer					
D6075	E		Implant supported retainer					
D6076	E		Implant supported retainer					
D6077	E		Implant supported retainer					
D6078	E		Implnt/abut suprtd fixd dent					
D6079	E		Implnt/abut suprtd fixd dent					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D6080	E		Implant maintenance		.	.	.	.
D6090	E		Repair implant		.	.	.	.
D6094	E	NI	Abut support crown titanium					
D6095	E		Odontics repr abutment		.	.	.	.
D6100	E		Removal of implant		.	.	.	.
D6190	E	NI	Radio/surgical implant index					
D6194	E	NI	Abut support retainer titani					
D6199	E		Implant procedure		.	.	.	.
D6205	E	NI	Pontic-indirect resin based					
D6210	E		Prosthodont high noble metal		.	.	.	.
D6211	E		Bridge base metal cast		.	.	.	.
D6212	E		Bridge noble metal cast		.	.	.	.
D6214	E	NI	Pontic titanium					
D6240	E		Bridge porcelain high noble		.	.	.	.
D6241	E		Bridge porcelain base metal		.	.	.	.
D6242	E		Bridge porcelain nobel metal		.	.	.	.
D6245	E		Bridge porcelain/ceramic		.	.	.	.
D6250	E		Bridge resin w/high noble		.	.	.	.
D6251	E		Bridge resin base metal		.	.	.	.
D6252	E		Bridge resin w/noble metal		.	.	.	.
D6253	E		Provisional pontic		.	.	.	.
D6545	E		Dental retainr cast metl		.	.	.	.
D6548	E		Porcelain/ceramic retainer		.	.	.	.
D6600	E		Porcelain/ceramic inlay 2srf		.	.	.	.
D6601	E		Porc/ceram inlay >= 3 surfac		.	.	.	.
D6602	E		Cst hgh nble mtl inlay 2 srf		.	.	.	.
D6603	E		Cst hgh nble mtl inlay >=3sr		.	.	.	.
D6604	E		Cst bse mtl inlay 2 surfaces		.	.	.	.
D6605	E		Cst bse mtl inlay >= 3 surfa		.	.	.	.
D6606	E		Cast noble metal inlay 2 sur		.	.	.	.
D6607	E		Cst noble mtl inlay >=3 surf		.	.	.	.
D6608	E		Onlay porc/crmc 2 surfaces		.	.	.	.
D6609	E		Onlay porc/crmc >=3 surfaces		.	.	.	.
D6610	E		Onlay cst hgh nbl mtl 2 srfc		.	.	.	.
D6611	E		Onlay cst hgh nbl mtl >=3srf		.	.	.	.
D6612	E		Onlay cst base mtl 2 surface		.	.	.	.
D6613	E		Onlay cst base mtl >=3 surfa		.	.	.	.
D6614	E		Onlay cst nbl mtl 2 surfaces		.	.	.	.
D6615	E		Onlay cst nbl mtl >=3 surfac		.	.	.	.
D6624	E	NI	Inlay titanium					
D6634	E	NI	Onlay titanium					
D6710	E	NI	Crown-indirect resin based					
D6720	E		Retain crown resin w hi nble		.	.	.	.

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D6721	E		Crown resin w/base metal					
D6722	E		Crown resin w/noble metal					
D6740	E		Crown porcelain/ceramic					
D6750	E		Crown porcelain high noble					
D6751	E		Crown porcelain base metal					
D6752	E		Crown porcelain noble metal					
D6780	E		Crown 3/4 high noble metal					
D6781	E		Crown 3/4 cast based metal					
D6782	E		Crown 3/4 cast noble metal					
D6783	E		Crown 3/4 porcelain/ceramic					
D6790	E		Crown full high noble metal					
D6791	E		Crown full base metal cast					
D6792	E		Crown full noble metal cast					
D6793	E		Provisional retainer crown					
D6794	E	NI	Crown titanium					
D6920	S		Dental connector bar	0330	14.0629	801.35		160.27
D6930	E		Dental recement bridge					
D6940	E		Stress breaker					
D6950	E		Precision attachment					
D6970	E		Post & core plus retainer					
D6971	E		Cast post bridge retainer					
D6972	E		Prefab post & core plus reta					
D6973	E		Core build up for retainer					
D6975	E		Coping metal					
D6976	E		Each addtnl cast post					
D6977	E		Each addtl prefab post					
D6980	E		Bridge repair					
D6985	E		Pediatric partial denture fx					
D6999	E		Fixed prosthodontic proc					
D7111	S		Extraction coronal remnants	0330	14.0629	801.35		160.27
D7140	S		Extraction erupted tooth/exr	0330	14.0629	801.35		160.27
D7210	S		Rem imp tooth w mucoper flp	0330	14.0629	801.35		160.27
D7220	S		Impact tooth remov soft tiss	0330	14.0629	801.35		160.27
D7230	S		Impact tooth remov part bony	0330	14.0629	801.35		160.27
D7240	S		Impact tooth remov comp bony	0330	14.0629	801.35		160.27
D7241	S		Impact tooth rem bony w/comp	0330	14.0629	801.35		160.27
D7250	S		Tooth root removal	0330	14.0629	801.35		160.27
D7260	S		Oral antral fistula closure	0330	14.0629	801.35		160.27
D7261	S		Primary closure sinus perf	0330	14.0629	801.35		160.27
D7270	E		Tooth reimplantation					
D7272	E		Tooth transplantation					
D7280	E		Exposure impact tooth orthod					
D7281	D		Exposure tooth aid eruption					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D7282	E		Mobilize erupted/malpos toot					
D7283	B	NI	Place device impacted tooth					
D7285	E		Biopsy of oral tissue hard					
D7286	E		Biopsy of oral tissue soft					
D7287	E		Exfoliative cytolog collect					
D7288	B	NI	Brush biopsy					
D7290	E		Repositioning of teeth					
D7291	S		Transseptal fiberotomy	0330	14.0629	801.35		160.27
D7310	E		Alveoplasty w/ extraction					
D7311	E	NI	Alveoloplasty w/extract 1-3					
D7320	E		Alveoplasty w/o extraction					
D7321	B	NI	Alveoloplasty not w/extracts					
D7340	E		Vestibuloplasty ridge extens					
D7350	E		Vestibuloplasty exten graft					
D7410	E		Rad exc lesion up to 1.25 cm					
D7411	E		Excision benign lesion>1.25c					
D7412	E		Excision benign lesion compl					
D7413	E		Excision malig lesion<=1.25c					
D7414	E		Excision malig lesion>1.25cm					
D7415	E		Excision malig les complicat					
D7440	E		Malig tumor exc to 1.25 cm					
D7441	E		Malig tumor > 1.25 cm					
D7450	E		Rem odontogen cyst to 1.25cm					
D7451	E		Rem odontogen cyst > 1.25 cm					
D7460	E		Rem nonodonto cyst to 1.25cm					
D7461	E		Rem nonodonto cyst > 1.25 cm					
D7465	E		Lesion destruction					
D7471	E		Rem exostosis any site					
D7472	E		Removal of torus palatinus					
D7473	E		Remove torus mandibularis					
D7485	E		Surg reduct osseoustuberosit					
D7490	E		Maxilla or mandible resectio					
D7510	E		I&d absc intraoral soft tiss					
D7511	B	NI	Incision/drain abscess intra					
D7520	E		I&d abscess extraoral					
D7521	B	NI	Incision/drain abscess extra					
D7530	E		Removal fb skin/areolar tiss					
D7540	E		Removal of fb reaction					
D7550	E		Removal of sloughed off bone					
D7560	E		Maxillary sinusotomy					
D7610	E		Maxilla open reduct simple					
D7620	E		Clsd reduct simpl maxilla fx					
D7630	E		Open red simpl mandible fx					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D7640	E		Clsd red simpl mandible fx					
D7650	E		Open red simp malar/zygom fx					
D7660	E		Clsd red simp malar/zygom fx					
D7670	E		Closd rductn splint alveolus					
D7671	E		Alveolus open reduction					
D7680	E		Reduct simple facial bone fx					
D7710	E		Maxilla open reduct compound					
D7720	E		Clsd reduct compd maxilla fx					
D7730	E		Open reduct compd mandble fx					
D7740	E		Clsd reduct compd mandble fx					
D7750	E		Open red comp malar/zygma fx					
D7760	E		Clsd red comp malar/zygma fx					
D7770	E		Open reduc compd alveolus fx					
D7771	E		Alveolus clsd reduc stblz te					
D7780	E		Reduct compnd facial bone fx					
D7810	E		Tmj open reduct-dislocation					
D7820	E		Closed tmp manipulation					
D7830	E		Tmj manipulation under anest					
D7840	E		Removal of tmj condyle					
D7850	E		Tmj meniscectomy					
D7852	E		Tmj repair of joint disc					
D7854	E		Tmj excisn of joint membrane					
D7856	E		Tmj cutting of a muscle					
D7858	E		Tmj reconstruction					
D7860	E		Tmj cutting into joint					
D7865	E		Tmj reshaping components					
D7870	E		Tmj aspiration joint fluid					
D7871	E		Lysis + lavage w catheters					
D7872	E		Tmj diagnostic arthroscopy					
D7873	E		Tmj arthroscopy lysis adhesn					
D7874	E		Tmj arthroscopy disc reposit					
D7875	E		Tmj arthroscopy synovectomy					
D7876	E		Tmj arthroscopy discectomy					
D7877	E		Tmj arthroscopy debridement					
D7880	E		Occlusal orthotic appliance					
D7899	E		Tmj unspecified therapy					
D7910	E		Dent sutur recent wnd to 5cm					
D7911	E		Dental suture wound to 5 cm					
D7912	E		Suture complicate wnd > 5 cm					
D7920	E		Dental skin graft					
D7940	S		Reshaping bone orthognathic	0330	14.0629	801.35		160.27
D7941	E		Bone cutting ramus closed					
D7943	E		Cutting ramus open w/graft					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D7944	E		Bone cutting segmented					
D7945	E		Bone cutting body mandible					
D7946	E		Reconstruction maxilla total					
D7947	E		Reconstruct maxilla segment					
D7948	E		Reconstruct midface no graft					
D7949	E		Reconstruct midface w/graft					
D7950	E		Mandible graft					
D7953	E	NI	Bone replacement graft					
D7955	E		Repair maxillofacial defects					
D7960	E		Frenulectomy/frenulotomy					
D7963	E	NI	Frenuloplasty					
D7970	E		Excision hyperplastic tissue					
D7971	E		Excision pericoronal gingiva					
D7972	E		Surg redct fibrous tuberosit					
D7980	E		Sialolithotomy					
D7981	E		Excision of salivary gland					
D7982	E		Sialodochoplasty					
D7983	E		Closure of salivary fistula					
D7990	E		Emergency tracheotomy					
D7991	E		Dental coronoidectomy					
D7995	E		Synthetic graft facial bones					
D7996	E		Implant mandible for augment					
D7997	E		Appliance removal					
D7999	E		Oral surgery procedure					
D8010	E		Limited dental tx primary					
D8020	E		Limited dental tx transition					
D8030	E		Limited dental tx adolescent					
D8040	E		Limited dental tx adult					
D8050	E		Intercep dental tx primary					
D8060	E		Intercep dental tx transitn					
D8070	E		Compre dental tx transition					
D8080	E		Compre dental tx adolescent					
D8090	E		Compre dental tx adult					
D8210	E		Orthodontic rem appliance tx					
D8220	E		Fixed appliance therapy habt					
D8660	E		Preorthodontic tx visit					
D8670	E		Periodic orthodontc tx visit					
D8680	E		Orthodontic retention					
D8690	E		Orthodontic treatment					
D8691	E		Repair ortho appliance					
D8692	E		Replacement retainer					
D8999	E		Orthodontic procedure					
D9110	N		Tx dental pain minor proc					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D9210	E		Dent anesthesia w/o surgery					
D9211	E		Regional block anesthesia					
D9212	E		Trigeminal block anesthesia					
D9215	E		Local anesthesia					
D9220	E		General anesthesia					
D9221	E		General anesthesia ea ad 15m					
D9230	N		Analgesia					
D9241	E		Intravenous sedation					
D9242	E		IV sedation ea ad 30 m					
D9248	N		Sedation (non-iv)					
D9310	E		Dental consultation					
D9410	E		Dental house call					
D9420	E		Hospital call					
D9430	E		Office visit during hours					
D9440	E		Office visit after hours					
D9450	E		Case presentation tx plan					
D9610	E		Dent therapeutic drug inject					
D9630	S		Other drugs/medicaments	0330	14.0629	801.35		160.27
D9910	E		Dent appl desensitizing med					
D9911	E		Appl desensitizing resin					
D9920	E		Behavior management					
D9930	S		Treatment of complications	0330	14.0629	801.35		160.27
D9940	S		Dental occlusal guard	0330	14.0629	801.35		160.27
D9941	E		Fabrication athletic guard					
D9942	E	NI	Repair/reline occlusal guard					
D9950	S		Occlusion analysis	0330	14.0629	801.35		160.27
D9951	S		Limited occlusal adjustment	0330	14.0629	801.35		160.27
D9952	S		Complete occlusal adjustment	0330	14.0629	801.35		160.27
D9970	E		Enamel microabrasion					
D9971	E		Odontoplasty 1-2 teeth					
D9972	E		Extrnl bleaching per arch					
D9973	E		Extrnl bleaching per tooth					
D9974	E		Intrnl bleaching per tooth					
D9999	E		Adjunctive procedure					
E0100	Y		Cane adjust/fixed with tip					
E0105	Y		Cane adjust/fixed quad/3 pro					
E0110	Y		Crutch forearm pair					
E0111	Y		Crutch forearm each					
E0112	Y		Crutch underarm pair wood					
E0113	Y		Crutch underarm each wood					
E0114	Y		Crutch underarm pair no wood					
E0116	Y		Crutch underarm each no wood					
E0117	Y		Underarm springassist crutch					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0118	E		Crutch substitute					
E0130	Y		Walker rigid adjust/fixed ht					
E0135	Y		Walker folding adjust/fixed					
E0140	Y		Walker w trunk support					
E0141	Y		Rigid wheeled walker adj/fix					
E0143	Y		Walker folding wheeled w/o s					
E0144	Y		Enclosed walker w rear seat					
E0147	Y		Walker variable wheel resist					
E0148	Y		Heavyduty walker no wheels					
E0149	Y		Heavy duty wheeled walker					
E0153	Y		Forearm crutch platform atta					
E0154	Y		Walker platform attachment					
E0155	Y		Walker wheel attachment,pair					
E0156	Y		Walker seat attachment					
E0157	Y		Walker crutch attachment					
E0158	Y		Walker leg extenders set of4					
E0159	Y		Brake for wheeled walker					
E0160	Y		Sitz type bath or equipment					
E0161	Y		Sitz bath/equipment w/faucet					
E0162	Y		Sitz bath chair					
E0163	Y		Commode chair stationry fxd					
E0164	Y		Commode chair mobile fixed a					
E0165	Y		Commode chair stationry det					
E0166	Y		Commode chair mobile detach					
E0167	Y		Commode chair pail or pan					
E0168	Y		Heavyduty/wide commode chair					
E0169	Y		Seatlift incorp commodechair					
E0175	Y		Commode chair foot rest					
E0176	D		Air pressre pad/cushion nonp					
E0177	D		Water press pad/cushion nonp					
E0178	D		Gel pressre pad/cushion nonp					
E0179	D		Dry pressre pad/cushion nonp					
E0180	Y		Press pad alternating w pump					
E0181	Y		Press pad alternating w/ pum					
E0182	Y		Pressure pad alternating pum					
E0184	Y		Dry pressure mattress					
E0185	Y		Gel pressure mattress pad					
E0186	Y		Air pressure mattress					
E0187	Y		Water pressure mattress					
E0188	Y		Synthetic sheepskin pad					
E0189	Y		Lambswool sheepskin pad					
E0190	E		Positioning cushion					
E0191	Y		Protector heel or elbow					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0192	D		Pad wheelchr low press/posit					
E0193	Y		Powered air flotation bed					
E0194	Y		Air fluidized bed					
E0196	Y		Gel pressure mattress					
E0197	Y		Air pressure pad for mattres					
E0198	Y		Water pressure pad for mattr					
E0199	Y		Dry pressure pad for mattres					
E0200	Y		Heat lamp without stand					
E0202	Y		Phototherapy light w/ photom					
E0203	A		Therapeutic lightbox tabletp					
E0205	Y		Heat lamp with stand					
E0210	Y		Electric heat pad standard					
E0215	Y		Electric heat pad moist					
E0217	Y		Water circ heat pad w pump					
E0218	Y		Water circ cold pad w pump					
E0220	Y		Hot water bottle					
E0221	Y		Infrared heating pad system					
E0225	Y		Hydrocollator unit					
E0230	Y		Ice cap or collar					
E0231	E		Wound warming device					
E0232	E		Warming card for NWT					
E0235	Y		Paraffin bath unit portable					
E0236	Y		Pump for water circulating p					
E0238	Y		Heat pad non-electric moist					
E0239	Y		Hydrocollator unit portable					
E0240	E		Bath/shower chair					
E0241	E		Bath tub wall rail					
E0242	E		Bath tub rail floor					
E0243	E		Toilet rail					
E0244	E		Toilet seat raised					
E0245	E		Tub stool or bench					
E0246	E		Transfer tub rail attachment					
E0247	E		Trans bench w/wo comm open					
E0248	E		HDtrans bench w/wo comm open					
E0249	Y		Pad water circulating heat u					
E0250	Y		Hosp bed fixed ht w/ mattres					
E0251	Y		Hosp bed fixd ht w/o mattres					
E0255	Y		Hospital bed var ht w/ mattr					
E0256	Y		Hospital bed var ht w/o matt					
E0260	Y		Hosp bed semi-electr w/ matt					
E0261	Y		Hosp bed semi-electr w/o mat					
E0265	Y		Hosp bed total electr w/ mat					
E0266	Y		Hosp bed total elec w/o matt					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0270	E		Hospital bed institutional t					
E0271	Y		Mattress innerspring					
E0272	Y		Mattress foam rubber					
E0273	E		Bed board					
E0274	E		Over-bed table					
E0275	Y		Bed pan standard					
E0276	Y		Bed pan fracture					
E0277	Y		Powered pres-redu air mattrs					
E0280	Y		Bed cradle					
E0290	Y		Hosp bed fx ht w/o rails w/m					
E0291	Y		Hosp bed fx ht w/o rail w/o					
E0292	Y		Hosp bed var ht w/o rail w/o					
E0293	Y		Hosp bed var ht w/o rail w/					
E0294	Y		Hosp bed semi-elect w/ mattr					
E0295	Y		Hosp bed semi-elect w/o matt					
E0296	Y		Hosp bed total elect w/ matt					
E0297	Y		Hosp bed total elect w/o mat					
E0300	Y		Enclosed ped crib hosp grade					
E0301	Y		HD hosp bed, 350-600 lbs					
E0302	Y		Ex hd hosp bed > 600 lbs					
E0303	Y		Hosp bed hvy dty xtra wide					
E0304	Y		Hosp bed xtra hvy dty x wide					
E0305	Y		Rails bed side half length					
E0310	Y		Rails bed side full length					
E0315	E		Bed accessory brd/tbl/supprt					
E0316	Y		Bed safety enclosure					
E0325	Y		Urinal male jug-type					
E0326	Y		Urinal female jug-type					
E0350	E		Control unit bowel system					
E0352	E		Disposable pack w/bowel syst					
E0370	E		Air elevator for heel					
E0371	Y		Nonpower mattress overlay					
E0372	Y		Powered air mattress overlay					
E0373	Y		Nonpowered pressure mattress					
E0424	Y		Stationary compressed gas 02					
E0425	E		Gas system stationary compre					
E0430	E		Oxygen system gas portable					
E0431	Y		Portable gaseous 02					
E0434	Y		Portable liquid 02					
E0435	E		Oxygen system liquid portabl					
E0439	Y		Stationary liquid 02					
E0440	E		Oxygen system liquid station					
E0441	Y		Oxygen contents, gaseous					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0442	Y		Oxygen contents, liquid					
E0443	Y		Portable 02 contents, gas					
E0444	Y		Portable 02 contents, liquid					
E0445	A		Oximeter non-invasive					
E0450	Y		Vol control vent invasiv int					
E0454	D		Pressure ventilator					
E0455	Y		Oxygen tent excl croup/ped t					
E0457	Y		Chest shell					
E0459	Y		Chest wrap					
E0460	Y		Neg press vent portabl/statn					
E0461	Y		Vol control vent noninv int					
E0462	Y		Rocking bed w/ or w/o side r					
E0463	Y	NI	Press supp vent invasive int					
E0464	Y	NI	Press supp vent noninv int					
E0470	Y		RAD w/o backup non-inv intfc					
E0471	Y		RAD w/backup non inv intrfc					
E0472	Y		RAD w backup invasive intrfc					
E0480	Y		Percussor elect/pneum home m					
E0481	E		Intrpulmnry percuss vent sys					
E0482	Y		Cough stimulating device					
E0483	Y		Chest compression gen system					
E0484	Y		Non-elec oscillatory pep dvc					
E0500	Y		Ippb all types					
E0550	Y		Humidif extens supple w ippb					
E0555	Y		Humidifier for use w/ regula					
E0560	Y		Humidifier supplemental w/ i					
E0561	Y		Humidifier nonheated w PAP					
E0562	Y		Humidifier heated used w PAP					
E0565	Y		Compressor air power source					
E0570	Y		Nebulizer with compression					
E0571	Y		Aerosol compressor for svneb					
E0572	Y		Aerosol compressor adjust pr					
E0574	Y		Ultrasonic generator w svneb					
E0575	Y		Nebulizer ultrasonic					
E0580	Y		Nebulizer for use w/ regulat					
E0585	Y		Nebulizer w/ compressor & he					
E0590	Y		Dispensing fee dme neb drug					
E0600	Y		Suction pump portab hom modl					
E0601	Y		Cont airway pressure device					
E0602	Y		Manual breast pump					
E0603	A		Electric breast pump					
E0604	A		Hosp grade elec breast pump					
E0605	Y		Vaporizer room type					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0606	Y		Drainage board postural					
E0607	Y		Blood glucose monitor home					
E0610	Y		Pacemaker monitr audible/vis					
E0615	Y		Pacemaker monitr digital/vis					
E0616	N		Cardiac event recorder					
E0617	Y		Automatic ext defibrillator					
E0618	A		Apnea monitor					
E0619	A		Apnea monitor w recorder					
E0620	Y		Cap bld skin piercing laser					
E0621	Y		Patient lift sling or seat					
E0625	E		Patient lift bathroom or toi					
E0627	Y		Seat lift incorp lift-chair					
E0628	Y		Seat lift for pt furn-electr					
E0629	Y		Seat lift for pt furn-non-el					
E0630	Y		Patient lift hydraulic					
E0635	Y		Patient lift electric					
E0636	Y		PT support & positioning sys					
E0637	Y		Sit-stand w seatlift					
E0638	Y		Standing frame sys					
E0639	E	NI	Moveable patient lift system					
E0640	E	NI	Fixed patient lift system					
E0650	Y		Pneuma compresor non-segment					
E0651	Y		Pneum compressor segmental					
E0652	Y		Pneum compres w/cal pressure					
E0655	Y		Pneumatic appliance half arm					
E0660	Y		Pneumatic appliance full leg					
E0665	Y		Pneumatic appliance full arm					
E0666	Y		Pneumatic appliance half leg					
E0667	Y		Seg pneumatic appl full leg					
E0668	Y		Seg pneumatic appl full arm					
E0669	Y		Seg pneumatic appli half leg					
E0671	Y		Pressure pneum appl full leg					
E0672	Y		Pressure pneum appl full arm					
E0673	Y		Pressure pneum appl half leg					
E0675	Y		Pneumatic compression device					
E0691	Y		Uvl pnl 2 sq ft or less					
E0692	Y		Uvl sys panel 4 ft					
E0693	Y		Uvl sys panel 6 ft					
E0694	Y		Uvl md cabinet sys 6 ft					
E0700	E		Safety equipment					
E0701	Y		Helmet w face guard prefab					
E0710	E		Restraints any type					
E0720	Y		Tens two lead					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0730	Y		Tens four lead					
E0731	Y		Conductive garment for tens/					
E0740	Y		Incontinence treatment systm					
E0744	Y		Neuromuscular stim for scoli					
E0745	Y		Neuromuscular stim for shock					
E0746	E		Electromyograph biofeedback					
E0747	Y		Elec osteogen stim not spine					
E0748	Y		Elec osteogen stim spinal					
E0749	N		Elec osteogen stim implanted					
E0752	B		Neurostimulator electrode					
E0754	A		Pulsegenerator pt programmer					
E0755	E		Electronic salivary reflex s					
E0756	B		Implantable pulse generator					
E0757	N		Implantable RF receiver					
E0758	A		External RF transmitter					
E0759	A		Replace rdfrquncy transmittr					
E0760	Y		Osteogen ultrasound stimltor					
E0761	E		Nontherm electromgntc device					
E0765	Y		Nerve stimulator for tx n&v					
E0769	B	NI	Electric wound treatment dev					
E0776	Y		Iv pole					
E0779	Y		Amb infusion pump mechanical					
E0780	Y		Mech amb infusion pump <8hrs					
E0781	Y		External ambulatory infus pu					
E0782	N		Non-programble infusion pump					
E0783	N		Programmable infusion pump					
E0784	Y		Ext amb infusn pump insulin					
E0785	N		Replacement impl pump cathet					
E0786	N		Implantable pump replacement					
E0791	Y		Parenteral infusion pump sta					
E0830	N		Ambulatory traction device					
E0840	Y		Tract frame attach headboard					
E0849	Y	NI	Cervical pneum trac equip					
E0850	Y		Traction stand free standing					
E0855	Y		Cervical traction equipment					
E0860	Y		Tract equip cervical tract					
E0870	Y		Tract frame attach footboard					
E0880	Y		Trac stand free stand extrem					
E0890	Y		Traction frame attach pelvic					
E0900	Y		Trac stand free stand pelvic					
E0910	Y		Trapeze bar attached to bed					
E0920	Y		Fracture frame attached to b					
E0930	Y		Fracture frame free standing					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0935	Y		Exercise device passive moti					
E0940	Y		Trapeze bar free standing					
E0941	Y		Gravity assisted traction de					
E0942	Y		Cervical head harness/halter					
E0944	Y		Pelvic belt/harness/boot					
E0945	Y		Belt/harness extremity					
E0946	Y		Fracture frame dual w cross					
E0947	Y		Fracture frame attachmnts pe					
E0948	Y		Fracture frame attachmnts ce					
E0950	E		Tray					
E0951	E		Loop heel					
E0952	E		Toe loop/holder, each					
E0953	E		Pneumatic tire					
E0954	E		Wheelchair semi-pneumatic ca					
E0955	Y		Cushioned headrest					
E0956	Y		W/c lateral trunk/hip suppor					
E0957	Y		W/c medial thigh support					
E0958	A		Whlchr att- conv 1 arm drive					
E0959	B		Amputee adapter					
E0960	Y		W/c shoulder harness/straps					
E0961	B		Wheelchair brake extension					
E0962	D		Wheelchair 1 inch cushion					
E0963	D		Wheelchair 2 inch cushion					
E0964	D		Wheelchair 3 inch cushion					
E0965	D		Wheelchair 4 inch cushion					
E0966	B		Wheelchair head rest extensi					
E0967	Y		Wheelchair hand rims					
E0968	Y		Wheelchair commode seat					
E0969	Y		Wheelchair narrowing device					
E0970	B		Wheelchair no. 2 footplates					
E0971	B		Wheelchair anti-tipping devi					
E0972	A		Transfer board or device					
E0973	B		W/Ch access det adj armrest					
E0974	B		W/Ch access anti-rollback					
E0977	Y		Wheelchair wedge cushion					
E0978	B		W/C acc,saf belt pelv strap					
E0980	Y		Wheelchair safety vest					
E0981	Y		Seat upholstery, replacement					
E0982	Y		Back upholstery, replacement					
E0983	Y		Add pwr joystick					
E0984	Y		Add pwr tiller					
E0985	Y		W/c seat lift mechanism					
E0986	Y		Man w/c push-rim pow assist					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0990	B		Whellchair elevating leg res					
E0992	B		Wheelchair solid seat insert					
E0994	Y		Wheelchair arm rest					
E0995	B		Wheelchair calf rest					
E0996	B		Wheelchair tire solid					
E0997	Y		Wheelchair caster w/ a fork					
E0998	Y		Wheelchair caster w/o a fork					
E0999	Y		Wheelchr pneumatic tire w/wh					
E1000	B		Wheelchair tire pneumatic ca					
E1001	Y		Wheelchair wheel					
E1002	Y		Pwr seat tilt					
E1003	Y		Pwr seat recline					
E1004	Y		Pwr seat recline mech					
E1005	Y		Pwr seat recline pwr					
E1006	Y		Pwr seat combo w/o shear					
E1007	Y		Pwr seat combo w/shear					
E1008	Y		Pwr seat combo pwr shear					
E1009	Y		Add mech leg elevation					
E1010	Y		Add pwr leg elevation					
E1011	Y		Ped wc modify width adjustm					
E1012	D		Int seat sys planar ped w/c					
E1013	D		Int seat sys contour ped w/c					
E1014	Y		Reclining back add ped w/c					
E1015	Y		Shock absorber for man w/c					
E1016	Y		Shock absorber for power w/c					
E1017	Y		HD shck absrbr for hd man wc					
E1018	Y		HD shck absrber for hd powwc					
E1019	Y		HD feature power seat					
E1020	Y		Residual limb support system					
E1021	Y		Ex hd feature power seat					
E1025	Y		Pedwc lat/thor sup nocontour					
E1026	Y		Pedwc contoured lat/thor sup					
E1027	Y		Ped wc lat/ant support					
E1028	Y		W/c manual swingaway					
E1029	Y		W/c vent tray fixed					
E1030	Y		W/c vent tray gimbaled					
E1031	Y		Rollabout chair with casters					
E1035	Y		Patient transfer system					
E1037	Y		Transport chair, ped size					
E1038	Y		Transport chair pt wt <250lb					
E1039	Y	NI	Transport chair pt wt>=250lb					
E1050	A		Whelchr fxd full length arms					
E1060	A		Wheelchair detachable arms					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E1070	A		Wheelchair detachable foot r					
E1083	A		Hemi-wheelchair fixed arms					
E1084	A		Hemi-wheelchair detachable a					
E1085	A		Hemi-wheelchair fixed arms					
E1086	A		Hemi-wheelchair detachable a					
E1087	A		Wheelchair lightwt fixed arm					
E1088	A		Wheelchair lightweight det a					
E1089	A		Wheelchair lightwt fixed arm					
E1090	A		Wheelchair lightweight det a					
E1092	A		Wheelchair wide w/ leg rests					
E1093	A		Wheelchair wide w/ foot rest					
E1100	A		Whchr s-recl fxd arm leg res					
E1110	A		Wheelchair semi-recl detach					
E1130	A		Whlchr stand fxd arm ft rest					
E1140	A		Wheelchair standard detach a					
E1150	Y		Wheelchair standard w/ leg r					
E1160	A		Wheelchair fixed arms					
E1161	A		Manual adult wc w tiltinspac					
E1170	A		Whlchr ampu fxd arm leg rest					
E1171	A		Wheelchair amputee w/o leg r					
E1172	A		Wheelchair amputee detach ar					
E1180	A		Wheelchair amputee w/ foot r					
E1190	A		Wheelchair amputee w/ leg re					
E1195	A		Wheelchair amputee heavy dut					
E1200	A		Wheelchair amputee fixed arm					
E1210	Y		Whlchr moto ful arm leg rest					
E1211	Y		Wheelchair motorized w/ det					
E1212	A		Wheelchair motorized w full					
E1213	A		Wheelchair motorized w/ det					
E1220	A		Whlchr special size/constrc					
E1221	A		Wheelchair spec size w foot					
E1222	A		Wheelchair spec size w/ leg					
E1223	A		Wheelchair spec size w foot					
E1224	A		Wheelchair spec size w/ leg					
E1225	Y		Manual semi-reclining back					
E1226	B		Manual fully reclining back					
E1227	Y		Wheelchair spec sz spec ht a					
E1228	Y		Wheelchair spec sz spec ht b					
E1229	Y	NI	Pediatric wheelchair NOS					
E1230	Y		Power operated vehicle					
E1231	Y		Rigid ped w/c tilt-in-space					
E1232	Y		Folding ped wc tilt-in-space					
E1233	Y		Rig ped wc tltnspc w/o seat					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E1234	Y		Fld ped wc tltnspc w/o seat					
E1235	Y		Rigid ped wc adjustable					
E1236	Y		Folding ped wc adjustable					
E1237	Y		Rgd ped wc adjstabl w/o seat					
E1238	Y		Fld ped wc adjstabl w/o seat					
E1239	Y	NI	Ped power wheelchair NOS					
E1240	A		Whchr litwt det arm leg rest					
E1250	A		Wheelchair lightwt fixed arm					
E1260	A		Wheelchair lightwt foot rest					
E1270	A		Wheelchair lightweight leg r					
E1280	A		Whchr h-duty det arm leg res					
E1285	A		Wheelchair heavy duty fixed					
E1290	A		Wheelchair hvy duty detach a					
E1295	A		Wheelchair heavy duty fixed					
E1296	Y		Wheelchair special seat heig					
E1297	Y		Wheelchair special seat dept					
E1298	Y		Wheelchair spec seat depth/w					
E1300	E		Whirlpool portable					
E1310	Y		Whirlpool non-portable					
E1340	Y		Repair for DME, per 15 min					
E1353	Y		Oxygen supplies regulator					
E1355	Y		Oxygen supplies stand/rack					
E1372	Y		Oxy suppl heater for nebuliz					
E1390	Y		Oxygen concentrator					
E1391	Y		Oxygen concentrator, dual					
E1399	N		Durable medical equipment mi					
E1405	Y		O2/water vapor enrich w/heat					
E1406	Y		O2/water vapor enrich w/o he					
E1500	A		Centrifuge					
E1510	A		Kidney dialysate delivry sys					
E1520	A		Heparin infusion pump					
E1530	A		Replacement air bubble detec					
E1540	A		Replacement pressure alarm					
E1550	A		Bath conductivity meter					
E1560	A		Replace blood leak detector					
E1570	A		Adjustable chair for esrd pt					
E1575	A		Transducer protect/fld bar					
E1580	A		Unipuncture control system					
E1590	A		Hemodialysis machine					
E1592	A		Auto interm peritoneal dialy					
E1594	A		Cycler dialysis machine					
E1600	A		Deli/install chrg hemo equip					
E1610	A		Reverse osmosis h2o puri sys					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E1615	A		Deionizer H2O puri system					
E1620	A		Replacement blood pump					
E1625	A		Water softening system					
E1630	A		Reciprocating peritoneal dia					
E1632	A		Wearable artificial kidney					
E1634	B		Peritoneal dialysis clamp					
E1635	A		Compact travel hemodialyzer					
E1636	A		Sorbent cartridges per 10					
E1637	A		Hemostats for dialysis, each					
E1639	A		Dialysis scale					
E1699	A		Dialysis equipment noc					
E1700	Y		Jaw motion rehab system					
E1701	Y		Repl cushions for jaw motion					
E1702	Y		Repl measr scales jaw motion					
E1800	Y		Adjust elbow ext/flex device					
E1801	Y		SPS elbow device					
E1802	Y		Adjst forearm pro/sup device					
E1805	Y		Adjust wrist ext/flex device					
E1806	Y		SPS wrist device					
E1810	Y		Adjust knee ext/flex device					
E1811	Y		SPS knee device					
E1815	Y		Adjust ankle ext/flex device					
E1816	Y		SPS ankle device					
E1818	Y		SPS forearm device					
E1820	Y		Soft interface material					
E1821	Y		Replacement interface SPSD					
E1825	Y		Adjust finger ext/flex devc					
E1830	Y		Adjust toe ext/flex device					
E1840	Y		Adj shoulder ext/flex device					
E1841	Y	NI	Static str shldr dev rom adj					
E1902	A		AAC non-electronic board					
E2000	Y		Gastric suction pump hme mdl					
E2100	Y		Bld glucose monitor w voice					
E2101	Y		Bld glucose monitor w lance					
E2120	Y		Pulse gen sys tx endolymp fl					
E2201	Y		Man w/ch acc seat w>=20"<24"					
E2202	Y		Seat width 24-27 in					
E2203	Y		Frame depth less than 22 in					
E2204	Y		Frame depth 22 to 25 in					
E2205	Y	NI	Manual wc accessory, handrim					
E2206	Y	NI	Complete wheel lock assembly					
E2291	Y	NI	Planar back for ped size wc					
E2292	Y	NI	Planar seat for ped size wc					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E2293	Y	NI	Contour back for ped size wc					
E2294	Y	NI	Contour seat for ped size wc					
E2300	Y		Pwr seat elevation sys					
E2301	Y		Pwr standing					
E2310	Y		Electro connect btw control					
E2311	Y		Electro connect btw 2 sys					
E2320	Y		Hand chin control					
E2321	Y		Hand interface joystick					
E2322	Y		Mult mech switches					
E2323	Y		Special joystick handle					
E2324	Y		Chin cup interface					
E2325	Y		Sip and puff interface					
E2326	Y		Breath tube kit					
E2327	Y		Head control interface mech					
E2328	Y		Head/extremity control inter					
E2329	Y		Head control nonproportional					
E2330	Y		Head control proximity switc					
E2331	Y		Attendant control					
E2340	Y		W/c wdth 20-23 in seat frame					
E2341	Y		W/c wdth 24-27 in seat frame					
E2342	Y		W/c dpth 20-21 in seat frame					
E2343	Y		W/c dpth 22-25 in seat frame					
E2351	Y		Electronic SGD interface					
E2360	Y		22nf nonsealed leadacid					
E2361	Y		22nf sealed leadacid battery					
E2362	Y		Gr24 nonsealed leadacid					
E2363	Y		Gr24 sealed leadacid battery					
E2364	Y		U1nonsealed leadacid battery					
E2365	Y		U1 sealed leadacid battery					
E2366	Y		Battery charger, single mode					
E2367	Y		Battery charger, dual mode					
E2368	Y	NI	Power wc motor replacement					
E2369	Y	NI	Pwr wc gear box replacement					
E2370	Y	NI	Pwr wc motor/gear box combo					
E2399	Y		Noc interface					
E2402	Y		Neg press wound therapy pump					
E2500	Y		SGD digitized pre-rec <=8min					
E2502	Y		SGD prerec msg >8min <=20min					
E2504	Y		SGD prerec msg>20min <=40min					
E2506	Y		SGD prerec msg > 40 min					
E2508	Y		SGD spelling phys contact					
E2510	Y		SGD w multi methods msg/accs					
E2511	Y		SGD sftwre prgrm for PC/PDA					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E2512	Y		SGD accessory, mounting sys					
E2599	Y		SGD accessory noc					
E2601	Y	NI	Gen w/c cushion wdth < 22 in					
E2602	Y	NI	Gen w/c cushion wdth >=22 in					
E2603	Y	NI	Skin protect wc cus wd <22in					
E2604	Y	NI	Skin protect wc cus wd>=22in					
E2605	Y	NI	Position wc cush wdth <22 in					
E2606	Y	NI	Position wc cush wdth>=22 in					
E2607	Y	NI	Skin pro/pos wc cus wd <22in					
E2608	Y	NI	Skin pro/pos wc cus wd>=22in					
E2609	Y	NI	Custom fabricate w/c cushion					
E2610	B	NI	Powered w/c cushion					
E2611	Y	NI	Gen use back cush wdth <22in					
E2612	Y	NI	Gen use back cush wdth>=22in					
E2613	Y	NI	Position back cush wd <22in					
E2614	Y	NI	Position back cush wd>=22in					
E2615	Y	NI	Pos back post/lat wdth <22in					
E2616	Y	NI	Pos back post/lat wdth>=22in					
E2617	Y	NI	Custom fab w/c back cushion					
E2618	Y	NI	Wc acc solid seat supp base					
E2619	Y	NI	Replace cover w/c seat cush					
E2620	Y	NI	WC planar back cush wd <22in					
E2621	Y	NI	WC planar back cush wd>=22in					
E8000	E	NI	Posterior gait trainer					
E8001	E	NI	Upright gait trainer					
E8002	E	NI	Anterior gait trainer					
G0001	A		Drawing blood for specimen					
G0008	L		Admin influenza virus vac					
G0009	L		Admin pneumococcal vaccine					
G0010	K		Admin hepatitis b vaccine	0355	0.3596	20.49		4.10
G0027	A		Semen analysis					
G0030	S		PET imaging prev PET single	0285	12.9121	735.77	318.72	147.85
G0031	S		PET imaging prev PET multple	0285	12.9121	735.77	318.72	147.85
G0032	S		PET follow SPECT 78464 singl	0285	12.9121	735.77	318.72	147.85
G0033	S		PET follow SPECT 78464 mult	0285	12.9121	735.77	318.72	147.85
G0034	S		PET follow SPECT 76865 singl	0285	12.9121	735.77	318.72	147.85
G0035	S		PET follow SPECT 78465 mult	0285	12.9121	735.77	318.72	147.85
G0036	S		PET follow cornry angio sing	0285	12.9121	735.77	318.72	147.85
G0037	S		PET follow cornry angio mult	0285	12.9121	735.77	318.72	147.85
G0038	S		PET follow myocard perf sing	0285	12.9121	735.77	318.72	147.85
G0039	S		PET follow myocard perf mult	0285	12.9121	735.77	318.72	147.85
G0040	S		PET follow stress echo singl	0285	12.9121	735.77	318.72	147.85
G0041	S		PET follow stress echo mult	0285	12.9121	735.77	318.72	147.85

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G0042	S		PET follow ventriculogm sing	0285	12.9121	735.77	318.72	147.85
G0043	S		PET follow ventriculogm mult	0285	12.9121	735.77	318.72	147.85
G0044	S		PET following rest ECG singl	0285	12.9121	735.77	318.72	147.85
G0045	S		PET following rest ECG mult	0285	12.9121	735.77	318.72	147.85
G0046	S		PET follow stress ECG singl	0285	12.9121	735.77	318.72	147.85
G0047	S		PET follow stress ECG mult	0285	12.9121	735.77	318.72	147.85
G0101	V		CA screen;pelvic/breast exam	0600	0.9033	51.47		10.29
G0102	N		Prostate ca screening; dre					
G0103	A		Psa, total screening					
G0104	S		CA screen;flexi sigmoidscope	0159	2.8464	162.20		40.55
G0105	T		Colorectal scrn; hi risk ind	0158	7.7409	441.10		110.28
G0106	S		Colon CA screen;barium enema	0157	2.5110	143.08		28.62
G0107	A		CA screen; fecal blood test					
G0108	A		Diab manage trn per indiv					
G0109	A		Diab manage trn ind/group					
G0110	A		Nett pulm-rehab educ; ind					
G0111	A		Nett pulm-rehab educ; group					
G0112	A		Nett;nutrition guid, initial					
G0113	A		Nett;nutrition guid,subseqnt					
G0114	A		Nett; psychosocial consult					
G0115	A		Nett; psychological testing					
G0116	A		Nett; psychosocial counsel					
G0117	S		Glaucoma scrn hgh risk direc	0230	0.8019	45.69	14.97	9.14
G0118	S		Glaucoma scrn hgh risk direc	0230	0.8019	45.69	14.97	9.14
G0120	S		Colon ca scrn; barium enema	0157	2.5110	143.08		28.62
G0121	T		Colon ca scrn not hi rsk ind	0158	7.7409	441.10		110.28
G0122	E		Colon ca scrn; barium enema					
G0123	A		Screen cerv/vag thin layer					
G0124	A		Screen c/v thin layer by MD					
G0125	S		PET image pulmonary nodule	1513		1150.00		230.00
G0127	T		Trim nail(s)	0009	0.6817	38.85	8.34	7.77
G0128	B		CORF skilled nursing service					
G0129	P		Partial hosp prog service	0033	4.9370	281.33		56.27
G0130	X		Single energy x-ray study	0260	0.7698	43.87	19.74	8.77
G0141	E		Scr c/v cyto,autosys and md					
G0143	A		Scr c/v cyto,thinlayer,rescr					
G0144	A		Scr c/v cyto,thinlayer,rescr					
G0145	A		Scr c/v cyto,thinlayer,rescr					
G0147	A		Scr c/v cyto, automated sys					
G0148	A		Scr c/v cyto, autosys, rescr					
G0151	B		HHCP-serv of pt,ea 15 min					
G0152	B		HHCP-serv of ot,ea 15 min					
G0153	B		HHCP-svs of s/l path,ea 15mn					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G0154	B		HHCP-svs of rn,ea 15 min					
G0155	B		HHCP-svs of csw,ea 15 min					
G0156	B		HHCP-svs of aide,ea 15 min					
G0166	T		Extrnl counterpulse, per tx	0678	1.7931	102.18		20.44
G0168	N		Wound closure by adhesive					
G0173	S		Linear acc stereo radsur com	1528		5250.00		1050.00
G0175	V		OPPS Service,sched team conf	0602	1.3977	79.65		15.93
G0176	P		OPPS/PHP;activity therapy	0033	4.9370	281.33		56.27
G0177	P		OPPS/PHP; train & educ serv	0033	4.9370	281.33		56.27
G0179	E		MD recertification HHA PT					
G0180	E		MD certification HHA patient					
G0181	E		Home health care supervision					
G0182	E		Hospice care supervision					
G0186	T		Dstry eye lesn,fdr vssl tech	0235	5.1864	295.54	72.04	59.11
G0202	A		Screeningmammographydigital					
G0204	A		Diagnosticmammographydigital					
G0206	A		Diagnosticmammographydigital					
G0210	S		PET img wholebody dxlung	1513		1150.00		230.00
G0211	S		PET img wholbody init lung	1513		1150.00		230.00
G0212	S		PET img wholebod restag lung	1513		1150.00		230.00
G0213	S		PET img wholbody dx	1513		1150.00		230.00
G0214	S		PET img wholebod init	1513		1150.00		230.00
G0215	S		PETimg wholebod restag	1513		1150.00		230.00
G0216	S		PET img wholebod dx melanoma	1513		1150.00		230.00
G0217	S		PET img wholebod init melan	1513		1150.00		230.00
G0218	S		PET img wholebod restag mela	1513		1150.00		230.00
G0219	E		PET img wholbod melano nonco					
G0220	S		PET img wholebod dx lymphoma	1513		1150.00		230.00
G0221	S		PET imag wholbod init lympho	1513		1150.00		230.00
G0222	S		PET imag wholbod resta lymph	1513		1150.00		230.00
G0223	S		PET imag wholbod reg dx head	1513		1150.00		230.00
G0224	S		PET imag wholbod reg ini hea	1513		1150.00		230.00
G0225	S		PET whol restag headneckonly	1513		1150.00		230.00
G0226	S		PET img wholbody dx esophagl	1513		1150.00		230.00
G0227	S		PET img wholbod ini esophage	1513		1150.00		230.00
G0228	S		PET img wholbod restg esopha	1513		1150.00		230.00
G0229	S		PET img metaboloc brain pres	1513		1150.00		230.00
G0230	S		PET myocard viability post	1513		1150.00		230.00
G0231	S		PET WhBD colorec; gamma cam	1513		1150.00		230.00
G0232	S		PET whbd lymphoma; gamma cam	1513		1150.00		230.00
G0233	S		PET whbd melanoma; gamma cam	1513		1150.00		230.00
G0234	S		PET WhBD pulm nod; gamma cam	1513		1150.00		230.00
G0237	S		Therapeutic procd strg endur	0411	0.4194	23.90		4.78

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G0238	S		Oth resp proc, indiv	0411	0.4194	23.90		4.78
G0239	S		Oth resp proc, group	0411	0.4194	23.90		4.78
G0242	S		Multisource photon ster plan	1516		1450.00		290.00
G0243	S		Multisour photon stero treat	1528		5250.00		1050.00
G0244	S		Observ care by facility topt	0339	7.1646	408.26		81.65
G0245	V		Initial foot exam pt lops	0600	0.9033	51.47		10.29
G0246	V		Followup eval of foot pt lop	0600	0.9033	51.47		10.29
G0247	T		Routine footcare pt w lops	0009	0.6817	38.85	8.34	7.77
G0248	S		Demonstrate use home inr mon	1503		150.00		30.00
G0249	S		Provide test material,equipm	1503		150.00		30.00
G0250	E		MD review interpret of test					
G0251	S		Linear acc based stero radio	1513		1150.00		230.00
G0252	E		PET imaging initial dx					
G0253	S		PET image brst dection recur	1516		1450.00		290.00
G0254	S		PET image brst eval to tx	1516		1450.00		290.00
G0255	E		Current percep threshold tst					
G0257	S		Unsched dialysis ESRD pt hos	0170	6.2255	354.75		70.95
G0258	B		IV infusion during obs stay					
G0259	N		Inject for sacroiliac joint					
G0260	T		Inj for sacroiliac jt anesth	0206	5.4311	309.48	75.55	61.90
G0263	N		Adm with CHF, CP, asthma					
G0264	V		Assmt otr CHF, CP, asthma	0600	0.9033	51.47		10.29
G0265	A		Cryopresevation Freeze+stora					
G0266	A		Thawing + expansion froz cel					
G0267	S		Bone marrow or psc harvest	0110	3.7809	215.45		43.09
G0268	X		Removal of impacted wax md	0340	0.6328	36.06		7.21
G0269	N		Occlusive device in vein art					
G0270	A		MNT subs tx for change dx					
G0271	A		Group MNT 2 or more 30 mins					
G0275	N		Renal angio, cardiac cath					
G0278	N		Iliac art angio,cardiac cath					
G0279	A		Excorp shock tx, elbow epi					
G0280	A		Excorp shock tx other than					
G0281	A		Elec stim unattend for press					
G0282	E		Elect stim wound care not pd					
G0283	A		Elec stim other than wound					
G0288	S		Recon, CTA for surg plan	0417	4.6807	266.72		53.34
G0289	N		Arthro, loose body + chondro					
G0290	T		Drug-eluting stents, single	0656	105.1296	5990.60		1198.12
G0291	T		Drug-eluting stents,each add	0656	105.1296	5990.60		1198.12
G0292	D		Adm exp drugs,clinical trial					
G0293	S		Non-cov surg proc,clin trial	1505		350.00		70.00
G0294	S		Non-cov proc, clinical trial	1502		75.00		15.00

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G0295	E		Electromagnetic therapy onc					
G0296	S		PET imge restag thyrod cance	1513		1150.00		230.00
G0297	T		Insert single chamber/cd	0107	315.2469	17963.71	3612.57	3592.74
G0298	T		Insert dual chamber/cd	0107	315.2469	17963.71	3612.57	3592.74
G0299	T		Inser/repos single icd+leads	0108	423.3141	24121.71		4824.34
G0300	T		Insert reposit lead dual+gen	0108	423.3141	24121.71		4824.34
G0302	S		Pre-op service LVRS complete	1509		750.00		150.00
G0303	S		Pre-op service LVRS 10-15dos	1507		550.00		110.00
G0304	S		Pre-op service LVRS 1-9 dos	1504		250.00		50.00
G0305	S		Post op service LVRS min 6	1504		250.00		50.00
G0306	A		CBC/diffwbc w/o platelet					
G0307	A		CBC without platelet					
G0308	A		ESRD related svc 4+mo < 2yrs					
G0309	A		ESRD related svc 2-3mo <2yrs					
G0310	A		ESRD related svc 1 vst <2yrs					
G0311	A		ESRD related svs 4+mo 2-11yr					
G0312	A		ESRD relate svs 2-3 mo 2-11y					
G0313	A		ESRD related svs 1 mon 2-11y					
G0314	A		ESRD related svs 4+ mo 12-19					
G0315	A		ESRD related svs 2-3mo/12-19					
G0316	A		ESRD related svs 1vis/12-19y					
G0317	A		ESRD related svs 4+mo 20+yrs					
G0318	A		ESRD related svs 2-3 mo 20+y					
G0319	A		ESRD related svs 1visit 20+y					
G0320	A		ESD related svs home undr 2					
G0321	A		ESRDrelatedsvs home mo 2-11y					
G0322	A		ESRD related svs hom mo12-19					
G0323	A		ESRD related svs home mo 20+					
G0324	A		ESRD relate svs home/dy <2yr					
G0325	A		ESRD relate home/day/ 2-11yr					
G0326	A		ESRD relate home/dy 12-19yr					
G0327	A		ESRD relate home/dy 20+yrs					
G0328	A		Fecal blood scrn immunoassay					
G0329	A	NF	Electromagntic tx for ulcers					
G0330	S	NI	PET image initial dx cervcal	1516		1450.00		290.00
G0331	S	NI	PET image restage ovarian ca	1516		1450.00		290.00
G0336	S	NI	PET imaging brain alzheimers	1516		1450.00		290.00
G0337	A	NI	Hospice evaluation preelecti					
G0338	S		Linear accelerator stero pln	1513		1150.00		230.00
G0339	S		Robot lin-radsurg com, first	1528		5250.00		1050.00
G0340	S		Robt lin-radsurg fractx 2-5	1525		3750.00		750.00
G0341	C	NI	Percutaneous islet celltrans					
G0342	C	NI	Laparoscopy islet cell trans					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G0343	C	NI	Laparotomy islet cell transp					
G0344	V	NI	Initial preventive exam	0601	0.9847	56.11		11.22
G0345	B	NI	IV infuse hydration, initial					
G0346	B	NI	Each additional infuse hour					
G0347	B	NI	IV infusion therapy/diagnost					
G0348	B	NI	Each additional hr up to 8hr					
G0349	B	NI	Additional sequential infuse					
G0350	B	NI	Concurrent infusion					
G0351	B	NI	Therapeutic/diagnostic injec					
G0353	B	NI	IV push,single orinitial dru					
G0354	B	NI	Each addition sequential IV					
G0355	B	NI	Chemo adminisrate subcut/IM					
G0356	B	NI	Hormonal anti-neoplastic					
G0357	B	NI	IV push single/initial subst					
G0358	B	NI	IV push each additional drug					
G0359	B	NI	Chemotherapy IV one hr initi					
G0360	B	NI	Each additional hr 1-8 hrs					
G0361	B	NI	Prolong chemo infuse>8hrs pu					
G0362	B	NI	Each add sequential infusion					
G0363	B	NI	Irrigate implanted venous de					
G0364	X	NI	Bone marrow aspirate &biopsy	0342	0.2068	11.78	5.30	2.36
G0365	S	NI	Vessel mapping hemo access	0267	2.4250	138.18	62.18	27.64
G0366	B	NI	EKG for initial prevent exam					
G0367	S	NI	EKG tracing for initial prev	0099	0.3812	21.72		4.34
G0368	A	NI	EKG interpret & report preve					
G3001	S		Admin + supply, tositumomab	1522		2250.00		450.00
G9001	B		MCCD, initial rate					
G9002	B		MCCD,maintenance rate					
G9003	B		MCCD, risk adj hi, initial					
G9004	B		MCCD, risk adj lo, initial					
G9005	B		MCCD, risk adj, maintenance					
G9006	B		MCCD, Home monitoring					
G9007	B		MCCD, sch team conf					
G9008	B		Mccd,phys coor-care ovrsght					
G9009	E		MCCD, risk adj, level 3					
G9010	E		MCCD, risk adj, level 4					
G9011	E		MCCD, risk adj, level 5					
G9012	E		Other Specified Case Mgmt					
G9013	E	NI	ESRD demo bundle level I					
G9014	E	NI	ESRD demo bundle-level II					
G9016	E		Demo-smoking cessation coun					
G9017	A	NI	Amantadine HCL, oral					
G9018	A	NI	Zanamivir, inh pwdr					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G9019	A	NI	Oseltamivir phosp					
G9020	A	NI	Rimantadine HCL					
J0120	K		Tetracyclin injection	9028	1.7547	99.99		20.00
J0128	G	NI	Abarelix injection	9216		67.62		13.52
J0130	K		Abciximab injection	1605		448.22		89.64
J0135	K	NI	Adalimumab injection	1083		620.64		124.13
J0150	K		Injection adenosine 6 MG	0379	0.2163	12.33		2.47
J0152	K		Adenosine injection	0917	0.1528	8.71		1.74
J0170	N		Adrenalin epinephrin inject					
J0180	G	NI	Agalsidase beta injection	9208		121.14		24.23
J0190	N		Inj biperiden lactate/5 mg					
J0200	N		Alatrofloxacin mesylate					
J0205	K		Alglucerase injection	0900		37.53		7.51
J0207	K		Amifostine	7000		395.75		79.15
J0210	N		Methyldopate hcl injection					
J0215	B		Alefacept					
J0256	K		Alpha 1 proteinase inhibitor	0901		3.43		0.69
J0270	B		Alprostadil for injection					
J0275	B		Alprostadil urethral suppos					
J0280	N		Aminophyllin 250 MG inj					
J0282	K		Amiodarone HCl	9029	0.1931	11.00		2.20
J0285	K		Amphotericin B	9030	0.3622	20.64		4.13
J0287	K		Amphotericin b lipid complex	9024		19.09		3.82
J0288	K		Ampho b cholesteryl sulfate	0735		15.20		3.04
J0289	K		Amphotericin b liposome inj	0736		31.27		6.25
J0290	N		Ampicillin 500 MG inj					
J0295	N		Ampicillin sodium per 1.5 gm					
J0300	N		Amobarbital 125 MG inj					
J0330	N		Succinycholine chloride inj					
J0350	K		Injection anistreplase 30 u	1606		2353.53		470.71
J0360	N		Hydralazine hcl injection					
J0380	N		Inj metaraminol bitartrate					
J0390	N		Chloroquine injection					
J0395	K		Arbutamine HCl injection	9031	1.1947	68.08		13.62
J0456	N		Azithromycin					
J0460	N		Atropine sulfate injection					
J0470	N		Dimecaprol injection					
J0475	K		Baclofen 10 MG injection	9032	0.1874	10.68		2.14
J0476	B		Baclofen intrathecal trial					
J0500	N		Dicyclomine injection					
J0515	N		Inj benztropine mesylate					
J0520	N		Bethanechol chloride inject					
J0530	N		Penicillin g benzathine inj					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J0540	N		Penicillin g benzathine inj					
J0550	N		Penicillin g benzathine inj					
J0560	N		Penicillin g benzathine inj					
J0570	N		Penicillin g benzathine inj					
J0580	N		Penicillin g benzathine inj					
J0583	K		Bivalirudin	9111		1.52		0.30
J0585	K		Botulinum toxin a per unit	0902		4.32		0.86
J0587	K		Botulinum toxin type B	9018		7.68		1.54
J0592	N		Buprenorphine hydrochloride					
J0595	K		Butorphanol tartrate 1 mg	0703		5.00		1.00
J0600	N		Edetate calcium disodium inj					
J0610	N		Calcium gluconate injection					
J0620	N		Calcium glycer & lact/10 ML					
J0630	N		Calcitonin salmon injection					
J0636	N		Inj calcitriol per 0.1 mcg					
J0637	K		Caspofungin acetate	9019		28.78		5.76
J0640	N		Leucovorin calcium injection					
J0670	N		Inj mepivacaine HCL/10 ml					
J0690	N		Cefazolin sodium injection					
J0692	N		Cefepime HCl for injection					
J0694	N		Cefoxitin sodium injection					
J0696	N		Ceftriaxone sodium injection					
J0697	N		Sterile cefuroxime injection					
J0698	N		Cefotaxime sodium injection					
J0702	N		Betamethasone acet&sod phosp					
J0704	N		Betamethasone sod phosp/4 MG					
J0706	N		Caffeine citrate injection					
J0710	N		Cephapirin sodium injection					
J0713	N		Inj ceftazidime per 500 mg					
J0715	N		Ceftizoxime sodium / 500 MG					
J0720	N		Chloramphenicol sodium injec					
J0725	N		Chorionic gonadotropin/1000u					
J0735	N		Clonidine hydrochloride					
J0740	K		Cidofovir injection	9033	7.1527	407.58		81.52
J0743	K		Cilastatin sodium injection	0846	0.1994	11.37		2.27
J0744	N		Ciprofloxacin iv					
J0745	N		Inj codeine phosphate /30 MG					
J0760	N		Colchicine injection					
J0770	N		Colistimethate sodium inj					
J0780	N		Prochlorperazine injection					
J0800	N		Corticotropin injection					
J0835	N		Inj cosyntropin per 0.25 MG					
J0850	K		Cytomegalovirus imm IV /vial	0903		622.13		124.43

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J0878	G	NI	Daptomycin injection	9124		0.28		0.06
J0880	E		Darbepoetin alfa injection					
J0895	N		Deferoxamine mesylate inj					
J0900	K		Testosterone enanthate inj	0848	0.6713	38.27		7.65
J0945	K		Brompheniramine maleate inj	9034	1.0356	59.01		11.80
J0970	N		Estradiol valerate injection					
J1000	N		Depo-estradiol cypionate inj					
J1020	N		Methylprednisolone 20 MG inj					
J1030	N		Methylprednisolone 40 MG inj					
J1040	N		Methylprednisolone 80 MG inj					
J1051	K		Medroxyprogesterone inj	9035	0.3082	17.56		3.51
J1055	E		Medrxyprogester acetate inj					
J1056	E		MA/EC contraceptiveinjection					
J1060	N		Testosterone cypionate 1 ML					
J1070	N		Testosterone cypionat 100 MG					
J1080	N		Testosterone cypionat 200 MG					
J1094	N		Inj dexamethasone acetate					
J1100	N		Dexamethasone sodium phos					
J1110	N		Inj dihydroergotamine mesylt					
J1120	N		Acetazolamid sodium injectio					
J1160	N		Digoxin injection					
J1165	N		Phenytoin sodium injection					
J1170	N		Hydromorphone injection					
J1180	N		Dyphylline injection					
J1190	K		Dexrazoxane HCl injection	0726		113.28		22.66
J1200	N		Diphenhydramine hcl injectio					
J1205	N		Chlorothiazide sodium inj					
J1212	K		Dimethyl sulfoxide 50% 50 ML	9036	0.9360	53.34		10.67
J1230	K		Methadone injection	9037	0.2337	13.32		2.66
J1240	N		Dimenhydrinate injection					
J1245	K		Dipyridamole injection	0380	0.2053	11.70		2.34
J1250	N		Inj dobutamine HCL/250 mg					
J1260	K		Dolasetron mesylate	0750		14.38		2.88
J1270	N		Injection, doxercalciferol					
J1320	N		Amitriptyline injection					
J1325	K		Epoprostenol injection	7003		15.78		3.16
J1327	K		Eptifibatide injection	1607		11.21		2.24
J1330	N		Ergonovine maleate injection					
J1335	N		Ertapenem injection					
J1364	N		Erythro lactobionate /500 MG					
J1380	N		Estradiol valerate 10 MG inj					
J1390	N		Estradiol valerate 20 MG inj					
J1410	K		Inj estrogen conjugate 25 MG	9038	0.7986	45.51		9.10

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J1435	N		Injection estrone per 1 MG					
J1436	N		Etidronate disodium inj					
J1438	K		Etanercept injection	1608		135.56		27.11
J1440	K		Filgrastim 300 mcg injection	0728		162.41		32.48
J1441	K		Filgrastim 480 mcg injection	7049		274.40		54.88
J1450	N		Fluconazole					
J1452	K		Intraocular Fomivirsen na	9040	16.4925	939.79		187.96
J1455	K		Foscarnet sodium injection	0866	0.2069	11.80		2.36
J1457	K	NI	Gallium nitrate injection	1085		0.23		0.05
J1460	K		Gamma globulin 1 CC inj	9041	0.5550	31.63		6.33
J1470	B		Gamma globulin 2 CC inj					
J1480	B		Gamma globulin 3 CC inj					
J1490	B		Gamma globulin 4 CC inj					
J1500	B		Gamma globulin 5 CC inj					
J1510	B		Gamma globulin 6 CC inj					
J1520	B		Gamma globulin 7 CC inj					
J1530	B		Gamma globulin 8 CC inj					
J1540	B		Gamma globulin 9 CC inj					
J1550	B		Gamma globulin 10 CC inj					
J1560	B		Gamma globulin > 10 CC inj					
J1563	K		IV immune globulin	0905		80.68		16.14
J1564	K		Immune globulin 10 mg	9021		0.75		0.15
J1565	K		RSV-ivig	0906		16.55		3.31
J1570	N		Ganciclovir sodium injection					
J1580	N		Garamycin gentamicin inj					
J1590	N		Gatifloxacin injection					
J1595	N		Injection glatiramer acetate					
J1600	N		Gold sodium thiomaleate inj					
J1610	K		Glucagon hydrochloride/1 MG	9042	0.8100	46.16		9.23
J1620	K		Gonadorelin hydroch/ 100 mcg	7005	0.2998	17.08		3.42
J1626	K		Granisetron HCl injection	0764		16.20		3.24
J1630	N		Haloperidol injection					
J1631	N		Haloperidol decanoate inj					
J1642	N		Inj heparin sodium per 10 u					
J1644	N		Inj heparin sodium per 1000u					
J1645	N		Dalteparin sodium					
J1650	N		Inj enoxaparin sodium					
J1652	N		Fondaparinux sodium					
J1655	N		Tinzaparin sodium injection					
J1670	N		Tetanus immune globulin inj					
J1700	N		Hydrocortisone acetate inj					
J1710	N		Hydrocortisone sodium ph inj					
J1720	N		Hydrocortisone sodium succ i					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J1730	N		Diazoxide injection					
J1742	K		Ibutilide fumarate injection	9044	2.1724	123.79		24.76
J1745	K		Infliximab injection	7043		57.40		11.48
J1750	K		Iron dextran	9045	0.2593	14.78		2.96
J1756	K		Iron sucrose injection	9046	0.0093	0.53		0.11
J1785	K		Injection imiglucerase /unit	0916		3.75		0.75
J1790	N		Droperidol injection					
J1800	N		Propranolol injection					
J1810	E		Droperidol/fentanyl inj					
J1815	N		Insulin injection					
J1817	N		Insulin for insulin pump use					
J1825	E		Interferon beta-1a					
J1830	K		Interferon beta-1b / .25 MG	0910		58.73		11.75
J1835	K		Itraconazole injection	9047	0.7389	42.10		8.42
J1840	N		Kanamycin sulfate 500 MG inj					
J1850	N		Kanamycin sulfate 75 MG inj					
J1885	N		Ketorolac tromethamine inj					
J1890	N		Cephalothin sodium injection					
J1931	G	NI	Laronidase injection	9209		22.74		4.55
J1940	N		Furosemide injection					
J1950	K		Leuprolide acetate /3.75 MG	0800		451.98		90.40
J1955	B		Inj levocarnitine per 1 gm					
J1956	N		Levofloxacin injection					
J1960	N		Levorphanol tartrate inj					
J1980	N		Hyoscyamine sulfate inj					
J1990	N		Chlordiazepoxide injection					
J2001	N		Lidocaine injection					
J2010	N		Lincomycin injection					
J2020	K		Linezolid injection	9001		32.15		6.43
J2060	N		Lorazepam injection					
J2150	N		Mannitol injection					
J2175	N		Meperidine hydrochl /100 MG					
J2180	N		Meperidine/promethazine inj					
J2185	K		Meropenem	0729		36.26		7.25
J2210	N		Methylergonovin maleate inj					
J2250	N		Inj midazolam hydrochloride					
J2260	K		Inj milrinone lactate / 5 MG	7007	0.1442	8.22		1.64
J2270	N		Morphine sulfate injection					
J2271	N		Morphine so4 injection 100mg					
J2275	N		Morphine sulfate injection					
J2280	K		Inj, moxifloxacin 100 mg	1046		8.75		1.75
J2300	N		Inj nalbuphine hydrochloride					
J2310	N		Inj naloxone hydrochloride					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J2320	N		Nandrolone decanoate 50 MG					
J2321	N		Nandrolone decanoate 100 MG					
J2322	N		Nandrolone decanoate 200 MG					
J2324	K		Nesiritide	9114		132.47		26.49
J2353	K		Octreotide injection, depot	1207		69.44		13.89
J2354	K		Octreotide inj, non-depot	7031		3.72		0.74
J2355	K		Oprelvekin injection	7011		248.16		49.63
J2357	G	NI	Omalizumab injection	9300		15.24		3.05
J2360	N		Orphenadrine injection					
J2370	N		Phenylephrine hcl injection					
J2400	N		Chloroprocaine hcl injection					
J2405	K		Ondansetron hcl injection	0768		5.54		1.11
J2410	N		Oxymorphone hcl injection					
J2430	K		Pamidronate disodium /30 MG	0730		128.74		25.75
J2440	N		Papaverin hcl injection					
J2460	N		Oxytetracycline injection					
J2469	G	NI	Palonosetron HCl	9210		18.25		3.65
J2501	N		Paricalcitol					
J2505	K		Injection, pegfilgrastim 6mg	9119		2448.50		489.70
J2510	N		Penicillin g procaine inj					
J2515	N		Pentobarbital sodium inj					
J2540	N		Penicillin g potassium inj					
J2543	N		Piperacillin/tazobactam					
J2545	Y		Pentamidine isethionte/300mg					
J2550	N		Promethazine hcl injection					
J2560	N		Phenobarbital sodium inj					
J2590	N		Oxytocin injection					
J2597	K		Inj desmopressin acetate	9048	0.0794	4.52		0.90
J2650	N		Prednisolone acetate inj					
J2670	N		Totazoline hcl injection					
J2675	N		Inj progesterone per 50 MG					
J2680	N		Fluphenazine decanoate 25 MG					
J2690	N		Procainamide hcl injection					
J2700	N		Oxacillin sodium injeciton					
J2710	N		Neostigmine methylslfte inj					
J2720	N		Inj protamine sulfate/10 MG					
J2725	K		Inj protirelin per 250 mcg	9049	0.7161	40.81		8.16
J2730	N		Pralidoxime chloride inj					
J2760	K		Phentolaine mesylate inj	0845	0.3651	20.82		4.16
J2765	N		Metoclopramide hcl injection					
J2770	N		Quinupristin/dalfopristin					
J2780	N		Ranitidine hydrochloride inj					
J2783	G		Rasburicase	0738		106.04		21.21

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J2788	K		Rho d immune globulin 50 mcg	9023		30.38		6.08
J2790	N		Rho d immune globulin inj					
J2792	K		Rho(D) immune globulin h, sd	1609		17.95		3.59
J2794	G	NI	Risperidone, long acting	9125		4.58		0.92
J2795	N		Ropivacaine HCl injection					
J2800	N		Methocarbamol injection					
J2810	N		Inj theophylline per 40 MG					
J2820	K		Sargramostim injection	0731		25.39		5.08
J2910	N		Aurothioglucose injeciton					
J2912	N		Sodium chloride injection					
J2916	K		Na ferric gluconate complex	9050	0.1058	6.03		1.21
J2920	N		Methylprednisolone injection					
J2930	N		Methylprednisolone injection					
J2940	N		Somatrem injection					
J2941	K		Somatropin injection	7034		280.87		56.17
J2950	N		Promazine hcl injection					
J2993	K		Reteplase injection	9005		1192.09		238.42
J2995	K		Inj streptokinase /250000 IU	0911	0.7618	43.41		8.68
J2997	K		Alteplase recombinant	7048	0.3165	18.04		3.61
J3000	N		Streptomycin injection					
J3010	N		Fentanyl citrate injeciton					
J3030	N		Sumatriptan succinate / 6 MG					
J3070	N		Pentazocine injection					
J3100	K		Tenecteplase injection	9002		2350.98		470.20
J3105	N		Terbutaline sulfate inj					
J3110	B	NI	Teriparatide injection					
J3120	N		Testosterone enanthate inj					
J3130	N		Testosterone enanthate inj					
J3140	N		Testosterone suspension inj					
J3150	N		Testosteron propionate inj					
J3230	N		Chlorpromazine hcl injection					
J3240	K		Thyrotropin injection	9108		617.50		123.50
J3245	D		Tirofiban hydrochloride					
J3246	K	NI	Tirofiban HCl	7041		8.24		1.65
J3250	N		Trimethobenzamide hcl inj					
J3260	N		Tobramycin sulfate injection					
J3265	N		Injection torsemide 10 mg/ml					
J3280	N		Thiethylperazine maleate inj					
J3301	N		Triamcinolone acetonide inj					
J3302	N		Triamcinolone diacetate inj					
J3303	N		Triamcinolone hexacetonl inj					
J3305	K		Inj trimetrexate glucoronate	7045		142.50		28.50
J3310	N		Perphenazine injeciton					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J3315	K		Triptorelin pamoate	9122		362.78		72.56
J3320	N		Spectinomycn di-hcl inj					
J3350	K		Urea injection	9051	1.2239	69.74		13.95
J3360	N		Diazepam injection					
J3364	N		Urokinase 5000 IU injection					
J3365	K		Urokinase 250,000 IU inj	7036	2.1873	124.64		24.93
J3370	N		Vancomycin hcl injection					
J3395	D		Verteporfin injection					
J3396	K	NI	Verteporfin injection	1203		8.49		1.70
J3400	N		Triflupromazine hcl inj					
J3410	N		Hydroxyzine hcl injection					
J3411	K		Thiamine hcl 100 mg	1049		0.95		0.19
J3415	K		Pyridoxine hcl 100 mg	1050		2.64		0.53
J3420	N		Vitamin b12 injection					
J3430	N		Vitamin k phytonadione inj					
J3465	K		Injection, voriconazole	1052		4.54		0.91
J3470	N		Hyaluronidase injection					
J3475	N		Inj magnesium sulfate					
J3480	N		Inj potassium chloride					
J3485	N		Zidovudine					
J3486	G		Ziprasidone mesylate	9204		18.22		3.64
J3487	K		Zoledronic acid	9115		197.87		39.57
J3490	N		Drugs unclassified injection					
J3520	E		Edetate disodium per 150 mg					
J3530	K		Nasal vaccine inhalation	9053	1.6217	92.41		18.48
J3535	E		Metered dose inhaler drug					
J3570	E		Laetrile amygdalin vit B17					
J3590	N		Unclassified biologics					
J7030	N		Normal saline solution infus					
J7040	N		Normal saline solution infus					
J7042	N		5% dextrose/normal saline					
J7050	N		Normal saline solution infus					
J7051	N		Sterile saline/water					
J7060	N		5% dextrose/water					
J7070	N		D5w infusion					
J7100	N		Dextran 40 infusion					
J7110	N		Dextran 75 infusion					
J7120	N		Ringers lactate infusion					
J7130	N		Hypertonic saline solution					
J7190	K		Factor viii	0925		0.76		0.15
J7191	K		Factor VIII (porcine)	0926		1.78		0.36
J7192	K		Factor viii recombinant	0927		1.10		0.22
J7193	K		Factor IX non-recombinant	0931		0.98		0.20

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J7194	K		Factor ix complex	0928		0.32		0.06
J7195	K		Factor IX recombinant	0932		0.98		0.20
J7197	N		Antithrombin iii injection					
J7198	K		Anti-inhibitor	0929		1.29		0.26
J7199	B		Hemophilia clot factor noc					
J7300	E		Intraut copper contraceptive					
J7302	E		Levonorgestrel iu contracept					
J7303	E		Contraceptive vaginal ring					
J7304	E	NI	Contraceptive hormone patch					
J7308	K		Aminolevulinic acid hcl top	7308		88.76		17.75
J7310	N		Ganciclovir long act implant					
J7317	K		Sodium hyaluronate injection	7316	0.9466	53.94		10.79
J7320	K		Hylan G-F 20 injection	1611		203.70		40.74
J7330	B		Cultured chondrocytes implnt					
J7340	E		Metabolic active D/E tissue					
J7342	K		Metabolically active tissue	9054	0.1255	7.15		1.43
J7343	B	NI	Nonmetabolic act d/e tissue					
J7344	N	NI	Nonmetabolic active tissue					
J7350	K		Injectable human tissue	9055	0.1412	8.05		1.61
J7500	N		Azathioprine oral 50mg					
J7501	K		Azathioprine parenteral	0887		30.18		6.04
J7502	K		Cyclosporine oral 100 mg	0888	0.0312	1.78		0.36
J7504	K		Lymphocyte immune globulin	0890		243.50		48.70
J7505	K		Monoclonal antibodies	7038		747.31		149.46
J7506	N		Prednisone oral					
J7507	K		Tacrolimus oral per 1 MG	0891		3.05		0.61
J7509	N		Methylprednisolone oral					
J7510	N		Prednisolone oral per 5 mg					
J7511	K		Antithymocyte globuln rabbit	9104		312.41		62.48
J7513	K		Daclizumab, parenteral	1612		393.78		78.76
J7515	N		Cyclosporine oral 25 mg					
J7516	N		Cyclosporin parenteral 250mg					
J7517	K		Mycophenolate mofetil oral	9015		2.46		0.49
J7518	G	NI	Mycophenolic acid	9219		2.43		0.49
J7520	K		Sirolimus, oral	9020		6.23		1.25
J7525	N		Tacrolimus injection					
J7599	N		Immunosuppressive drug noc					
J7608	Y		Acetylcysteine inh sol u d					
J7611	Y	NI	Albuterol concentrated form					
J7612	Y	NI	Levalbuterol concentrated					
J7613	Y	NI	Albuterol unit dose					
J7614	Y	NI	Levalbuterol unit dose					
J7616	Y	NI	Albuterol compound solution					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J7617	Y	NI	Levalbuterol compounded sol					
J7618	D		Albuterol inh sol con					
J7619	D		Albuterol inh sol u d					
J7621	D		(Levo)albuterol/Ipra-bromide					
J7622	A		Beclomethasone inhalatn sol					
J7624	A		Betamethasone inhalation sol					
J7626	A		Budesonide inhalation sol					
J7628	Y		Bitolterol mes inhal sol con					
J7629	Y		Bitolterol mes inh sol u d					
J7631	Y		Cromolyn sodium inh sol u d					
J7633	N		Budesonide concentrated sol					
J7635	Y		Atropine inhal sol con					
J7636	Y		Atropine inhal sol unit dose					
J7637	Y		Dexamethasone inhal sol con					
J7638	Y		Dexamethasone inhal sol u d					
J7639	Y		Dornase alpha inhal sol u d					
J7641	A		Flunisolide, inhalation sol					
J7642	Y		Glycopyrrolate inhal sol con					
J7643	Y		Glycopyrrolate inhal sol u d					
J7644	Y		Ipratropium brom inh sol u d					
J7648	Y		Isoetharine hcl inh sol con					
J7649	Y		Isoetharine hcl inh sol u d					
J7658	Y		Isoproterenolhcl inh sol con					
J7659	Y		Isoproterenol hcl inh sol ud					
J7668	Y		Metaproterenol inh sol con					
J7669	Y		Metaproterenol inh sol u d					
J7674	K	NI	Methacholine chloride, neb	0867		0.47		0.09
J7680	Y		Terbutaline so4 inh sol con					
J7681	Y		Terbutaline so4 inh sol u d					
J7682	Y		Tobramycin inhalation sol					
J7683	Y		Triamcinolone inh sol con					
J7684	Y		Triamcinolone inh sol u d					
J7699	Y		Inhalation solution for DME					
J7799	Y		Non-inhalation drug for DME					
J8499	E		Oral prescrip drug non chemo					
J8501	E	NI	Oral aprepitant					
J8510	K		Oral busulfan	7015		2.08		0.42
J8520	K		Capecitabine, oral, 150 mg	7042		2.96		0.59
J8521	E		Capecitabine, oral, 500 mg					
J8530	N		Cyclophosphamide oral 25 MG					
J8560	K		Etoposide oral 50 MG	0802		21.91		4.38
J8565	E	NI	Gefitinib oral					
J8600	N		Melphalan oral 2 MG					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J8610	N		Methotrexate oral 2.5 MG					
J8700	K		Temozolomide	1086		6.42		1.28
J8999	B		Oral prescription drug chemo					
J9000	K		Doxorubic hcl 10 MG vl chemo	0847		4.69		0.94
J9001	K		Doxorubicin hcl liposome inj	7046		343.78		68.76
J9010	K		Alemtuzumab injection	9110		541.45		108.29
J9015	K		Aldesleukin/single use vial	0807		680.35		136.07
J9017	K		Arsenic trioxide	9012		34.10		6.82
J9020	K		Asparaginase injection	0814		54.71		10.94
J9031	K		Bcg live intravesical vac	0809		139.90		27.98
J9035	G	NI	Bevacizumab injection	9214		57.13		11.43
J9040	K		Bleomycin sulfate injection	0857		88.32		17.66
J9041	G	NI	Bortezomib injection	9207		27.53		5.51
J9045	K		Carboplatin injection	0811		129.96		25.99
J9050	K		Carmus bischl nitro inj	0812		65.94		13.19
J9055	G	NI	Cetuximab injection	9215		49.87		9.97
J9060	K		Cisplatin 10 MG injection	0813		7.73		1.55
J9062	B		Cisplatin 50 MG injection					
J9065	K		Inj cladribine per 1 MG	0858		24.84		4.97
J9070	K		Cyclophosphamide 100 MG inj	0815		2.77		0.55
J9080	B		Cyclophosphamide 200 MG inj					
J9090	B		Cyclophosphamide 500 MG inj					
J9091	B		Cyclophosphamide 1.0 grm inj					
J9092	B		Cyclophosphamide 2.0 grm inj					
J9093	K		Cyclophosphamide lyophilized	0816		2.36		0.47
J9094	B		Cyclophosphamide lyophilized					
J9095	B		Cyclophosphamide lyophilized					
J9096	B		Cyclophosphamide lyophilized					
J9097	B		Cyclophosphamide lyophilized					
J9098	N		Cytarabine liposome					
J9100	K		Cytarabine hcl 100 MG inj	0817		1.55		0.31
J9110	B		Cytarabine hcl 500 MG inj					
J9120	N		Dactinomycin actinomycin d					
J9130	K		Dacarbazine 100 mg inj	0819		6.14		1.23
J9140	B		Dacarbazine 200 MG inj					
J9150	K		Daunorubicin	0820		35.94		7.19
J9151	K		Daunorubicin citrate liposom	0821		56.44		11.29
J9160	K		Denileukin diftitox, 300 mcg	1084		1232.88		246.58
J9165	K		Diethylstilbestrol injection	0822		6.98		1.40
J9170	K		Docetaxel	0823		312.69		62.54
J9178	K		Inj, epirubicin hcl, 2 mg	1167		24.14		4.83
J9181	K		Etoposide 10 MG inj	0824		0.83		0.17
J9182	B		Etoposide 100 MG inj					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J9185	K		Fludarabine phosphate inj	0842		311.09		62.22
J9190	N		Fluorouracil injection					
J9200	K		Floxuridine injection	0827		66.24		13.25
J9201	K		Gemcitabine HCl	0828		105.73		21.15
J9202	K		Goserelin acetate implant	0810		390.09		78.02
J9206	K		Irinotecan injection	0830		127.33		25.47
J9208	K		Ifosfomide injection	0831		72.81		14.56
J9209	K		Mesna injection	0732		17.66		3.53
J9211	K		Idarubicin hcl injection	0832	1.1684	66.58		13.32
J9212	N		Interferon alfacon-1					
J9213	K		Interferon alfa-2a inj	0834		30.48		6.10
J9214	K		Interferon alfa-2b inj	0836		13.00		2.60
J9215	K		Interferon alfa-n3 inj	0865		8.17		1.63
J9216	K		Interferon gamma 1-b inj	0838		209.22		41.84
J9217	K		Leuprolide acetate suspnsion	9217		543.72		108.74
J9218	K		Leuprolide acetate injeciton	0861		14.48		2.90
J9219	K		Leuprolide acetate implant	7051		4717.72		943.54
J9230	N		Mechlorethamine hcl inj					
J9245	K		Inj melphalan hydrochl 50 MG	0840		367.03		73.41
J9250	N		Methotrexate sodium inj					
J9260	B		Methotrexate sodium inj					
J9263	B		Oxaliplatin					
J9265	K		Paclitaxel injection	0863		79.04		15.81
J9266	K		Pegaspargase/singl dose vial	0843		1247.08		249.42
J9268	K		Pentostatin injection	0844		1683.24		336.65
J9270	K		Plicamycin (mithramycin) inj	0860		93.80		18.76
J9280	K		Mitomycin 5 MG inj	0862		30.91		6.18
J9290	B		Mitomycin 20 MG inj					
J9291	B		Mitomycin 40 MG inj					
J9293	K		Mitoxantrone hydrochl / 5 MG	0864		313.96		62.79
J9300	K		Gemtuzumab ozogamicin	9004		2183.81		436.76
J9305	G	NI	Pemetrexed injection	9213		40.54		8.11
J9310	K		Rituximab cancer treatment	0849		437.83		87.57
J9320	N		Streptozocin injection					
J9340	K		Thiotepa injection	0851		45.31		9.06
J9350	K		Topotecan	0852		697.76		139.55
J9355	K		Trastuzumab	1613		50.79		10.16
J9357	N		Valrubicin, 200 mg					
J9360	N		Vinblastine sulfate inj					
J9370	N		Vincristine sulfate 1 MG inj					
J9375	B		Vincristine sulfate 2 MG inj					
J9380	B		Vincristine sulfate 5 MG inj					
J9390	K		Vinorelbine tartrate/10 mg	0855		95.23		19.05

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J9395	K		Injection, Fulvestrant	9120		79.65		15.93
J9600	K		Porfimer sodium	0856		2274.78		454.96
J9999	N		Chemotherapy drug					
K0001	Y		Standard wheelchair					
K0002	Y		Stnd hemi (low seat) whlchr					
K0003	Y		Lightweight wheelchair					
K0004	Y		High strength ltwt whlchr					
K0005	Y		Ultralightweight wheelchair					
K0006	Y		Heavy duty wheelchair					
K0007	Y		Extra heavy duty wheelchair					
K0009	Y		Other manual wheelchair/base					
K0010	Y		Stnd wt frame power whlchr					
K0011	Y		Stnd wt pwr whlchr w control					
K0012	Y		Ltwt portbl power whlchr					
K0014	Y		Other power whlchr base					
K0015	Y		Detach non-adjus hght armrst					
K0017	Y		Detach adjust armrest base					
K0018	Y		Detach adjust armrst upper					
K0019	Y		Arm pad each					
K0020	Y		Fixed adjust armrest pair					
K0023	D		Planr back insrt foam w/strp					
K0024	D		Plnr back insrt foam w/hrdwr					
K0037	Y		High mount flip-up footrest					
K0038	Y		Leg strap each					
K0039	Y		Leg strap h style each					
K0040	Y		Adjustable angle footplate					
K0041	Y		Large size footplate each					
K0042	Y		Standard size footplate each					
K0043	Y		Ftrst lower extension tube					
K0044	Y		Ftrst upper hanger bracket					
K0045	Y		Footrest complete assembly					
K0046	Y		Elevat legrst low extension					
K0047	Y		Elevat legrst up hangr brack					
K0050	Y		Ratchet assembly					
K0051	Y		Cam relese assem ftrst/lgrst					
K0052	Y		Swingaway detach footrest					
K0053	Y		Elevate footrest articulate					
K0056	Y		Seat ht <17 or >=21 ltwt wc					
K0059	D		Plastic coated handrim each					
K0060	D		Steel handrim each					
K0061	D		Aluminum handrim each					
K0064	Y		Zero pressure tube flat free					
K0065	Y		Spoke protectors					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
K0066	Y		Solid tire any size each					
K0067	Y		Pneumatic tire any size each					
K0068	Y		Pneumatic tire tube each					
K0069	Y		Rear whl complete solid tire					
K0070	Y		Rear whl compl pneum tire					
K0071	Y		Front castr compl pneum tire					
K0072	Y		Frnt cstr cmpl sem-pneum tir					
K0073	Y		Caster pin lock each					
K0074	Y		Pneumatic caster tire each					
K0075	Y		Semi-pneumatic caster tire					
K0076	Y		Solid caster tire each					
K0077	Y		Front caster assem complete					
K0078	Y		Pneumatic caster tire tube					
K0081	D		Wheel lock assembly complete					
K0090	Y		Rear tire power wheelchair					
K0091	Y		Rear tire tube power whlchr					
K0092	Y		Rear assem cmplt powr whlchr					
K0093	Y		Rear zero pressure tire tube					
K0094	Y		Wheel tire for power base					
K0095	Y		Wheel tire tube each base					
K0096	Y		Wheel assem powr base complt					
K0097	Y		Wheel zero presure tire tube					
K0098	Y		Drive belt power wheelchair					
K0099	Y		Pwr wheelchair front caster					
K0102	Y		Crutch and cane holder					
K0104	Y		Cylinder tank carrier					
K0105	Y		Iv hanger					
K0106	Y		Arm trough each					
K0108	Y		W/c component-accessory NOS					
K0114	D		Whlchr back suprt inr frame					
K0115	D		Back module orthotic system					
K0116	D		Back & seat modul orthot sys					
K0195	Y		Elevating whlchair leg rests					
K0415	B		RX antiemetic drg, oral NOS					
K0416	B		Rx antiemetic drg,rectal NOS					
K0452	Y		Wheelchair bearings					
K0455	Y		Pump uninterrupted infusion					
K0462	Y		Temporary replacement eqpmnt					
K0552	Y		Supply/ext inf pump syr type					
K0600	Y		Functional neuromuscularstim					
K0601	Y		Repl batt silver oxide 1.5 v					
K0602	Y		Repl batt silver oxide 3 v					
K0603	Y		Repl batt alkaline 1.5 v					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
K0604	Y		Repl batt lithium 3.6 v					
K0605	Y		Repl batt lithium 4.5 v					
K0606	Y		AED garment w elec analysis					
K0607	Y		Repl batt for AED					
K0608	Y		Repl garment for AED					
K0609	Y		Repl electrode for AED					
K0618	A		TLSO 2 piece rigid shell					
K0619	A		TLSO 3 piece rigid shell					
K0620	A		Tubular elastic dressing					
K0627	D		Cervical pneum trac equip					
K0628	Y	NF	Multi den insert direct form					
K0629	Y	NF	Multi den insert custom mold					
K0630	Y	NF	SIO flex pelvisacral prefab					
K0631	Y	NF	SIO flex pelvisacral custom					
K0632	Y	NF	SIO panel prefab					
K0633	Y	NF	SIO panel custom					
K0634	Y	NF	LO flexibl L1-below L5 pre					
K0635	Y	NF	LO sag stays/panels pre-fab					
K0636	Y	NF	LO sagitt rigid panel prefab					
K0637	Y	NF	LO flex w/o rigid stays pre					
K0638	Y	NF	LSO flex w/rigid stays cust					
K0639	Y	NF	LSO post rigid panel pre					
K0640	Y	NF	LSO sag-coro rigid frame pre					
K0641	Y	NF	LSO sag-cor rigid frame cust					
K0642	Y	NF	LSO flexion control prefab					
K0643	Y	NF	LSO flexion control custom					
K0644	Y	NF	LSO sagit rigid panel prefab					
K0645	Y	NF	LSO sagittal rigid panel cus					
K0646	Y	NF	LSO sag-coronal panel prefab					
K0647	Y	NF	LSO sag-coronal panel custom					
K0648	Y	NF	LSO s/c shell/panel prefab					
K0649	Y	NF	LSO s/c shell/panel custom					
K0650	D		Gen w/c cushion width < 22"					
K0651	D		Gen w/c cushion width > 22"					
K0652	D		Skin pro w/c cus wd < 22"					
K0653	D		Skin protect w/c cus wd>=22"					
K0654	D		Position w/c cush width <22"					
K0655	D		Position w/c cush width >22"					
K0656	D		Skin pro/pos w/c cus wd <22"					
K0657	D		Skin pro/pos w/c cus wd>=22"					
K0658	D		Custom fabricate w/c cushion					
K0659	D		Powered w/c cushion					
K0660	D		Gen use back cush width <22"					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
K0661	D		Gen use back cush width >22"					
K0662	D		Position back cush wdth <22"					
K0663	D		Position back cush wdth >22"					
K0664	D		Pos back post/lat width <22"					
K0665	D		Pos back post/lat width >22"					
K0666	D		Custom fab w/c back cushion					
K0667	D		Mt hardwre man/light pwr w/c					
K0668	D		Replace cover w/c seat cush					
K0669	Y	NF	Seat/back cus no sadmerc ver					
L0100	A		Cranial orthosis/helmet mold					
L0110	A		Cranial orthosis/helmet nonm					
L0112	A		Cranial cervical orthosis					
L0120	A		Cerv flexible non-adjustable					
L0130	A		Flex thermoplastic collar mo					
L0140	A		Cervical semi-rigid adjustab					
L0150	A		Cerv semi-rig adj molded chn					
L0160	A		Cerv semi-rig wire occ/mand					
L0170	A		Cervical collar molded to pt					
L0172	A		Cerv col thermplas foam 2 pi					
L0174	A		Cerv col foam 2 piece w thor					
L0180	A		Cer post col occ/man sup adj					
L0190	A		Cerv collar supp adj cerv ba					
L0200	A		Cerv col supp adj bar & thor					
L0210	A		Thoracic rib belt					
L0220	A		Thor rib belt custom fabrica					
L0430	A	NI	Dewall posture protector					
L0450	A		TLSO flex prefab thoracic					
L0452	A		tlso flex custom fab thoraci					
L0454	A		TLSO flex prefab sacrococ-T9					
L0456	A		TLSO flex prefab					
L0458	A		TLSO 2Mod symphis-xipho pre					
L0460	A		TLSO2Mod symphysis-stern pre					
L0462	A		TLSO 3Mod sacro-scap pre					
L0464	A		TLSO 4Mod sacro-scap pre					
L0466	A		TLSO rigid frame pre soft ap					
L0468	A		TLSO rigid frame prefab pelv					
L0470	A		TLSO rigid frame pre subclav					
L0472	A		TLSO rigid frame hyperex pre					
L0476	D		TLSO flexion compres jac pre					
L0478	D		TLSO flexion compres jac cus					
L0480	A		TLSO rigid plastic custom fa					
L0482	A		TLSO rigid lined custom fab					
L0484	A		TLSO rigid plastic cust fab					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L0486	A		TLSO rigidlined cust fab two					
L0488	A		TLSO rigid lined pre one pie					
L0490	A		TLSO rigid plastic pre one					
L0500	D		Lso flex surgical support					
L0510	D		Lso flexible custom fabricat					
L0515	D		Lso flex elas w/ rig post pa					
L0520	D		Lso a-p-l control with apron					
L0530	D		Lso ant-pos control w apron					
L0540	D		Lso lumbar flexion a-p-l					
L0550	D		Lso a-p-l control molded					
L0560	D		Lso a-p-l w interface					
L0561	D		Prefab lso					
L0565	D		Lso a-p-l control custom					
L0600	D		Sacroiliac flex surg support					
L0610	D		Sacroiliac flexible custm fa					
L0620	D		Sacroiliac semi-rig w apron					
L0700	A		Ctlso a-p-l control molded					
L0710	A		Ctlso a-p-l control w/ inter					
L0810	A		Halo cervical into jckt vest					
L0820	A		Halo cervical into body jack					
L0830	A		Halo cerv into milwaukee typ					
L0860	A		Magnetic resonanc image comp					
L0861	A		Halo repl liner/interface					
L0960	E		Post surgical support pads					
L0970	A		Tlso corset front					
L0972	A		Lso corset front					
L0974	A		Tlso full corset					
L0976	A		Lso full corset					
L0978	A		Axillary crutch extension					
L0980	A		Peroneal straps pair					
L0982	A		Stocking supp grips set of f					
L0984	A		Protective body sock each					
L0999	A		Add to spinal orthosis NOS					
L1000	A		Ctlso milwauke initial model					
L1005	A		Tension based scoliosis orth					
L1010	A		Ctlso axilla sling					
L1020	A		Kyphosis pad					
L1025	A		Kyphosis pad floating					
L1030	A		Lumbar bolster pad					
L1040	A		Lumbar or lumbar rib pad					
L1050	A		Sternal pad					
L1060	A		Thoracic pad					
L1070	A		Trapezius sling					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L1080	A		Outrigger					
L1085	A		Outrigger bil w/ vert extens					
L1090	A		Lumbar sling					
L1100	A		Ring flange plastic/leather					
L1110	A		Ring flange plas/leather mol					
L1120	A		Covers for upright each					
L1200	A		Furnsh initial orthosis only					
L1210	A		Lateral thoracic extension					
L1220	A		Anterior thoracic extension					
L1230	A		Milwaukee type superstructur					
L1240	A		Lumbar derotation pad					
L1250	A		Anterior asis pad					
L1260	A		Anterior thoracic derotation					
L1270	A		Abdominal pad					
L1280	A		Rib gusset (elastic) each					
L1290	A		Lateral trochanteric pad					
L1300	A		Body jacket mold to patient					
L1310	A		Post-operative body jacket					
L1499	A		Spinal orthosis NOS					
L1500	A		Thkao mobility frame					
L1510	A		Thkao standing frame					
L1520	A		Thkao swivel walker					
L1600	A		Abduct hip flex frejka w cvr					
L1610	A		Abduct hip flex frejka covr					
L1620	A		Abduct hip flex pavlik harne					
L1630	A		Abduct control hip semi-flex					
L1640	A		Pelv band/spread bar thigh c					
L1650	A		HO abduction hip adjustable					
L1652	A		HO bi thighcuffs w sprdr bar					
L1660	A		HO abduction static plastic					
L1680	A		Pelvic & hip control thigh c					
L1685	A		Post-op hip abduct custom fa					
L1686	A		HO post-op hip abduction					
L1690	A		Combination bilateral HO					
L1700	A		Leg perthes orth toronto typ					
L1710	A		Legg perthes orth newington					
L1720	A		Legg perthes orthosis trilat					
L1730	A		Legg perthes orth scottish r					
L1750	A		Legg perthes sling					
L1755	A		Legg perthes patten bottom t					
L1800	A		Knee orthoses elas w stays					
L1810	A		Ko elastic with joints					
L1815	A		Elastic with condylar pads					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L1820	A		Ko elas w/ condyle pads & jo					
L1825	A		Ko elastic knee cap					
L1830	A		Ko immobilizer canvas longit					
L1831	A		Knee orth pos locking joint					
L1832	A		KO adj jnt pos rigid support					
L1834	A		Ko w/0 joint rigid molded to					
L1836	A		Rigid KO wo joints					
L1840	A		Ko derot ant cruciate custom					
L1843	A		KO single upright custom fit					
L1844	A		Ko w/adj jt rot cntrl molded					
L1845	A		Ko w/ adj flex/ext rotat cus					
L1846	A		Ko w adj flex/ext rotat mold					
L1847	A		KO adjustable w air chambers					
L1850	A		Ko swedish type					
L1855	A		Ko plas doub upright jnt mol					
L1858	A		Ko polycentric pneumatic pad					
L1860	A		Ko supracondylar socket mold					
L1870	A		Ko doub upright lacers molde					
L1880	A		Ko doub upright cuffs/lacers					
L1900	A		Afo sprng wir drsflx calf bd					
L1901	A		Prefab ankle orthosis					
L1902	A		Afo ankle gauntlet					
L1904	A		Afo molded ankle gauntlet					
L1906	A		Afo multiligamentus ankle su					
L1907	A		AFO supramalleolar custom					
L1910	A		Afo sing bar clasp attach sh					
L1920	A		Afo sing upright w/ adjust s					
L1930	A		Afo plastic					
L1932	Y	NI	Afo rig ant tib prefab TCF/=					
L1940	A		Afo molded to patient plasti					
L1945	A		Afo molded plas rig ant tib					
L1950	A		Afo spiral molded to pt plas					
L1951	A		AFO spiral prefabricated					
L1960	A		Afo pos solid ank plastic mo					
L1970	A		Afo plastic molded w/ankle j					
L1971	A		AFO w/ankle joint, prefab					
L1980	A		Afo sing solid stirrup calf					
L1990	A		Afo doub solid stirrup calf					
L2000	A		Kafo sing fre stirr thi/calf					
L2005	Y	NI	KAFO sng/dbl mechanical act					
L2010	A		Kafo sng solid stirrup w/o j					
L2020	A		Kafo dbl solid stirrup band/					
L2030	A		Kafo dbl solid stirrup w/o j					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L2035	A		KAFO plastic pediatric size					
L2036	A		Kafo plas doub free knee mol					
L2037	A		Kafo plas sing free knee mol					
L2038	A		Kafo w/o joint multi-axis an					
L2039	A		KAFO,plstic,medlat rotat con					
L2040	A		Hkafo torsion bil rot straps					
L2050	A		Hkafo torsion cable hip pelv					
L2060	A		Hkafo torsion ball bearing j					
L2070	A		Hkafo torsion unilat rot str					
L2080	A		Hkafo unilat torsion cable					
L2090	A		Hkafo unilat torsion ball br					
L2106	A		Afo tib fx cast plaster mold					
L2108	A		Afo tib fx cast molded to pt					
L2112	A		Afo tibial fracture soft					
L2114	A		Afo tib fx semi-rigid					
L2116	A		Afo tibial fracture rigid					
L2126	A		Kafo fem fx cast thermoplas					
L2128	A		Kafo fem fx cast molded to p					
L2132	A		Kafo femoral fx cast soft					
L2134	A		Kafo fem fx cast semi-rigid					
L2136	A		Kafo femoral fx cast rigid					
L2180	A		Plas shoe insert w ank joint					
L2182	A		Drop lock knee					
L2184	A		Limited motion knee joint					
L2186	A		Adj motion knee jnt lerman t					
L2188	A		Quadrilateral brim					
L2190	A		Waist belt					
L2192	A		Pelvic band & belt thigh fla					
L2200	A		Limited ankle motion ea jnt					
L2210	A		Dorsiflexion assist each joi					
L2220	A		Dorsi & plantar flex ass/res					
L2230	A		Split flat caliper stirr & p					
L2232	Y	NI	Rocker bottom, contact AFO					
L2240	A		Round caliper and plate atta					
L2250	A		Foot plate molded stirrup at					
L2260	A		Reinforced solid stirrup					
L2265	A		Long tongue stirrup					
L2270	A		Varus/valgus strap padded/li					
L2275	A		Plastic mod low ext pad/line					
L2280	A		Molded inner boot					
L2300	A		Abduction bar jointed adjust					
L2310	A		Abduction bar-straight					
L2320	A		Non-molded lacer					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L2330	A		Lacer molded to patient mode					
L2335	A		Anterior swing band					
L2340	A		Pre-tibial shell molded to p					
L2350	A		Prosthetic type socket molde					
L2360	A		Extended steel shank					
L2370	A		Patten bottom					
L2375	A		Torsion ank & half solid sti					
L2380	A		Torsion straight knee joint					
L2385	A		Straight knee joint heavy du					
L2390	A		Offset knee joint each					
L2395	A		Offset knee joint heavy duty					
L2397	A		Suspension sleeve lower ext					
L2405	A		Knee joint drop lock ea jnt					
L2415	A		Knee joint cam lock each joi					
L2425	A		Knee disc/dial lock/adj flex					
L2430	A		Knee jnt ratchet lock ea jnt					
L2435	D		Knee joint polycentric joint					
L2492	A		Knee lift loop drop lock rin					
L2500	A		Thi/glut/ischia wgt bearing					
L2510	A		Th/wght bear quad-lat brim m					
L2520	A		Th/wght bear quad-lat brim c					
L2525	A		Th/wght bear nar m-l brim mo					
L2526	A		Th/wght bear nar m-l brim cu					
L2530	A		Thigh/wght bear lacer non-mo					
L2540	A		Thigh/wght bear lacer molded					
L2550	A		Thigh/wght bear high roll cu					
L2570	A		Hip clevis type 2 posit jnt					
L2580	A		Pelvic control pelvic sling					
L2600	A		Hip clevis/thrust bearing fr					
L2610	A		Hip clevis/thrust bearing lo					
L2620	A		Pelvic control hip heavy dut					
L2622	A		Hip joint adjustable flexion					
L2624	A		Hip adj flex ext abduct cont					
L2627	A		Plastic mold recipro hip & c					
L2628	A		Metal frame recipro hip & ca					
L2630	A		Pelvic control band & belt u					
L2640	A		Pelvic control band & belt b					
L2650	A		Pelv & thor control gluteal					
L2660	A		Thoracic control thoracic ba					
L2670	A		Thorac cont paraspinal uprig					
L2680	A		Thorac cont lat support upri					
L2750	A		Plating chrome/nickel pr bar					
L2755	A		Carbon graphite lamination					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L2760	A		Extension per extension per					
L2768	A		Ortho sidebar disconnect					
L2770	A		Low ext orthosis per bar/jnt					
L2780	A		Non-corrosive finish					
L2785	A		Drop lock retainer each					
L2795	A		Knee control full kneecap					
L2800	A		Knee cap medial or lateral p					
L2810	A		Knee control condylar pad					
L2820	A		Soft interface below knee se					
L2830	A		Soft interface above knee se					
L2840	A		Tibial length sock fx or equ					
L2850	A		Femoral lgth sock fx or equa					
L2860	A		Torsion mechanism knee/ankle					
L2999	A		Lower extremity orthosis NOS					
L3000	B		Ft insert ucb berkeley shell					
L3001	B		Foot insert remov molded spe					
L3002	B		Foot insert plastazote or eq					
L3003	B		Foot insert silicone gel eac					
L3010	B		Foot longitudinal arch suppo					
L3020	B		Foot longitud/metatarsal sup					
L3030	B		Foot arch support remov prem					
L3031	E		Foot lamin/prepreg composite					
L3040	B		Ft arch suprt premold longit					
L3050	B		Foot arch supp premold metat					
L3060	B		Foot arch supp longitud/meta					
L3070	B		Arch suprt att to sho longit					
L3080	B		Arch supp att to shoe metata					
L3090	B		Arch supp att to shoe long/m					
L3100	B		Hallus-valgus nght dynamic s					
L3140	B		Abduction rotation bar shoe					
L3150	B		Abduct rotation bar w/o shoe					
L3160	B		Shoe styled positioning dev					
L3170	B		Foot plastic heel stabilizer					
L3201	B		Oxford w supinat/pronat inf					
L3202	B		Oxford w/ supinat/pronator c					
L3203	B		Oxford w/ supinator/pronator					
L3204	B		Hightop w/ supp/pronator inf					
L3206	B		Hightop w/ supp/pronator chi					
L3207	B		Hightop w/ supp/pronator jun					
L3208	B		Surgical boot each infant					
L3209	B		Surgical boot each child					
L3211	B		Surgical boot each junior					
L3212	B		Benesch boot pair infant					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L3213	B		Benesch boot pair child					
L3214	B		Benesch boot pair junior					
L3215	B		Orthopedic ftwear ladies oxf					
L3216	B		Orthoped ladies shoes dpth i					
L3217	B		Ladies shoes hightop depth i					
L3219	B		Orthopedic mens shoes oxford					
L3221	B		Orthopedic mens shoes dpth i					
L3222	B		Mens shoes hightop depth inl					
L3224	A		Woman's shoe oxford brace					
L3225	A		Man's shoe oxford brace					
L3230	B		Custom shoes depth inlay					
L3250	B		Custom mold shoe remov prost					
L3251	B		Shoe molded to pt silicone s					
L3252	B		Shoe molded plastazote cust					
L3253	B		Shoe molded plastazote cust					
L3254	B		Orth foot non-stndard size/w					
L3255	B		Orth foot non-standard size/					
L3257	B		Orth foot add charge split s					
L3260	B		Ambulatory surgical boot eac					
L3265	B		Plastazote sandal each					
L3300	B		Sho lift taper to metatarsal					
L3310	B		Shoe lift elev heel/sole neo					
L3320	B		Shoe lift elev heel/sole cor					
L3330	B		Lifts elevation metal extens					
L3332	B		Shoe lifts tapered to one-ha					
L3334	B		Shoe lifts elevation heel /i					
L3340	B		Shoe wedge sach					
L3350	B		Shoe heel wedge					
L3360	B		Shoe sole wedge outside sole					
L3370	B		Shoe sole wedge between sole					
L3380	B		Shoe clubfoot wedge					
L3390	B		Shoe outflare wedge					
L3400	B		Shoe metatarsal bar wedge ro					
L3410	B		Shoe metatarsal bar between					
L3420	B		Full sole/heel wedge btween					
L3430	B		Sho heel count plast reinfor					
L3440	B		Heel leather reinforced					
L3450	B		Shoe heel sach cushion type					
L3455	B		Shoe heel new leather standa					
L3460	B		Shoe heel new rubber standar					
L3465	B		Shoe heel thomas with wedge					
L3470	B		Shoe heel thomas extend to b					
L3480	B		Shoe heel pad & depress for					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L3485	B		Shoe heel pad removable for					
L3500	B		Ortho shoe add leather insol					
L3510	B		Orthopedic shoe add rub insl					
L3520	B		O shoe add felt w leath insl					
L3530	B		Ortho shoe add half sole					
L3540	B		Ortho shoe add full sole					
L3550	B		O shoe add standard toe tap					
L3560	B		O shoe add horseshoe toe tap					
L3570	B		O shoe add instep extension					
L3580	B		O shoe add instep velcro clo					
L3590	B		O shoe convert to sof counte					
L3595	B		Ortho shoe add march bar					
L3600	B		Trans shoe calip plate exist					
L3610	B		Trans shoe caliper plate new					
L3620	B		Trans shoe solid stirrup exi					
L3630	B		Trans shoe solid stirrup new					
L3640	B		Shoe dennis browne splint bo					
L3649	B		Orthopedic shoe modifica NOS					
L3650	A		Shlder fig 8 abduct restrain					
L3651	A		Prefab shoulder orthosis					
L3652	A		Prefab dbl shoulder orthosis					
L3660	A		Abduct restrainer canvas&web					
L3670	A		Acromio/clavicular canvas&we					
L3675	A		Canvas vest SO					
L3677	E		SO hard plastic stabilizer					
L3700	A		Elbow orthoses elas w stays					
L3701	A		Prefab elbow orthosis					
L3710	A		Elbow elastic with metal joi					
L3720	A		Forearm/arm cuffs free motio					
L3730	A		Forearm/arm cuffs ext/flex a					
L3740	A		Cuffs adj lock w/ active con					
L3760	A		EO withjoint, Prefabricated					
L3762	A		Rigid EO wo joints					
L3800	A		Whfo short opponen no attach					
L3805	A		Whfo long opponens no attach					
L3807	A		WHFO,no joint, prefabricated					
L3810	A		Whfo thumb abduction bar					
L3815	A		Whfo second m.p. abduction a					
L3820	A		Whfo ip ext asst w/ mp ext s					
L3825	A		Whfo m.p. extension stop					
L3830	A		Whfo m.p. extension assist					
L3835	A		Whfo m.p. spring extension a					
L3840	A		Whfo spring swivel thumb					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L3845	A		Whfo thumb ip ext ass w/ mp					
L3850	A		Action wrist w/ dorsiflex as					
L3855	A		Whfo adj m.p. flexion contro					
L3860	A		Whfo adj m.p. flex ctrl & i.					
L3890	B		Torsion mechanism wrist/elbo					
L3900	A		Hinge extension/flex wrist/f					
L3901	A		Hinge ext/flex wrist finger					
L3902	E		Whfo ext power compress gas					
L3904	A		Whfo electric custom fitted					
L3906	A		Wrist gauntlet molded to pt					
L3907	A		Whfo wrst gauntlt thmb spica					
L3908	A		Wrist cock-up non-molded					
L3909	A		Prefab wrist orthosis					
L3910	A		Whfo swanson design					
L3911	A		Prefab hand finger orthosis					
L3912	A		Flex glove w/elastic finger					
L3914	A		WHO wrist extension cock-up					
L3916	A		Whfo wrist extens w/ outrigg					
L3917	A		Prefab metacarpl fx orthosis					
L3918	A		HFO knuckle bender					
L3920	A		Knuckle bender with outrigge					
L3922	A		Knuckle bend 2 seg to flex j					
L3923	A		HFO, no joint, prefabricated					
L3924	A		Oppenheimer					
L3926	A		Thomas suspension					
L3928	A		Finger extension w/ clock sp					
L3930	A		Finger extension with wrist					
L3932	A		Safety pin spring wire					
L3934	A		Safety pin modified					
L3936	A		Palmer					
L3938	A		Dorsal wrist					
L3940	A		Dorsal wrist w/ outrigger at					
L3942	A		Reverse knuckle bender					
L3944	A		Reverse knuckle bend w/ outr					
L3946	A		HFO composite elastic					
L3948	A		Finger knuckle bender					
L3950	A		Oppenheimer w/ knuckle bend					
L3952	A		Oppenheimer w/ rev knuckle 2					
L3954	A		Spreading hand					
L3956	A		Add joint upper ext orthosis					
L3960	A		Sewho airplan desig abdu pos					
L3962	A		Sewho erbs palsey design abd					
L3963	A		Molded w/ articulating elbow					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L3964	Y		Seo mobile arm sup att to wc					
L3965	Y		Arm supp att to wc rancho ty					
L3966	Y		Mobile arm supports reclinin					
L3968	Y		Friction dampening arm supp					
L3969	Y		Monosuspension arm/hand supp					
L3970	Y		Elevat proximal arm support					
L3972	Y		Offset/lat rocker arm w/ ela					
L3974	Y		Mobile arm support supinator					
L3980	A		Upp ext fx orthosis humeral					
L3982	A		Upper ext fx orthosis rad/ul					
L3984	A		Upper ext fx orthosis wrist					
L3985	A		Forearm hand fx orth w/ wr h					
L3986	A		Humeral rad/ulna wrist fx or					
L3995	A		Sock fracture or equal each					
L3999	A		Upper limb orthosis NOS					
L4000	A		Repl girdle milwaukee orth					
L4002	Y	NI	Replace strap, any orthosis					
L4010	A		Replace trilateral socket br					
L4020	A		Replace quadlat socket brim					
L4030	A		Replace socket brim cust fit					
L4040	A		Replace molded thigh lacer					
L4045	A		Replace non-molded thigh lac					
L4050	A		Replace molded calf lacer					
L4055	A		Replace non-molded calf lace					
L4060	A		Replace high roll cuff					
L4070	A		Replace prox & dist upright					
L4080	A		Repl met band kafo-afo prox					
L4090	A		Repl met band kafo-afo calf/					
L4100	A		Repl leath cuff kafo prox th					
L4110	A		Repl leath cuff kafo-afo cal					
L4130	A		Replace pretibial shell					
L4205	A		Ortho dvc repair per 15 min					
L4210	A		Orth dev repair/repl minor p					
L4350	A		Ankle control orthosi prefab					
L4360	A		Pneumati walking boot prefab					
L4370	A		Pneumatic full leg splint					
L4380	A		Pneumatic knee splint					
L4386	A		Non-pneum walk boot prefab					
L4392	A		Replace AFO soft interface					
L4394	A		Replace foot drop spint					
L4396	A		Static AFO					
L4398	A		Foot drop splint recumbent					
L5000	A		Sho insert w arch toe filler					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L5010	A		Mold socket ank hgt w/ toe f					
L5020	A		Tibial tubercle hgt w/ toe f					
L5050	A		Ank symes mold sckt sach ft					
L5060	A		Symes met fr leath socket ar					
L5100	A		Molded socket shin sach foot					
L5105	A		Plast socket jts/thgh lacer					
L5150	A		Mold sckt ext knee shin sach					
L5160	A		Mold socket bent knee shin s					
L5200	A		Kne sing axis fric shin sach					
L5210	A		No knee/ankle joints w/ ft b					
L5220	A		No knee joint with artic ali					
L5230	A		Fem focal defic constant fri					
L5250	A		Hip canad sing axi cons fric					
L5270	A		Tilt table locking hip sing					
L5280	A		Hemipelvect canad sing axis					
L5301	A		BK mold socket SACH ft endo					
L5311	A		Knee disart, SACH ft, endo					
L5321	A		AK open end SACH					
L5331	A		Hip disart canadian SACH ft					
L5341	A		Hemipelvectomy canadian SACH					
L5400	A		Postop dress & 1 cast chg bk					
L5410	A		Postop dsg bk ea add cast ch					
L5420	A		Postop dsg & 1 cast chg ak/d					
L5430	A		Postop dsg ak ea add cast ch					
L5450	A		Postop app non-wgt bear dsg					
L5460	A		Postop app non-wgt bear dsg					
L5500	A		Init bk ptb plaster direct					
L5505	A		Init ak ischal plstr direct					
L5510	A		Prep BK ptb plaster molded					
L5520	A		Perp BK ptb thermopls direct					
L5530	A		Prep BK ptb thermopls molded					
L5535	A		Prep BK ptb open end socket					
L5540	A		Prep BK ptb laminated socket					
L5560	A		Prep AK ischial plast molded					
L5570	A		Prep AK ischial direct form					
L5580	A		Prep AK ischial thermo mold					
L5585	A		Prep AK ischial open end					
L5590	A		Prep AK ischial laminated					
L5595	A		Hip disartic sach thermopls					
L5600	A		Hip disart sach laminat mold					
L5610	A		Above knee hydracadence					
L5611	A		Ak 4 bar link w/fric swing					
L5613	A		Ak 4 bar ling w/hydraul swig					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L5614	A		4-bar link above knee w/swng					
L5616	A		Ak univ multiplex sys frict					
L5617	A		AK/BK self-aligning unit ea					
L5618	A		Test socket symes					
L5620	A		Test socket below knee					
L5622	A		Test socket knee disarticula					
L5624	A		Test socket above knee					
L5626	A		Test socket hip disarticulat					
L5628	A		Test socket hemipelvectomy					
L5629	A		Below knee acrylic socket					
L5630	A		Syme typ expandabl wall sckt					
L5631	A		Ak/knee disartic acrylic soc					
L5632	A		Symes type ptb brim design s					
L5634	A		Symes type poster opening so					
L5636	A		Symes type medial opening so					
L5637	A		Below knee total contact					
L5638	A		Below knee leather socket					
L5639	A		Below knee wood socket					
L5640	A		Knee disarticulat leather so					
L5642	A		Above knee leather socket					
L5643	A		Hip flex inner socket ext fr					
L5644	A		Above knee wood socket					
L5645	A		Bk flex inner socket ext fra					
L5646	A		Below knee cushion socket					
L5647	A		Below knee suction socket					
L5648	A		Above knee cushion socket					
L5649	A		Isch containmt/narrow m-l so					
L5650	A		Tot contact ak/knee disart s					
L5651	A		Ak flex inner socket ext fra					
L5652	A		Suction susp ak/knee disart					
L5653	A		Knee disart expand wall sock					
L5654	A		Socket insert symes					
L5655	A		Socket insert below knee					
L5656	A		Socket insert knee articulat					
L5658	A		Socket insert above knee					
L5661	A		Multi-durometer symes					
L5665	A		Multi-durometer below knee					
L5666	A		Below knee cuff suspension					
L5668	A		Socket insert w/o lock lower					
L5670	A		Bk molded supracondylar susp					
L5671	A		BK/AK locking mechanism					
L5672	A		Bk removable medial brim sus					
L5673	A		Socket insert w lock mech					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L5674	D		Bk suspension sleeve					
L5675	D		Bk heavy duty susp sleeve					
L5676	A		Bk knee joints single axis p					
L5677	A		Bk knee joints polycentric p					
L5678	A		Bk joint covers pair					
L5679	A		Socket insert w/o lock mech					
L5680	A		Bk thigh lacer non-molded					
L5681	A		Intl custm cong/latyp insert					
L5682	A		Bk thigh lacer glut/ischia m					
L5683	A		Initial custom socket insert					
L5684	A		Bk fork strap					
L5685	Y	NI	Below knee sus/seal sleeve					
L5686	A		Bk back check					
L5688	A		Bk waist belt webbing					
L5690	A		Bk waist belt padded and lin					
L5692	A		Ak pelvic control belt light					
L5694	A		Ak pelvic control belt pad/l					
L5695	A		Ak sleeve susp neoprene/equa					
L5696	A		Ak/knee disartic pelvic join					
L5697	A		Ak/knee disartic pelvic band					
L5698	A		Ak/knee disartic silesian ba					
L5699	A		Shoulder harness					
L5700	A		Replace socket below knee					
L5701	A		Replace socket above knee					
L5702	A		Replace socket hip					
L5704	A		Custom shape cover BK					
L5705	A		Custom shape cover AK					
L5706	A		Custom shape cvr knee disart					
L5707	A		Custom shape cvr hip disart					
L5710	A		Kne-shin exo sng axi mnl loc					
L5711	A		Knee-shin exo mnl lock ultra					
L5712	A		Knee-shin exo frict swg & st					
L5714	A		Knee-shin exo variable frict					
L5716	A		Knee-shin exo mech stance ph					
L5718	A		Knee-shin exo frct swg & sta					
L5722	A		Knee-shin pneum swg frct exo					
L5724	A		Knee-shin exo fluid swing ph					
L5726	A		Knee-shin ext jnts fld swg e					
L5728	A		Knee-shin fluid swg & stance					
L5780	A		Knee-shin pneum/hydra pneum					
L5781	A		Lower limb pros vacuum pump					
L5782	A		HD low limb pros vacuum pump					
L5785	A		Exoskeletal bk ultralt mater					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L5790	A		Exoskeletal ak ultra-light m					
L5795	A		Exoskel hip ultra-light mate					
L5810	A		Endoskel knee-shin mnl lock					
L5811	A		Endo knee-shin mnl lck ultra					
L5812	A		Endo knee-shin frct swg & st					
L5814	A		Endo knee-shin hydral swg ph					
L5816	A		Endo knee-shin polyc mch sta					
L5818	A		Endo knee-shin frct swg & st					
L5822	A		Endo knee-shin pneum swg frc					
L5824	A		Endo knee-shin fluid swing p					
L5826	A		Miniature knee joint					
L5828	A		Endo knee-shin fluid swg/sta					
L5830	A		Endo knee-shin pneum/swg pha					
L5840	A		Multi-axial knee/shin system					
L5845	A		Knee-shin sys stance flexion					
L5846	D		Knee-shin sys microprocessor					
L5847	D		Microprocessor cntrl feature					
L5848	A		Knee-shin sys hydraul stance					
L5850	A		Endo ak/hip knee extens assi					
L5855	A		Mech hip extension assist					
L5856	Y	NI	Elec knee-shin swing/stance					
L5857	Y	NI	Elec knee-shin swing only					
L5910	A		Endo below knee alignable sy					
L5920	A		Endo ak/hip alignable system					
L5925	A		Above knee manual lock					
L5930	A		High activity knee frame					
L5940	A		Endo bk ultra-light material					
L5950	A		Endo ak ultra-light material					
L5960	A		Endo hip ultra-light materia					
L5962	A		Below knee flex cover system					
L5964	A		Above knee flex cover system					
L5966	A		Hip flexible cover system					
L5968	A		Multiaxial ankle w dorsiflex					
L5970	A		Foot external keel sach foot					
L5972	A		Flexible keel foot					
L5974	A		Foot single axis ankle/foot					
L5975	A		Combo ankle/foot prosthesis					
L5976	A		Energy storing foot					
L5978	A		Ft prosth multiaxial ankl/ft					
L5979	A		Multi-axial ankle/ft prosth					
L5980	A		Flex foot system					
L5981	A		Flex-walk sys low ext prosth					
L5982	A		Exoskeletal axial rotation u					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L5984	A		Endoskeletal axial rotation					
L5985	A		Lwr ext dynamic prosth pylon					
L5986	A		Multi-axial rotation unit					
L5987	A		Shank ft w vert load pylon					
L5988	A		Vertical shock reducing pylo					
L5989	D		Pylon w elctrnc force sensor					
L5990	A		User adjustable heel height					
L5995	A		Lower ext pros heavyduty fea					
L5999	A		Lowr extremity prosthes NOS					
L6000	A		Par hand robin-aids thum rem					
L6010	A		Hand robin-aids little/ring					
L6020	A		Part hand robin-aids no fing					
L6025	A		Part hand disart myoelectric					
L6050	A		Wrst MLd sck flx hng tri pad					
L6055	A		Wrst mold sock w/exp interfa					
L6100	A		Elb mold sock flex hinge pad					
L6110	A		Elbow mold sock suspension t					
L6120	A		Elbow mold doub splt soc ste					
L6130	A		Elbow stump activated lock h					
L6200	A		Elbow mold outsid lock hinge					
L6205	A		Elbow molded w/ expand inter					
L6250	A		Elbow inter loc elbow forarm					
L6300	A		Shlder disart int lock elbow					
L6310	A		Shoulder passive restor comp					
L6320	A		Shoulder passive restor cap					
L6350	A		Thoracic intern lock elbow					
L6360	A		Thoracic passive restor comp					
L6370	A		Thoracic passive restor cap					
L6380	A		Postop dsg cast chg wrst/elb					
L6382	A		Postop dsg cast chg elb dis/					
L6384	A		Postop dsg cast chg shlder/t					
L6386	A		Postop ea cast chg & realign					
L6388	A		Postop applicat rigid dsg on					
L6400	A		Below elbow prosth tiss shap					
L6450	A		Elb disart prosth tiss shap					
L6500	A		Above elbow prosth tiss shap					
L6550	A		Shldr disar prosth tiss shap					
L6570	A		Scap thorac prosth tiss shap					
L6580	A		Wrist/elbow bowden cable mol					
L6582	A		Wrist/elbow bowden cbl dir f					
L6584	A		Elbow fair lead cable molded					
L6586	A		Elbow fair lead cable dir fo					
L6588	A		Shdr fair lead cable molded					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L6590	A		Shdr fair lead cable direct					
L6600	A		Polycentric hinge pair					
L6605	A		Single pivot hinge pair					
L6610	A		Flexible metal hinge pair					
L6615	A		Disconnect locking wrist uni					
L6616	A		Disconnect insert locking wr					
L6620	A		Flexion/extension wrist unit					
L6623	A		Spring-ass rot wrst w/ latch					
L6625	A		Rotation wrst w/ cable lock					
L6628	A		Quick disconn hook adapter o					
L6629	A		Lamination collar w/ couplin					
L6630	A		Stainless steel any wrist					
L6632	A		Latex suspension sleeve each					
L6635	A		Lift assist for elbow					
L6637	A		Nudge control elbow lock					
L6638	A		Elec lock on manual pw elbow					
L6640	A		Shoulder abduction joint pai					
L6641	A		Excursion amplifier pulley t					
L6642	A		Excursion amplifier lever ty					
L6645	A		Shoulder flexion-abduction j					
L6646	A		Multipo locking shoulder jnt					
L6647	A		Shoulder lock actuator					
L6648	A		Ext pwrd shlder lock/unlock					
L6650	A		Shoulder universal joint					
L6655	A		Standard control cable extra					
L6660	A		Heavy duty control cable					
L6665	A		Teflon or equal cable lining					
L6670	A		Hook to hand cable adapter					
L6672	A		Harness chest/shlder saddle					
L6675	A		Harness figure of 8 sing con					
L6676	A		Harness figure of 8 dual con					
L6680	A		Test sock wrist disart/bel e					
L6682	A		Test sock elbw disart/above					
L6684	A		Test socket shldr disart/tho					
L6686	A		Suction socket					
L6687	A		Frame typ socket bel elbow/w					
L6688	A		Frame typ sock above elb/dis					
L6689	A		Frame typ socket shoulder di					
L6690	A		Frame typ sock interscap-tho					
L6691	A		Removable insert each					
L6692	A		Silicone gel insert or equal					
L6693	A		Lockingelbow forearm cntrbal					
L6694	Y	NI	Elbow socket ins use w/lock					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L6695	Y	NI	Elbow socket ins use w/o lck					
L6696	Y	NI	Cus elbo skt in for con/atyp					
L6697	Y	NI	Cus elbo skt in not con/atyp					
L6698	Y	NI	Below/above elbow lock mech					
L6700	A		Terminal device model #3					
L6705	A		Terminal device model #5					
L6710	A		Terminal device model #5x					
L6715	A		Terminal device model #5xa					
L6720	A		Terminal device model #6					
L6725	A		Terminal device model #7					
L6730	A		Terminal device model #7lo					
L6735	A		Terminal device model #8					
L6740	A		Terminal device model #8x					
L6745	A		Terminal device model #88x					
L6750	A		Terminal device model #10p					
L6755	A		Terminal device model #10x					
L6765	A		Terminal device model #12p					
L6770	A		Terminal device model #99x					
L6775	A		Terminal device model#555					
L6780	A		Terminal device model #ss555					
L6790	A		Hooks-accu hook or equal					
L6795	A		Hooks-2 load or equal					
L6800	A		Hooks-aprl vc or equal					
L6805	A		Modifier wrist flexion unit					
L6806	A		Trs grip vc or equal					
L6807	A		Term device grip1/2 or equal					
L6808	A		Term device infant or child					
L6809	A		Trs super sport passive					
L6810	A		Pincher tool otto bock or eq					
L6825	A		Hands dorrance vo					
L6830	A		Hand aprl vc					
L6835	A		Hand sierra vo					
L6840	A		Hand becker imperial					
L6845	A		Hand becker lock grip					
L6850	A		Term dvc-hand becker plylite					
L6855	A		Hand robin-aids vo					
L6860	A		Hand robin-aids vo soft					
L6865	A		Hand passive hand					
L6867	A		Hand detroit infant hand					
L6868	A		Passive inf hand steeper/hos					
L6870	A		Hand child mitt					
L6872	A		Hand nyu child hand					
L6873	A		Hand mech inf steeper or equ					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L6875	A		Hand bock vc					
L6880	A		Hand bock vo					
L6881	A		Autograsp feature ul term dv					
L6882	A		Microprocessor control uplmb					
L6890	A		Prefab glove for term device					
L6895	A		Custom glove for term device					
L6900	A		Hand restorat thumb/1 finger					
L6905	A		Hand restoration multiple fi					
L6910	A		Hand restoration no fingers					
L6915	A		Hand restoration replacmnt g					
L6920	A		Wrist disarticul switch ctrl					
L6925	A		Wrist disart myoelectronic c					
L6930	A		Below elbow switch control					
L6935	A		Below elbow myoelectronic ct					
L6940	A		Elbow disarticulation switch					
L6945	A		Elbow disart myoelectronic c					
L6950	A		Above elbow switch control					
L6955	A		Above elbow myoelectronic ct					
L6960	A		Shldr disartic switch contro					
L6965	A		Shldr disartic myoelectronic					
L6970	A		Interscapular-thor switch ct					
L6975	A		Interscap-thor myoelectronic					
L7010	A		Hand otto back steeper/eq sw					
L7015	A		Hand sys teknik village swit					
L7020	A		Electronic greifer switch ct					
L7025	A		Electron hand myoelectronic					
L7030	A		Hand sys teknik vill myoelec					
L7035	A		Electron greifer myoelectro					
L7040	A		Prehensile actuator hosmer s					
L7045	A		Electron hook child michigan					
L7170	A		Electronic elbow hosmer swit					
L7180	A		Electronic elbow sequential					
L7181	Y	NI	Electronic elbo simultaneous					
L7185	A		Electron elbow adolescent sw					
L7186	A		Electron elbow child switch					
L7190	A		Elbow adolescent myoelectron					
L7191	A		Elbow child myoelectronic ct					
L7260	A		Electron wrist rotator otto					
L7261	A		Electron wrist rotator utah					
L7266	A		Servo control steeper or equ					
L7272	A		Analogue control unb or equa					
L7274	A		Proportional ctl 12 volt uta					
L7360	A		Six volt bat otto bock/eq ea					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L7362	A		Battery chrgr six volt otto					
L7364	A		Twelve volt battery utah/equ					
L7366	A		Battery chrgr 12 volt utah/e					
L7367	A		Replacemnt lithium ionbatter					
L7368	A		Lithium ion battery charger					
L7499	A		Upper extremity prosthes NOS					
L7500	A		Prosthetic dvc repair hourly					
L7510	A		Prosthetic device repair rep					
L7520	A		Repair prosthesis per 15 min					
L7900	A		Male vacuum erection system					
L8000	A		Mastectomy bra					
L8001	A		Breast prosthesis bra & form					
L8002	A		Brst prsth bra & bilat form					
L8010	A		Mastectomy sleeve					
L8015	A		Ext breastprosthesis garment					
L8020	A		Mastectomy form					
L8030	A		Breast prosthesis silicone/e					
L8035	A		Custom breast prosthesis					
L8039	A		Breast prosthesis NOS					
L8040	A		Nasal prosthesis					
L8041	A		Midfacial prosthesis					
L8042	A		Orbital prosthesis					
L8043	A		Upper facial prosthesis					
L8044	A		Hemi-facial prosthesis					
L8045	A		Auricular prosthesis					
L8046	A		Partial facial prosthesis					
L8047	A		Nasal septal prosthesis					
L8048	A		Unspec maxillofacial prosth					
L8049	A		Repair maxillofacial prosth					
L8100	E		Compression stocking BK18-30					
L8110	A		Compression stocking BK30-40					
L8120	A		Compression stocking BK40-50					
L8130	E		Gc stocking thighlngth 18-30					
L8140	E		Gc stocking thighlngth 30-40					
L8150	E		Gc stocking thighlngth 40-50					
L8160	E		Gc stocking full lngth 18-30					
L8170	E		Gc stocking full lngth 30-40					
L8180	E		Gc stocking full lngth 40-50					
L8190	E		Gc stocking waistlngth 18-30					
L8195	E		Gc stocking waistlngth 30-40					
L8200	E		Gc stocking waistlngth 40-50					
L8210	E		Gc stocking custom made					
L8220	E		Gc stocking lymphedema					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L8230	E		Gc stocking garter belt					
L8239	E		G compression stocking NOS					
L8300	A		Truss single w/ standard pad					
L8310	A		Truss double w/ standard pad					
L8320	A		Truss addition to std pad wa					
L8330	A		Truss add to std pad scrotal					
L8400	A		Sheath below knee					
L8410	A		Sheath above knee					
L8415	A		Sheath upper limb					
L8417	A		Pros sheath/sock w gel cushn					
L8420	A		Prosthetic sock multi ply BK					
L8430	A		Prosthetic sock multi ply AK					
L8435	A		Pros sock multi ply upper lm					
L8440	A		Shrinker below knee					
L8460	A		Shrinker above knee					
L8465	A		Shrinker upper limb					
L8470	A		Pros sock single ply BK					
L8480	A		Pros sock single ply AK					
L8485	A		Pros sock single ply upper l					
L8490	D		Air seal suction reten systm					
L8499	A		Unlisted misc prosthetic ser					
L8500	A		Artificial larynx					
L8501	A		Tracheostomy speaking valve					
L8505	A		Artificial larynx, accessory					
L8507	A		Trach-esoph voice pros pt in					
L8509	A		Trach-esoph voice pros md in					
L8510	A		Voice amplifier					
L8511	A		Indwelling trach insert					
L8512	A		Gel cap for trach voice pros					
L8513	A		Trach pros cleaning device					
L8514	A		Repl trach puncture dilator					
L8515	Y	NI	Gel cap app device for trach					
L8600	N		Implant breast silicone/eq					
L8603	N		Collagen imp urinary 2.5 ml					
L8606	N		Synthetic implnt urinary 1ml					
L8610	N		Ocular implant					
L8612	N		Aqueous shunt prosthesis					
L8613	N		Ossicular implant					
L8614	N		Cochlear device/system					
L8615	Y	NI	Coch implant headset replace					
L8616	Y	NI	Coch implant microphone repl					
L8617	Y	NI	Coch implant trans coil repl					
L8618	Y	NI	Coch implant tran cable repl					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L8619	A		Replace cochlear processor					
L8620	Y	NI	Repl lithium ion battery					
L8621	Y	NI	Repl zinc air battery					
L8622	Y	NI	Repl alkaline battery					
L8630	N		Metacarpophalangeal implant					
L8631	A		MCP joint repl 2 pc or more					
L8641	N		Metatarsal joint implant					
L8642	N		Hallux implant					
L8658	N		Interphalangeal joint spacer					
L8659	A		Interphalangeal joint repl					
L8670	N		Vascular graft, synthetic					
L8699	N		Prosthetic implant NOS					
L9900	A		O&P supply/accessory/service					
M0064	X		Visit for drug monitoring	0374	1.0880	62.00		12.40
M0075	E		Cellular therapy					
M0076	E		Prolotherapy					
M0100	E		Intragastric hypothermia					
M0300	E		IV chelationtherapy					
M0301	E		Fabric wrapping of aneurysm					
P2028	A		Cephalin floculation test					
P2029	A		Congo red blood test					
P2031	E		Hair analysis					
P2033	A		Blood thymol turbidity					
P2038	A		Blood mucoprotein					
P3000	A		Screen pap by tech w md supv					
P3001	B		Screening pap smear by phys					
P7001	E		Culture bacterial urine					
P9010	K		Whole blood for transfusion	0950	1.9805	112.85		22.57
P9011	K		Blood split unit	0967	1.4533	82.81		16.56
P9012	K		Cryoprecipitate each unit	0952	0.8467	48.25		9.65
P9016	K		RBC leukocytes reduced	0954	2.9079	165.70		33.14
P9017	K		Plasma 1 donor frz w/in 8 hr	9508	1.1117	63.35		12.67
P9019	K		Platelets, each unit	0957	0.8453	48.17		9.63
P9020	K		Plaelet rich plasma unit	0958	2.6561	151.35		30.27
P9021	K		Red blood cells unit	0959	1.9881	113.29		22.66
P9022	K		Washed red blood cells unit	0960	3.4014	193.82		38.76
P9023	K		Frozen plasma, pooled, sd	0949	1.3689	78.00		15.60
P9031	K		Platelets leukocytes reduced	1013	1.5161	86.39		17.28
P9032	K		Platelets, irradiated	9500	1.5559	88.66		17.73
P9033	K		Platelets leukoreduced irrad	0968	2.7068	154.24		30.85
P9034	K		Platelets, pheresis	9507	7.6823	437.76		87.55
P9035	K		Platelet pheres leukoreduced	9501	8.3026	473.11		94.62
P9036	K		Platelet pheresis irradiated	9502	5.8578	333.80		66.76

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
P9037	K		Plate pheres leukoredu irrad	1019	10.3081	587.39		117.48
P9038	K		RBC irradiated	9505	2.0849	118.80		23.76
P9039	K		RBC deglycerolized	9504	5.2108	296.93		59.39
P9040	K		RBC leukoreduced irradiated	0969	3.6080	205.59		41.12
P9041	K		Albumin (human),5%, 50ml	0961	0.3303	18.82		3.76
P9043	K		Plasma protein fract,5%,50ml	0956	1.1719	66.78		13.36
P9044	K		Cryoprecipitatereducedplasma	1009	1.0793	61.50		12.30
P9045	K		Albumin (human), 5%, 250 ml	0963	1.0624	60.54		12.11
P9046	K		Albumin (human), 25%, 20 ml	0964	0.2284	13.01		2.60
P9047	K		Albumin (human), 25%, 50ml	0965	0.9181	52.32		10.46
P9048	K		Plasmaprotein fract,5%,250ml	0966	5.6751	323.38		64.68
P9050	K		Granulocytes, pheresis unit	9506	17.8797	1018.84		203.77
P9051	K		Blood, l/r, cmv-neg	1010	2.9433	167.72		33.54
P9052	K		Platelets, hla-m, l/r, unit	1011	9.9709	568.17		113.63
P9053	K		Plt, pher, l/r cmv-neg, irr	1020	9.7863	557.65		111.53
P9054	K		Blood, l/r, froz/degly/wash	1016	4.7085	268.30		53.66
P9055	K		Plt, aph/pher, l/r, cmv-neg	1017	8.3586	476.30		95.26
P9056	K		Blood, l/r, irradiated	1018	3.2064	182.71		36.54
P9057	K		RBC, frz/deg/wsh, l/r, irrad	1021	5.5861	318.31		63.66
P9058	K		RBC, l/r, cmv-neg, irrad	1022	4.7977	273.39		54.68
P9059	K		Plasma, frz between 8-24hour	0955	1.3026	74.23		14.85
P9060	K		Fr frz plasma donor retested	9503	1.3397	76.34		15.27
P9603	A		One-way allow prorated miles					
P9604	A		One-way allow prorated trip					
P9612	N		Catheterize for urine spec					
P9615	N		Urine specimen collect mult					
Q0035	X		Cardiokymography	0100	2.4975	142.32	41.44	28.46
Q0081	B		Infusion ther other than che					
Q0083	B		Chemo by other than infusion					
Q0084	B		Chemotherapy by infusion					
Q0085	B		Chemo by both infusion and o					
Q0091	T		Obtaining screen pap smear	0191	0.1831	10.43	2.93	2.09
Q0092	N		Set up port xray equipment					
Q0111	A		Wet mounts/ w preparations					
Q0112	A		Potassium hydroxide preps					
Q0113	A		Pinworm examinations					
Q0114	A		Fern test					
Q0115	A		Post-coital mucous exam					
Q0136	K		Non esrd epoetin alpha inj	0733		11.09		2.22
Q0137	K		Darbepoetin alfa, non-esrd	0734		3.66		0.73
Q0144	E		Azithromycin dihydrate, oral					
Q0163	N		Diphenhydramine HCl 50mg					
Q0164	N		Prochlorperazine maleate 5mg					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
Q0165	B		Prochlorperazine maleate10mg					
Q0166	K		Granisetron HCl 1 mg oral	0765		39.04		7.81
Q0167	N		Dronabinol 2.5mg oral					
Q0168	B		Dronabinol 5mg oral					
Q0169	N		Promethazine HCl 12.5mg oral					
Q0170	B		Promethazine HCl 25 mg oral					
Q0171	N		Chlorpromazine HCl 10mg oral					
Q0172	B		Chlorpromazine HCl 25mg oral					
Q0173	N		Trimethobenzamide HCl 250mg					
Q0174	N		Thiethylperazine maleate10mg					
Q0175	N		Perphenazine 4mg oral					
Q0176	B		Perphenazine 8mg oral					
Q0177	N		Hydroxyzine pamoate 25mg					
Q0178	B		Hydroxyzine pamoate 50mg					
Q0179	K		Ondansetron HCl 8mg oral	0769		26.12		5.22
Q0180	K		Dolasetron mesylate oral	0763		63.28		12.66
Q0181	E		Unspecified oral anti-emetic					
Q0182	D		Nonmetabolic act d/e tissue					
Q0183	D		Nonmetabolic active tissue					
Q0187	K		Factor viia recombinant	1409		1410.34		282.07
Q1001	N		Ntiol category 1					
Q1002	N		Ntiol category 2					
Q1003	N		Ntiol category 3					
Q1004	N		Ntiol category 4					
Q1005	N		Ntiol category 5					
Q2001	E		Oral cabergoline 0.5 mg					
Q2002	K		Elliotts b solution per ml	7022		1.50		0.30
Q2003	K		Aprotinin, 10,000 kiu	7019		12.51		2.50
Q2004	N		Bladder calculi irrig sol					
Q2005	K		Corticorelin ovine triflutat	7024		353.70		70.74
Q2006	K		Digoxin immune fab (ovine)	7025		332.00		66.40
Q2007	K		Ethanolamine oleate 100 mg	7026		63.29		12.66
Q2008	K		Fomepizole, 15 mg	7027		10.04		2.01
Q2009	K		Fosphenytoin, 50 mg	7028		5.31		1.06
Q2011	K		Hemin, per 1 mg	7030		6.47		1.29
Q2012	N		Pegademase bovine, 25 iu					
Q2013	K		Pentastarch 10% solution	7040		131.99		26.40
Q2014	N		Sermorelin acetate, 0.5 mg					
Q2017	K		Teniposide, 50 mg	7035		224.94		44.99
Q2018	K		Urofollitropin, 75 iu	7037		56.59		11.32
Q2019	K		Basiliximab	1615		1461.34		292.27
Q2020	E		Histrelin acetate					
Q2021	K		Lepirudin	9057		130.30		26.06

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
Q2022	K		VonWillebrandFactrCmplxperIU	1618		0.83		0.17
Q3000	K		Rubidium RB-82	9025		153.39		30.68
Q3001	N		Brachytherapy Radioelements					
Q3002	K		Gallium ga 67	1619		27.10		5.42
Q3003	K		Technetium tc99m bicisate	1620		370.60		74.12
Q3004	N		Xenon xe 133					
Q3005	K		Technetium tc99m mertiatide	1622		31.13		6.23
Q3006	N		Technetium tc99m glucepatate					
Q3007	K		Sodium phosphate p32	1624		94.98		19.00
Q3008	K		Indium 111-in pentetreotide	1625		1079.00		215.80
Q3009	N		Technetium tc99m oxidronate					
Q3010	N		Technetium tc99mlabeledrbcs					
Q3011	K		Chromic phosphate p32	1628	2.5841	147.25		29.45
Q3012	K		Cyanocobalamin cobalt co57	1089		85.49		17.10
Q3014	A		Telehealth facility fee					
Q3019	A		ALS emer trans no ALS serv					
Q3020	A		ALS nonemer trans no ALS ser					
Q3025	K		IM inj interferon beta 1-a	9022		74.44		14.89
Q3026	E		Subc inj interferon beta-1a					
Q3031	N		Collagen skin test					
Q4001	B		Cast sup body cast plaster					
Q4002	B		Cast sup body cast fiberglas					
Q4003	B		Cast sup shoulder cast plstr					
Q4004	B		Cast sup shoulder cast fbrgl					
Q4005	B		Cast sup long arm adult plst					
Q4006	B		Cast sup long arm adult fbrg					
Q4007	B		Cast sup long arm ped plster					
Q4008	B		Cast sup long arm ped fbrgls					
Q4009	B		Cast sup sht arm adult plstr					
Q4010	B		Cast sup sht arm adult fbrgl					
Q4011	B		Cast sup sht arm ped plaster					
Q4012	B		Cast sup sht arm ped fbrglas					
Q4013	B		Cast sup gauntlet plaster					
Q4014	B		Cast sup gauntlet fiberglass					
Q4015	B		Cast sup gauntlet ped plster					
Q4016	B		Cast sup gauntlet ped fbrgls					
Q4017	B		Cast sup lng arm splint plst					
Q4018	B		Cast sup lng arm splint fbrg					
Q4019	B		Cast sup lng arm splnt ped p					
Q4020	B		Cast sup lng arm splnt ped f					
Q4021	B		Cast sup sht arm splint plst					
Q4022	B		Cast sup sht arm splint fbrg					
Q4023	B		Cast sup sht arm splnt ped p					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
Q4024	B		Cast sup sht arm splnt ped f					
Q4025	B		Cast sup hip spica plaster					
Q4026	B		Cast sup hip spica fiberglas					
Q4027	B		Cast sup hip spica ped plstr					
Q4028	B		Cast sup hip spica ped fbrgl					
Q4029	B		Cast sup long leg plaster					
Q4030	B		Cast sup long leg fiberglass					
Q4031	B		Cast sup lng leg ped plaster					
Q4032	B		Cast sup lng leg ped fbrgls					
Q4033	B		Cast sup lng leg cylinder pl					
Q4034	B		Cast sup lng leg cylinder fb					
Q4035	B		Cast sup lngleg cylndr ped p					
Q4036	B		Cast sup lngleg cylndr ped f					
Q4037	B		Cast sup shrt leg plaster					
Q4038	B		Cast sup shrt leg fiberglass					
Q4039	B		Cast sup shrt leg ped plster					
Q4040	B		Cast sup shrt leg ped fbrgls					
Q4041	B		Cast sup lng leg splnt plstr					
Q4042	B		Cast sup lng leg splnt fbrgl					
Q4043	B		Cast sup lng leg splnt ped p					
Q4044	B		Cast sup lng leg splnt ped f					
Q4045	B		Cast sup sht leg splnt plstr					
Q4046	B		Cast sup sht leg splnt fbrgl					
Q4047	B		Cast sup sht leg splnt ped p					
Q4048	B		Cast sup sht leg splnt ped f					
Q4049	B		Finger splint, static					
Q4050	B		Cast supplies unlisted					
Q4051	B		Splint supplies misc					
Q4054	A		Darbepoetin alfa, esrd use					
Q4055	A		Epoetin alfa, esrd use					
Q4075	K		Acyclovir, 5 mg	1062		0.03		0.01
Q4076	K		Dopamine hcl, 40 mg	1070		0.81		0.16
Q4077	K		Treprostinil, 1 mg	1082		54.02		10.80
R0070	N		Transport portable x-ray					
R0075	N		Transport port x-ray multipl					
R0076	N		Transport portable EKG					
V2020	A		Vision svcs frames purchases					
V2025	E		Eyeglasses delux frames					
V2100	A		Lens spher single plano 4.00					
V2101	A		Single visn sphere 4.12-7.00					
V2102	A		Singl visn sphere 7.12-20.00					
V2103	A		Spherocylindr 4.00d/12-2.00d					
V2104	A		Spherocylindr 4.00d/2.12-4d					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
V2105	A		Spherocylinder 4.00d/4.25-6d					
V2106	A		Spherocylinder 4.00d/>6.00d					
V2107	A		Spherocylinder 4.25d/12-2d					
V2108	A		Spherocylinder 4.25d/2.12-4d					
V2109	A		Spherocylinder 4.25d/4.25-6d					
V2110	A		Spherocylinder 4.25d/over 6d					
V2111	A		Spherocylindr 7.25d/.25-2.25					
V2112	A		Spherocylindr 7.25d/2.25-4d					
V2113	A		Spherocylindr 7.25d/4.25-6d					
V2114	A		Spherocylinder over 12.00d					
V2115	A		Lens lenticular bifocal					
V2118	A		Lens aniseikonic single					
V2121	A		Lenticular lens, single					
V2199	A		Lens single vision not oth c					
V2200	A		Lens spher bifoc plano 4.00d					
V2201	A		Lens sphere bifocal 4.12-7.0					
V2202	A		Lens sphere bifocal 7.12-20.					
V2203	A		Lens sphcyl bifocal 4.00d/.1					
V2204	A		Lens sphcy bifocal 4.00d/2.1					
V2205	A		Lens sphcy bifocal 4.00d/4.2					
V2206	A		Lens sphcy bifocal 4.00d/ove					
V2207	A		Lens sphcy bifocal 4.25-7d/.					
V2208	A		Lens sphcy bifocal 4.25-7/2.					
V2209	A		Lens sphcy bifocal 4.25-7/4.					
V2210	A		Lens sphcy bifocal 4.25-7/ov					
V2211	A		Lens sphcy bifo 7.25-12/.25-					
V2212	A		Lens sphcyl bifo 7.25-12/2.2					
V2213	A		Lens sphcyl bifo 7.25-12/4.2					
V2214	A		Lens sphcyl bifocal over 12.					
V2215	A		Lens lenticular bifocal					
V2218	A		Lens aniseikonic bifocal					
V2219	A		Lens bifocal seg width over					
V2220	A		Lens bifocal add over 3.25d					
V2221	A		Lenticular lens, bifocal					
V2299	A		Lens bifocal speciality					
V2300	A		Lens sphere trifocal 4.00d					
V2301	A		Lens sphere trifocal 4.12-7.					
V2302	A		Lens sphere trifocal 7.12-20					
V2303	A		Lens sphcy trifocal 4.0/.12-					
V2304	A		Lens sphcy trifocal 4.0/2.25					
V2305	A		Lens sphcy trifocal 4.0/4.25					
V2306	A		Lens sphcyl trifocal 4.00/>6					
V2307	A		Lens sphcy trifocal 4.25-7/.					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
V2308	A		Lens sphc trifocal 4.25-7/2.					
V2309	A		Lens sphc trifocal 4.25-7/4.					
V2310	A		Lens sphc trifocal 4.25-7/>6					
V2311	A		Lens sphc trifo 7.25-12/.25-					
V2312	A		Lens sphc trifo 7.25-12/2.25					
V2313	A		Lens sphc trifo 7.25-12/4.25					
V2314	A		Lens sphcyl trifocal over 12					
V2315	A		Lens lenticular trifocal					
V2318	A		Lens aniseikonic trifocal					
V2319	A		Lens trifocal seg width > 28					
V2320	A		Lens trifocal add over 3.25d					
V2321	A		Lenticular lens, trifocal					
V2399	A		Lens trifocal speciality					
V2410	A		Lens variab asphericity sing					
V2430	A		Lens variable asphericity bi					
V2499	A		Variable asphericity lens					
V2500	A		Contact lens pmma spherical					
V2501	A		Cntct lens pmma-toric/prism					
V2502	A		Contact lens pmma bifocal					
V2503	A		Cntct lens pmma color vision					
V2510	A		Cntct gas permeable sphericl					
V2511	A		Cntct toric prism ballast					
V2512	A		Cntct lens gas permbl bifocl					
V2513	A		Contact lens extended wear					
V2520	A		Contact lens hydrophilic					
V2521	A		Cntct lens hydrophilic toric					
V2522	A		Cntct lens hydrophil bifocl					
V2523	A		Cntct lens hydrophil extend					
V2530	A		Contact lens gas impermeable					
V2531	A		Contact lens gas permeable					
V2599	A		Contact lens/es other type					
V2600	A		Hand held low vision aids					
V2610	A		Single lens spectacle mount					
V2615	A		Telescop/othr compound lens					
V2623	A		Plastic eye prosth custom					
V2624	A		Polishing artifical eye					
V2625	A		Enlargemnt of eye prosthesis					
V2626	A		Reduction of eye prosthesis					
V2627	A		Scleral cover shell					
V2628	A		Fabrication & fitting					
V2629	A		Prosthetic eye other type					
V2630	N		Anter chamber intraocul lens					
V2631	N		Iris support intraoclr lens					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
V2632	N		Post chmbr intraocular lens					
V2700	A		Balance lens					
V2702	E	NI	Deluxe lens feature					
V2710	A		Glass/plastic slab off prism					
V2715	A		Prism lens/es					
V2718	A		Fresnell prism press-on lens					
V2730	A		Special base curve					
V2744	A		Tint photochromatic lens/es					
V2745	A		Tint, any color/solid/grad					
V2750	A		Anti-reflective coating					
V2755	A		UV lens/es					
V2756	E		Eye glass case					
V2760	A		Scratch resistant coating					
V2761	B		Mirror coating					
V2762	A		Polarization, any lens					
V2770	A		Occluder lens/es					
V2780	A		Oversize lens/es					
V2781	B		Progressive lens per lens					
V2782	A		Lens, 1.54-1.65 p/1.60-1.79g					
V2783	A		Lens, >= 1.66 p/>=1.80 g					
V2784	A		Lens polycarb or equal					
V2785	F		Corneal tissue processing					
V2786	A		Occupational multifocal lens					
V2790	N		Amniotic membrane					
V2797	A		Vis item/svc in other code					
V2799	A		Miscellaneous vision service					
V5008	E		Hearing screening					
V5010	E		Assessment for hearing aid					
V5011	E		Hearing aid fitting/checking					
V5014	E		Hearing aid repair/modifying					
V5020	E		Conformity evaluation					
V5030	E		Body-worn hearing aid air					
V5040	E		Body-worn hearing aid bone					
V5050	E		Hearing aid monaural in ear					
V5060	E		Behind ear hearing aid					
V5070	E		Glasses air conduction					
V5080	E		Glasses bone conduction					
V5090	E		Hearing aid dispensing fee					
V5095	E		Implant mid ear hearing pros					
V5100	E		Body-worn bilat hearing aid					
V5110	E		Hearing aid dispensing fee					
V5120	E		Body-worn binaur hearing aid					
V5130	E		In ear binaural hearing aid					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
V5140	E		Behind ear binaur hearing ai					
V5150	E		Glasses binaural hearing aid					
V5160	E		Dispensing fee binaural					
V5170	E		Within ear cros hearing aid					
V5180	E		Behind ear cros hearing aid					
V5190	E		Glasses cros hearing aid					
V5200	E		Cros hearing aid dispens fee					
V5210	E		In ear bicros hearing aid					
V5220	E		Behind ear bicros hearing ai					
V5230	E		Glasses bicros hearing aid					
V5240	E		Dispensing fee bicros					
V5241	E		Dispensing fee, monaural					
V5242	E		Hearing aid, monaural, cic					
V5243	E		Hearing aid, monaural, itc					
V5244	E		Hearing aid, prog, mon, cic					
V5245	E		Hearing aid, prog, mon, itc					
V5246	E		Hearing aid, prog, mon, ite					
V5247	E		Hearing aid, prog, mon, bte					
V5248	E		Hearing aid, binaural, cic					
V5249	E		Hearing aid, binaural, itc					
V5250	E		Hearing aid, prog, bin, cic					
V5251	E		Hearing aid, prog, bin, itc					
V5252	E		Hearing aid, prog, bin, ite					
V5253	E		Hearing aid, prog, bin, bte					
V5254	E		Hearing id, digit, mon, cic					
V5255	E		Hearing aid, digit, mon, itc					
V5256	E		Hearing aid, digit, mon, ite					
V5257	E		Hearing aid, digit, mon, bte					
V5258	E		Hearing aid, digit, bin, cic					
V5259	E		Hearing aid, digit, bin, itc					
V5260	E		Hearing aid, digit, bin, ite					
V5261	E		Hearing aid, digit, bin, bte					
V5262	E		Hearing aid, disp, monaural					
V5263	E		Hearing aid, disp, binaural					
V5264	E		Ear mold/insert					
V5265	E		Ear mold/insert, disp					
V5266	E		Battery for hearing device					
V5267	E		Hearing aid supply/accessory					
V5268	E		ALD Telephone Amplifier					
V5269	E		Alerting device, any type					
V5270	E		ALD, TV amplifier, any type					
V5271	E		ALD, TV caption decoder					
V5272	E		Tdd					

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
V5273	E		ALD for cochlear implant					
V5274	E		ALD unspecified					
V5275	E		Ear impression					
V5298	E		Hearing aid noc					
V5299	B		Hearing service					
V5336	E		Repair communication device					
V5362	E		Speech screening					
V5363	E		Language screening					
V5364	E		Dysphagia screening					

Addendum D1.--Payment Status Indicators for the Hospital Outpatient Prospective Payment System

Indicator	Item/code/service	OPPS Payment Status
A	Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS, e.g.: • Ambulance Services • Clinical Diagnostic Laboratory Services • Non-Implantable Prosthetic and Orthotic Devices • EPO for ESRD Patients • Physical, Occupational, and Speech Therapy • Routine Dialysis Services for ESRD Patients Provided in a Certified Dialysis Unit of a Hospital • Diagnostic Mammography • Screening Mammography	Not paid under OPPS. Paid by Intermediaries under a fee schedule or payment system other than OPPS.
B	Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x,13x, and 14x).	Not paid under OPPS. • May be paid by intermediaries when submitted on a different bill type, e.g., 75x (CORF), but not paid under OPPS. • An alternate code that is recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x, 13x, and 14x) may be available.
C	Inpatient Procedures	Not paid under OPPS. Admit patient. Bill as inpatient.
D	Discontinued Codes	Not paid under OPPS.
E	Items, Codes, and Services: • That are not covered by Medicare based on Statutory Exclusion. • That are not covered by Medicare for	Not paid under OPPS.

Indicator	Item/code/service	OPPS Payment Status
	reasons other than Statutory Exclusion. • That are not recognized by Medicare but for which an alternate code for the same item or service may be available. • For which separate payment is not provided by Medicare.	
F	Corneal Tissue Acquisition; Certain CRNA Services	Not paid under OPPS. Paid at reasonable cost.
G	Pass-through Drugs, Biologicals, and Radiopharmaceutical Agents	Paid under OPPS; Separate APC payment includes Pass-Through amount.
H	(1) Pass-through Device Categories; (2) Brachytherapy Sources	Paid under OPPS; (1) Separate cost-based Pass-Through payment; (2) Separate cost-based Non-Pass-Through payment.
K	Non-Pass-Through Drugs, Biologicals, and Radiopharmaceuticals Agents	Paid under OPPS; Separate APC payment.
L	Influenza Vaccine; Pneumococcal Pneumonia Vaccine	Not paid under OPPS. Paid at reasonable cost; Not subject to deductible or coinsurance.
N	Items and Services packaged into APC Rates	Paid under OPPS; Payment is packaged into payment for other services, including outliers, therefore, there is no separate APC payment.
P	Partial Hospitalization	Paid under OPPS; Per diem APC payment.
S	Significant Procedure, Not Discounted when Multiple	Paid under OPPS; Separate APC payment.
T	Significant Procedure, Multiple Reduction Applies	Paid under OPPS; Separate APC payment.
V	Clinic or Emergency Department Visit	Paid under OPPS; Separate APC payment.
Y	Non-Implantable Durable Medical Equipment	Not paid under OPPS. All institutional providers other than Home Health Agencies bill to DMERC.
X	Ancillary Services	Paid under OPPS; Separate APC payment.

Addendum D2.--Comment Indicators

Comment Indicator	Descriptor
NF	New code, final APC assignment; Comments were accepted on a proposed APC assignment in the Proposed Rule; APC assignment is no longer open to comment.
NI	New code, 7/12/2004 interim APC assignment; Comments will be accepted on the interim APC assignment for the new code.

Addendum E.--CPT Codes That Are Paid Only As Inpatient Procedures

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
00176	C	Anesth, pharyngeal surgery
00192	C	Anesth, facial bone surgery
00214	C	Anesth, skull drainage
00215	C	Anesth, skull repair/fract
0021T	C	Fetal oximetry, trnsvag/cerv
0024T	C	Transcath cardiac reduction
0033T	C	Endovasc taa repr incl subcl
0034T	C	Endovasc taa repr w/o subcl
0035T	C	Insert endovasc prosth, taa
0036T	C	Endovasc prosth, taa, add-on
0037T	C	Artery transpose/endovas taa
0038T	C	Rad endovasc taa rpr w/cover
0039T	C	Rad s/i, endovasc taa repair
00404	C	Anesth, surgery of breast
00406	C	Anesth, surgery of breast
0040T	C	Rad s/i, endovasc taa prosth
00452	C	Anesth, surgery of shoulder
00474	C	Anesth, surgery of rib(s)
0048T	C	Implant ventricular device
0049T	C	External circulation assist
0050T	C	Removal circulation assist
0051T	C	Implant total heart system
00524	C	Anesth, chest drainage

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
0052T	C	Replace component heart syst
0053T	C	Replace component heart syst
00540	C	Anesth, chest surgery
00542	C	Anesth, release of lung
00546	C	Anesth, lung,chest wall surg
00560	C	Anesth, open heart surgery
00561	C	Anesth, heart surg < age 1
00562	C	Anesth, open heart surgery
00580	C	Anesth, heart/lung transplnt
00604	C	Anesth, sitting procedure
00622	C	Anesth, removal of nerves
00632	C	Anesth, removal of nerves
00634	C	Anesth for chemonucleolysis
00670	C	Anesth, spine, cord surgery
0075T	C	Perq stent/chest vert art
0076T	C	S&i stent/chest vert art
0077T	C	Cereb therm perfusion probe
0078T	C	Endovasc aort repr w/device
0079T	C	Endovasc visc extnsn repr
00792	C	Anesth, hemorr/excise liver
00794	C	Anesth, pancreas removal
00796	C	Anesth, for liver transplant
0080T	C	Endovasc aort repr rad s&i
00802	C	Anesth, fat layer removal
0081T	C	Endovasc visc extnsn s&i
00844	C	Anesth, pelvis surgery
00846	C	Anesth, hysterectomy
00848	C	Anesth, pelvic organ surg
00864	C	Anesth, removal of bladder
00865	C	Anesth, removal of prostate
00866	C	Anesth, removal of adrenal
00868	C	Anesth, kidney transplant
00882	C	Anesth, major vein ligation
00904	C	Anesth, perineal surgery
00908	C	Anesth, removal of prostate
00932	C	Anesth, amputation of penis
00934	C	Anesth, penis, nodes removal
00936	C	Anesth, penis, nodes removal

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
00944	C	Anesth, vaginal hysterectomy
01140	C	Anesth, amputation at pelvis
01150	C	Anesth, pelvic tumor surgery
01190	C	Anesth, pelvis nerve removal
01212	C	Anesth, hip disarticulation
01214	C	Anesth, hip arthroplasty
01232	C	Anesth, amputation of femur
01234	C	Anesth, radical femur surg
01272	C	Anesth, femoral artery surg
01274	C	Anesth, femoral embolectomy
01402	C	Anesth, knee arthroplasty
01404	C	Anesth, amputation at knee
01442	C	Anesth, knee artery surg
01444	C	Anesth, knee artery repair
01486	C	Anesth, ankle replacement
01502	C	Anesth, lwr leg embolectomy
01632	C	Anesth, surgery of shoulder
01634	C	Anesth, shoulder joint amput
01636	C	Anesth, forequarter amput
01638	C	Anesth, shoulder replacement
01652	C	Anesth, shoulder vessel surg
01654	C	Anesth, shoulder vessel surg
01656	C	Anesth, arm-leg vessel surg
01756	C	Anesth, radical humerus surg
01990	C	Support for organ donor
11004	C	Debride genitalia & perineum
11005	C	Debride abdom wall
11006	C	Debride genit/per/abdom wall
11008	C	Remove mesh from abd wall
15756	C	Free muscle flap, microvasc
15757	C	Free skin flap, microvasc
15758	C	Free fascial flap, microvasc
16035	C	Incision of burn scab, initi
16036	C	Escharotomy; add'l incision
19200	C	Removal of breast

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
19220	C	Removal of breast
19271	C	Revision of chest wall
19272	C	Extensive chest wall surgery
19361	C	Breast reconstruction
19364	C	Breast reconstruction
19367	C	Breast reconstruction
19368	C	Breast reconstruction
19369	C	Breast reconstruction
20660	C	Apply, rem fixation device
20661	C	Application of head brace
20662	C	Application of pelvis brace
20663	C	Application of thigh brace
20664	C	Halo brace application
20802	C	Replantation, arm, complete
20805	C	Replant forearm, complete
20808	C	Replantation hand, complete
20816	C	Replantation digit, complete
20822	C	Replantation digit, complete
20824	C	Replantation thumb, complete
20827	C	Replantation thumb, complete
20838	C	Replantation foot, complete
20930	C	Spinal bone allograft
20931	C	Spinal bone allograft
20936	C	Spinal bone autograft
20937	C	Spinal bone autograft
20938	C	Spinal bone autograft
20955	C	Fibula bone graft, microvasc
20956	C	Iliac bone graft, microvasc
20957	C	Mt bone graft, microvasc
20962	C	Other bone graft, microvasc
20969	C	Bone/skin graft, microvasc
20970	C	Bone/skin graft, iliac crest
20972	C	Bone/skin graft, metatarsal
20973	C	Bone/skin graft, great toe
21045	C	Extensive jaw surgery
21141	C	Reconstruct midface, lefort
21142	C	Reconstruct midface, lefort

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
21143	C	Reconstruct midface, lefort
21145	C	Reconstruct midface, lefort
21146	C	Reconstruct midface, lefort
21147	C	Reconstruct midface, lefort
21150	C	Reconstruct midface, lefort
21151	C	Reconstruct midface, lefort
21154	C	Reconstruct midface, lefort
21155	C	Reconstruct midface, lefort
21159	C	Reconstruct midface, lefort
21160	C	Reconstruct midface, lefort
21172	C	Reconstruct orbit/forehead
21175	C	Reconstruct orbit/forehead
21179	C	Reconstruct entire forehead
21180	C	Reconstruct entire forehead
21182	C	Reconstruct cranial bone
21183	C	Reconstruct cranial bone
21184	C	Reconstruct cranial bone
21188	C	Reconstruction of midface
21193	C	Reconst lwr jaw w/o graft
21194	C	Reconst lwr jaw w/graft
21195	C	Reconst lwr jaw w/o fixation
21196	C	Reconst lwr jaw w/fixation
21247	C	Reconstruct lower jaw bone
21255	C	Reconstruct lower jaw bone
21256	C	Reconstruction of orbit
21268	C	Revise eye sockets
21343	C	Treatment of sinus fracture

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
21344	C	Treatment of sinus fracture
21346	C	Treat nose/jaw fracture
21347	C	Treat nose/jaw fracture
21348	C	Treat nose/jaw fracture
21360	C	Treat cheek bone fracture
21365	C	Treat cheek bone fracture
21366	C	Treat cheek bone fracture
21385	C	Treat eye socket fracture
21386	C	Treat eye socket fracture
21387	C	Treat eye socket fracture
21395	C	Treat eye socket fracture
21408	C	Treat eye socket fracture
21422	C	Treat mouth roof fracture
21423	C	Treat mouth roof fracture
21431	C	Treat craniofacial fracture
21432	C	Treat craniofacial fracture
21433	C	Treat craniofacial fracture
21435	C	Treat craniofacial fracture
21436	C	Treat craniofacial fracture
21495	C	Treat hyoid bone fracture
21510	C	Drainage of bone lesion
21615	C	Removal of rib
21616	C	Removal of rib and nerves
21620	C	Partial removal of sternum
21627	C	Sternal debridement
21630	C	Extensive sternum surgery
21632	C	Extensive sternum surgery
21705	C	Revision of neck muscle/rib
21740	C	Reconstruction of sternum
21750	C	Repair of sternum separation
21810	C	Treatment of rib fracture(s)
21825	C	Treat sternum fracture
22110	C	Remove part of neck vertebra
22112	C	Remove part, thorax vertebra
22114	C	Remove part, lumbar vertebra
22116	C	Remove extra spine segment
22210	C	Revision of neck spine

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
22212	C	Revision of thorax spine
22214	C	Revision of lumbar spine
22216	C	Revise, extra spine segment
22220	C	Revision of neck spine
22224	C	Revision of lumbar spine
22226	C	Revise, extra spine segment
22318	C	Treat odontoid fx w/o graft
22319	C	Treat odontoid fx w/graft
22325	C	Treat spine fracture
22326	C	Treat neck spine fracture
22327	C	Treat thorax spine fracture
22328	C	Treat each add spine fx
22532	C	Lat thorax spine fusion
22533	C	Lat lumbar spine fusion
22534	C	Lat thor/lumb, add'l seg
22548	C	Neck spine fusion
22554	C	Neck spine fusion
22556	C	Thorax spine fusion
22558	C	Lumbar spine fusion
22585	C	Additional spinal fusion
22590	C	Spine & skull spinal fusion
22595	C	Neck spinal fusion
22600	C	Neck spine fusion
22610	C	Thorax spine fusion
22630	C	Lumbar spine fusion
22632	C	Spine fusion, extra segment
22800	C	Fusion of spine
22802	C	Fusion of spine
22804	C	Fusion of spine
22808	C	Fusion of spine
22810	C	Fusion of spine
22812	C	Fusion of spine
22818	C	Kyphectomy, 1-2 segments
22819	C	Kyphectomy, 3 or more
22830	C	Exploration of spinal fusion

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
22840	C	Insert spine fixation device
22841	C	Insert spine fixation device
22842	C	Insert spine fixation device
22843	C	Insert spine fixation device
22844	C	Insert spine fixation device
22845	C	Insert spine fixation device
22846	C	Insert spine fixation device
22847	C	Insert spine fixation device
22848	C	Insert pelv fixation device
22849	C	Reinsert spinal fixation
22850	C	Remove spine fixation device
22851	C	Apply spine prosth device
22852	C	Remove spine fixation device
22855	C	Remove spine fixation device
23200	C	Removal of collar bone
23210	C	Removal of shoulder blade
23220	C	Partial removal of humerus
23221	C	Partial removal of humerus
23222	C	Partial removal of humerus
23332	C	Remove shoulder foreign body
23472	C	Reconstruct shoulder joint
23900	C	Amputation of arm & girdle
23920	C	Amputation at shoulder joint
24900	C	Amputation of upper arm
24920	C	Amputation of upper arm

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
24930	C	Amputation follow-up surgery
24931	C	Amputate upper arm & implant
24940	C	Revision of upper arm
25900	C	Amputation of forearm
25905	C	Amputation of forearm
25909	C	Amputation follow-up surgery
25915	C	Amputation of forearm
25920	C	Amputate hand at wrist
25924	C	Amputation follow-up surgery
25927	C	Amputation of hand
25931	C	Amputation follow-up surgery
26551	C	Great toe-hand transfer
26553	C	Single transfer, toe-hand
26554	C	Double transfer, toe-hand
26556	C	Toe joint transfer
26992	C	Drainage of bone lesion
27005	C	Incision of hip tendon
27006	C	Incision of hip tendons
27025	C	Incision of hip/thigh fascia
27030	C	Drainage of hip joint
27036	C	Excision of hip joint/muscle
27054	C	Removal of hip joint lining
27070	C	Partial removal of hip bone
27071	C	Partial removal of hip bone
27075	C	Extensive hip surgery
27076	C	Extensive hip surgery
27077	C	Extensive hip surgery
27078	C	Extensive hip surgery
27079	C	Extensive hip surgery
27090	C	Removal of hip prosthesis
27091	C	Removal of hip prosthesis
27120	C	Reconstruction of hip socket
27122	C	Reconstruction of hip socket
27125	C	Partial hip replacement

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
27130	C	Total hip arthroplasty
27132	C	Total hip arthroplasty
27134	C	Revise hip joint replacement
27137	C	Revise hip joint replacement
27138	C	Revise hip joint replacement
27140	C	Transplant femur ridge
27146	C	Incision of hip bone
27147	C	Revision of hip bone
27151	C	Incision of hip bones
27156	C	Revision of hip bones
27158	C	Revision of pelvis
27161	C	Incision of neck of femur
27165	C	Incision/fixation of femur
27170	C	Repair/graft femur head/neck
27175	C	Treat slipped epiphysis
27176	C	Treat slipped epiphysis
27177	C	Treat slipped epiphysis
27178	C	Treat slipped epiphysis
27179	C	Revise head/neck of femur
27181	C	Treat slipped epiphysis
27185	C	Revision of femur epiphysis
27187	C	Reinforce hip bones
27215	C	Treat pelvic fracture(s)
27217	C	Treat pelvic ring fracture
27218	C	Treat pelvic ring fracture
27222	C	Treat hip socket fracture
27226	C	Treat hip wall fracture
27227	C	Treat hip fracture(s)
27228	C	Treat hip fracture(s)
27232	C	Treat thigh fracture
27236	C	Treat thigh fracture
27240	C	Treat thigh fracture
27244	C	Treat thigh fracture
27245	C	Treat thigh fracture
27248	C	Treat thigh fracture
27253	C	Treat hip dislocation
27254	C	Treat hip dislocation
27258	C	Treat hip dislocation
27259	C	Treat hip dislocation

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
27280	C	Fusion of sacroiliac joint
27282	C	Fusion of pubic bones
27284	C	Fusion of hip joint
27286	C	Fusion of hip joint
27290	C	Amputation of leg at hip
27295	C	Amputation of leg at hip
27303	C	Drainage of bone lesion
27365	C	Extensive leg surgery
27445	C	Revision of knee joint
27447	C	Total knee arthroplasty
27448	C	Incision of thigh
27450	C	Incision of thigh
27454	C	Realignment of thigh bone
27455	C	Realignment of knee
27457	C	Realignment of knee
27465	C	Shortening of thigh bone
27466	C	Lengthening of thigh bone
27468	C	Shorten/lengthen thighs
27470	C	Repair of thigh
27472	C	Repair/graft of thigh
27475	C	Surgery to stop leg growth
27477	C	Surgery to stop leg growth
27479	C	Surgery to stop leg growth
27485	C	Surgery to stop leg growth
27486	C	Revise/replace knee joint
27487	C	Revise/replace knee joint
27488	C	Removal of knee prosthesis
27495	C	Reinforce thigh
27506	C	Treatment of thigh fracture
27507	C	Treatment of thigh fracture
27511	C	Treatment of thigh fracture
27513	C	Treatment of thigh fracture
27514	C	Treatment of thigh fracture
27519	C	Treat thigh fx growth plate
27535	C	Treat knee fracture
27536	C	Treat knee fracture
27540	C	Treat knee fracture
27556	C	Treat knee dislocation
27557	C	Treat knee dislocation

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
27558	C	Treat knee dislocation
27580	C	Fusion of knee
27590	C	Amputate leg at thigh
27591	C	Amputate leg at thigh
27592	C	Amputate leg at thigh
27596	C	Amputation follow-up surgery
27598	C	Amputate lower leg at knee
27645	C	Extensive lower leg surgery
27646	C	Extensive lower leg surgery
27702	C	Reconstruct ankle joint
27703	C	Reconstruction, ankle joint
27712	C	Realignment of lower leg
27715	C	Revision of lower leg
27720	C	Repair of tibia
27722	C	Repair/graft of tibia
27724	C	Repair/graft of tibia
27725	C	Repair of lower leg
27727	C	Repair of lower leg
27880	C	Amputation of lower leg
27881	C	Amputation of lower leg
27882	C	Amputation of lower leg
27886	C	Amputation follow-up surgery
27888	C	Amputation of foot at ankle
28800	C	Amputation of midfoot
28805	C	Amputation thru metatarsal
31225	C	Removal of upper jaw
31230	C	Removal of upper jaw
31290	C	Nasal/sinus endoscopy, surg
31291	C	Nasal/sinus endoscopy, surg
31293	C	Nasal/sinus endoscopy, surg
31294	C	Nasal/sinus endoscopy, surg
31360	C	Removal of larynx
31365	C	Removal of larynx
31367	C	Partial removal of larynx
31368	C	Partial removal of larynx
31370	C	Partial removal of larynx
31375	C	Partial removal of larynx
31380	C	Partial removal of larynx

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
31382	C	Partial removal of larynx
31390	C	Removal of larynx & pharynx
31395	C	Reconstruct larynx & pharynx
31584	C	Treat larynx fracture
31587	C	Revision of larynx
31725	C	Clearance of airways
31760	C	Repair of windpipe
31766	C	Reconstruction of windpipe
31770	C	Repair/graft of bronchus
31775	C	Reconstruct bronchus
31780	C	Reconstruct windpipe
31781	C	Reconstruct windpipe
31786	C	Remove windpipe lesion
31800	C	Repair of windpipe injury
31805	C	Repair of windpipe injury
32035	C	Exploration of chest
32036	C	Exploration of chest
32095	C	Biopsy through chest wall
32100	C	Exploration/biopsy of chest
32110	C	Explore/repair chest
32120	C	Re-exploration of chest
32124	C	Explore chest free adhesions
32140	C	Removal of lung lesion(s)
32141	C	Remove/treat lung lesions
32150	C	Removal of lung lesion(s)
32151	C	Remove lung foreign body
32160	C	Open chest heart massage
32200	C	Drain, open, lung lesion
32215	C	Treat chest lining
32220	C	Release of lung
32225	C	Partial release of lung
32310	C	Removal of chest lining
32320	C	Free/remove chest lining
32402	C	Open biopsy chest lining
32440	C	Removal of lung
32442	C	Sleeve pneumonectomy
32445	C	Removal of lung
32480	C	Partial removal of lung
32482	C	Bilobectomy

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
32484	C	Segmentectomy
32486	C	Sleeve lobectomy
32488	C	Completion pneumonectomy
32491	C	Lung volume reduction
32500	C	Partial removal of lung
32501	C	Repair bronchus add-on
32520	C	Remove lung & revise chest
32522	C	Remove lung & revise chest
32525	C	Remove lung & revise chest
32540	C	Removal of lung lesion
32650	C	Thoracoscopy, surgical
32651	C	Thoracoscopy, surgical
32652	C	Thoracoscopy, surgical
32653	C	Thoracoscopy, surgical
32654	C	Thoracoscopy, surgical
32655	C	Thoracoscopy, surgical
32656	C	Thoracoscopy, surgical
32657	C	Thoracoscopy, surgical
32658	C	Thoracoscopy, surgical
32659	C	Thoracoscopy, surgical
32660	C	Thoracoscopy, surgical
32661	C	Thoracoscopy, surgical
32662	C	Thoracoscopy, surgical
32663	C	Thoracoscopy, surgical
32664	C	Thoracoscopy, surgical
32665	C	Thoracoscopy, surgical
32800	C	Repair lung hernia
32810	C	Close chest after drainage
32815	C	Close bronchial fistula
32820	C	Reconstruct injured chest
32850	C	Donor pneumonectomy
32851	C	Lung transplant, single
32852	C	Lung transplant with bypass
32853	C	Lung transplant, double
32854	C	Lung transplant with bypass
32855	C	Prepare donor lung, single
32856	C	Prepare donor lung, double
32900	C	Removal of rib(s)
32905	C	Revise & repair chest wall

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
32906	C	Revise & repair chest wall
32940	C	Revision of lung
32997	C	Total lung lavage
33015	C	Incision of heart sac
33020	C	Incision of heart sac
33025	C	Incision of heart sac
33030	C	Partial removal of heart sac
33031	C	Partial removal of heart sac
33050	C	Removal of heart sac lesion
33120	C	Removal of heart lesion
33130	C	Removal of heart lesion
33140	C	Heart revascularize (tmr)
33141	C	Heart tmr w/other procedure
33200	C	Insertion of heart pacemaker
33201	C	Insertion of heart pacemaker
33236	C	Remove electrode/thoracotomy
33237	C	Remove electrode/thoracotomy
33238	C	Remove electrode/thoracotomy
33243	C	Remove eltrd/thoracotomy
33245	C	Insert epic eltrd pace-defib
33246	C	Insert epic eltrd/generator
33250	C	Ablate heart dysrhythm focus
33251	C	Ablate heart dysrhythm focus
33253	C	Reconstruct atria
33261	C	Ablate heart dysrhythm focus
33300	C	Repair of heart wound
33305	C	Repair of heart wound
33310	C	Exploratory heart surgery
33315	C	Exploratory heart surgery
33320	C	Repair major blood vessel(s)
33321	C	Repair major vessel
33322	C	Repair major blood vessel(s)
33330	C	Insert major vessel graft
33332	C	Insert major vessel graft
33335	C	Insert major vessel graft
33400	C	Repair of aortic valve
33401	C	Valvuloplasty, open

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
33403	C	Valvuloplasty, w/cp bypass
33404	C	Prepare heart-aorta conduit
33405	C	Replacement of aortic valve
33406	C	Replacement of aortic valve
33410	C	Replacement of aortic valve
33411	C	Replacement of aortic valve
33412	C	Replacement of aortic valve
33413	C	Replacement of aortic valve
33414	C	Repair of aortic valve
33415	C	Revision, subvalvular tissue
33416	C	Revise ventricle muscle
33417	C	Repair of aortic valve
33420	C	Revision of mitral valve
33422	C	Revision of mitral valve
33425	C	Repair of mitral valve
33426	C	Repair of mitral valve
33427	C	Repair of mitral valve
33430	C	Replacement of mitral valve
33460	C	Revision of tricuspid valve
33463	C	Valvuloplasty, tricuspid
33464	C	Valvuloplasty, tricuspid
33465	C	Replace tricuspid valve
33468	C	Revision of tricuspid valve
33470	C	Revision of pulmonary valve
33471	C	Valvotomy, pulmonary valve
33472	C	Revision of pulmonary valve
33474	C	Revision of pulmonary valve
33475	C	Replacement, pulmonary valve
33476	C	Revision of heart chamber
33478	C	Revision of heart chamber
33496	C	Repair, prosth valve clot
33500	C	Repair heart vessel fistula
33501	C	Repair heart vessel fistula
33502	C	Coronary artery correction
33503	C	Coronary artery graft

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
33504	C	Coronary artery graft
33505	C	Repair artery w/tunnel
33506	C	Repair artery, translocation
33510	C	CABG, vein, single
33511	C	CABG, vein, two
33512	C	CABG, vein, three
33513	C	CABG, vein, four
33514	C	CABG, vein, five
33516	C	Cabg, vein, six or more
33517	C	CABG, artery-vein, single
33518	C	CABG, artery-vein, two
33519	C	CABG, artery-vein, three
33521	C	CABG, artery-vein, four
33522	C	CABG, artery-vein, five
33523	C	Cabg, art-vein, six or more
33530	C	Coronary artery, bypass/reop
33533	C	CABG, arterial, single
33534	C	CABG, arterial, two
33535	C	CABG, arterial, three
33536	C	Cabg, arterial, four or more
33542	C	Removal of heart lesion
33545	C	Repair of heart damage
33572	C	Open coronary endarterectomy
33600	C	Closure of valve
33602	C	Closure of valve
33606	C	Anastomosis/artery-aorta
33608	C	Repair anomaly w/conduit
33610	C	Repair by enlargement
33611	C	Repair double ventricle
33612	C	Repair double ventricle
33615	C	Repair, modified fontan
33617	C	Repair single ventricle
33619	C	Repair single ventricle
33641	C	Repair heart septum defect
33645	C	Revision of heart veins
33647	C	Repair heart septum defects
33660	C	Repair of heart defects
33665	C	Repair of heart defects
33670	C	Repair of heart chambers

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
33681	C	Repair heart septum defect
33684	C	Repair heart septum defect
33688	C	Repair heart septum defect
33690	C	Reinforce pulmonary artery
33692	C	Repair of heart defects
33694	C	Repair of heart defects
33697	C	Repair of heart defects
33702	C	Repair of heart defects
33710	C	Repair of heart defects
33720	C	Repair of heart defect
33722	C	Repair of heart defect
33730	C	Repair heart-vein defect(s)
33732	C	Repair heart-vein defect
33735	C	Revision of heart chamber
33736	C	Revision of heart chamber
33737	C	Revision of heart chamber
33750	C	Major vessel shunt
33755	C	Major vessel shunt
33762	C	Major vessel shunt
33764	C	Major vessel shunt & graft
33766	C	Major vessel shunt
33767	C	Major vessel shunt
33770	C	Repair great vessels defect
33771	C	Repair great vessels defect
33774	C	Repair great vessels defect
33775	C	Repair great vessels defect
33776	C	Repair great vessels defect
33777	C	Repair great vessels defect
33778	C	Repair great vessels defect
33779	C	Repair great vessels defect
33780	C	Repair great vessels defect
33781	C	Repair great vessels defect
33786	C	Repair arterial trunk
33788	C	Revision of pulmonary artery
33800	C	Aortic suspension
33802	C	Repair vessel defect

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
33803	C	Repair vessel defect
33813	C	Repair septal defect
33814	C	Repair septal defect
33820	C	Revise major vessel
33822	C	Revise major vessel
33824	C	Revise major vessel
33840	C	Remove aorta constriction
33845	C	Remove aorta constriction
33851	C	Remove aorta constriction
33852	C	Repair septal defect
33853	C	Repair septal defect
33860	C	Ascending aortic graft
33861	C	Ascending aortic graft
33863	C	Ascending aortic graft
33870	C	Transverse aortic arch graft
33875	C	Thoracic aortic graft
33877	C	Thoracoabdominal graft
33910	C	Remove lung artery emboli
33915	C	Remove lung artery emboli
33916	C	Surgery of great vessel
33917	C	Repair pulmonary artery
33918	C	Repair pulmonary atresia
33919	C	Repair pulmonary atresia
33920	C	Repair pulmonary atresia
33922	C	Transect pulmonary artery
33924	C	Remove pulmonary shunt
33930	C	Removal of donor heart/lung
33933	C	Prepare donor heart/lung
33935	C	Transplantation, heart/lung
33940	C	Removal of donor heart
33944	C	Prepare donor heart
33945	C	Transplantation of heart
33960	C	External circulation assist
33961	C	External circulation assist
33967	C	Insert ia percut device
33968	C	Remove aortic assist device
33970	C	Aortic circulation assist
33971	C	Aortic circulation assist
33973	C	Insert balloon device

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
33974	C	Remove intra-aortic balloon
33975	C	Implant ventricular device
33976	C	Implant ventricular device
33977	C	Remove ventricular device
33978	C	Remove ventricular device
33979	C	Insert intracorporeal device
33980	C	Remove intracorporeal device
34001	C	Removal of artery clot
34051	C	Removal of artery clot
34151	C	Removal of artery clot
34401	C	Removal of vein clot
34451	C	Removal of vein clot
34502	C	Reconstruct vena cava
34800	C	Endovasc abdo repair w/tube
34802	C	Endovasc abdo repr w/device
34803	C	Endovas aaa repr w/3-p part
34804	C	Endovasc abdo repr w/device
34805	C	Endovasc abdo repair w/pros
34808	C	Endovasc abdo occlud device
34812	C	Xpose for endoprosth, aortic
34813	C	Femoral endovas graft add-on
34820	C	Xpose for endoprosth, iliac
34825	C	Endovasc extend prosth, init
34826	C	Endovasc exten prosth, add'l
34830	C	Open aortic tube prosth repr
34831	C	Open aortoiliac prosth repr
34832	C	Open aortofemor prosth repr
34833	C	Xpose for endoprosth, iliac
34834	C	Xpose, endoprosth, brachial
34900	C	Endovasc iliac repr w/graft
35001	C	Repair defect of artery
35002	C	Repair artery rupture, neck
35005	C	Repair defect of artery
35013	C	Repair artery rupture, arm
35021	C	Repair defect of artery
35022	C	Repair artery rupture, chest
35045	C	Repair defect of arm artery
35081	C	Repair defect of artery
35082	C	Repair artery rupture, aorta

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
35091	C	Repair defect of artery
35092	C	Repair artery rupture, aorta
35102	C	Repair defect of artery
35103	C	Repair artery rupture, groin
35111	C	Repair defect of artery
35112	C	Repair artery rupture,spleen
35121	C	Repair defect of artery
35122	C	Repair artery rupture, belly
35131	C	Repair defect of artery
35132	C	Repair artery rupture, groin
35141	C	Repair defect of artery
35142	C	Repair artery rupture, thigh
35151	C	Repair defect of artery
35152	C	Repair artery rupture, knee
35182	C	Repair blood vessel lesion
35189	C	Repair blood vessel lesion
35211	C	Repair blood vessel lesion
35216	C	Repair blood vessel lesion
35221	C	Repair blood vessel lesion
35241	C	Repair blood vessel lesion
35246	C	Repair blood vessel lesion
35251	C	Repair blood vessel lesion
35271	C	Repair blood vessel lesion
35276	C	Repair blood vessel lesion
35281	C	Repair blood vessel lesion
35301	C	Rechanneling of artery
35311	C	Rechanneling of artery
35331	C	Rechanneling of artery
35341	C	Rechanneling of artery
35351	C	Rechanneling of artery
35355	C	Rechanneling of artery
35361	C	Rechanneling of artery
35363	C	Rechanneling of artery
35371	C	Rechanneling of artery
35372	C	Rechanneling of artery
35381	C	Rechanneling of artery
35390	C	Reoperation, carotid add-on
35400	C	Angioscopy
35450	C	Repair arterial blockage
35452	C	Repair arterial blockage

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
35454	C	Repair arterial blockage
35456	C	Repair arterial blockage
35480	C	Atherectomy, open
35481	C	Atherectomy, open
35482	C	Atherectomy, open
35483	C	Atherectomy, open
35501	C	Artery bypass graft
35506	C	Artery bypass graft
35507	C	Artery bypass graft
35508	C	Artery bypass graft
35509	C	Artery bypass graft
35510	C	Artery bypass graft
35511	C	Artery bypass graft
35512	C	Artery bypass graft
35515	C	Artery bypass graft
35516	C	Artery bypass graft
35518	C	Artery bypass graft
35521	C	Artery bypass graft
35522	C	Artery bypass graft
35525	C	Artery bypass graft
35526	C	Artery bypass graft
35531	C	Artery bypass graft
35533	C	Artery bypass graft
35536	C	Artery bypass graft
35541	C	Artery bypass graft
35546	C	Artery bypass graft
35548	C	Artery bypass graft
35549	C	Artery bypass graft
35551	C	Artery bypass graft
35556	C	Artery bypass graft
35558	C	Artery bypass graft
35560	C	Artery bypass graft
35563	C	Artery bypass graft
35565	C	Artery bypass graft
35566	C	Artery bypass graft
35571	C	Artery bypass graft
35583	C	Vein bypass graft
35585	C	Vein bypass graft
35587	C	Vein bypass graft
35600	C	Harvest artery for cabg

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
35601	C	Artery bypass graft
35606	C	Artery bypass graft
35612	C	Artery bypass graft
35616	C	Artery bypass graft
35621	C	Artery bypass graft
35623	C	Bypass graft, not vein
35626	C	Artery bypass graft
35631	C	Artery bypass graft
35636	C	Artery bypass graft
35641	C	Artery bypass graft
35642	C	Artery bypass graft
35645	C	Artery bypass graft
35646	C	Artery bypass graft
35647	C	Artery bypass graft
35650	C	Artery bypass graft
35651	C	Artery bypass graft
35654	C	Artery bypass graft
35656	C	Artery bypass graft
35661	C	Artery bypass graft
35663	C	Artery bypass graft
35665	C	Artery bypass graft
35666	C	Artery bypass graft
35671	C	Artery bypass graft
35681	C	Composite bypass graft
35682	C	Composite bypass graft
35683	C	Composite bypass graft
35691	C	Arterial transposition
35693	C	Arterial transposition
35694	C	Arterial transposition
35695	C	Arterial transposition
35697	C	Reimplant artery each
35700	C	Reoperation, bypass graft
35701	C	Exploration, carotid artery
35721	C	Exploration, femoral artery
35741	C	Exploration popliteal artery
35800	C	Explore neck vessels
35820	C	Explore chest vessels

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
35840	C	Explore abdominal vessels
35870	C	Repair vessel graft defect
35901	C	Excision, graft, neck
35905	C	Excision, graft, thorax
35907	C	Excision, graft, abdomen
36510	C	Insertion of catheter, vein
36660	C	Insertion catheter, artery
36822	C	Insertion of cannula(s)
36823	C	Insertion of cannula(s)
37140	C	Revision of circulation
37145	C	Revision of circulation
37160	C	Revision of circulation
37180	C	Revision of circulation
37181	C	Splice spleen/kidney veins
37182	C	Insert hepatic shunt (tips)
37183	C	Remove hepatic shunt (tips)
37195	C	Thrombolytic therapy, stroke
37215	C	Transcath stent, cca w/eps
37216	C	Transcath stent, cca w/o eps
37616	C	Ligation of chest artery
37617	C	Ligation of abdomen artery
37618	C	Ligation of extremity artery
37660	C	Revision of major vein
37788	C	Revascularization, penis
38100	C	Removal of spleen, total
38101	C	Removal of spleen, partial
38102	C	Removal of spleen, total
38115	C	Repair of ruptured spleen
38380	C	Thoracic duct procedure
38381	C	Thoracic duct procedure
38382	C	Thoracic duct procedure
38562	C	Removal, pelvic lymph nodes
38564	C	Removal, abdomen lymph nodes
38724	C	Removal of lymph nodes, neck
38746	C	Remove thoracic lymph nodes
38747	C	Remove abdominal lymph nodes

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
38765	C	Remove groin lymph nodes
38770	C	Remove pelvis lymph nodes
38780	C	Remove abdomen lymph nodes
39000	C	Exploration of chest
39010	C	Exploration of chest
39200	C	Removal chest lesion
39220	C	Removal chest lesion
39499	C	Chest procedure
39501	C	Repair diaphragm laceration
39502	C	Repair paraesophageal hernia
39503	C	Repair of diaphragm hernia
39520	C	Repair of diaphragm hernia
39530	C	Repair of diaphragm hernia
39531	C	Repair of diaphragm hernia
39540	C	Repair of diaphragm hernia
39541	C	Repair of diaphragm hernia
39545	C	Revision of diaphragm
39560	C	Resect diaphragm, simple
39561	C	Resect diaphragm, complex
39599	C	Diaphragm surgery procedure
41130	C	Partial removal of tongue
41135	C	Tongue and neck surgery
41140	C	Removal of tongue
41145	C	Tongue removal, neck surgery
41150	C	Tongue, mouth, jaw surgery
41153	C	Tongue, mouth, neck surgery
41155	C	Tongue, jaw, & neck surgery
42426	C	Excise parotid gland/lesion
42845	C	Extensive surgery of throat
42894	C	Revision of pharyngeal walls
42953	C	Repair throat, esophagus
42961	C	Control throat bleeding
42971	C	Control nose/throat bleeding
43045	C	Incision of esophagus

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
43100	C	Excision of esophagus lesion
43101	C	Excision of esophagus lesion
43107	C	Removal of esophagus
43108	C	Removal of esophagus
43112	C	Removal of esophagus
43113	C	Removal of esophagus
43116	C	Partial removal of esophagus
43117	C	Partial removal of esophagus
43118	C	Partial removal of esophagus
43121	C	Partial removal of esophagus
43122	C	Partial removal of esophagus
43123	C	Partial removal of esophagus
43124	C	Removal of esophagus
43135	C	Removal of esophagus pouch
43300	C	Repair of esophagus
43305	C	Repair esophagus and fistula
43310	C	Repair of esophagus
43312	C	Repair esophagus and fistula
43313	C	Esophagoplasty congenital
43314	C	Tracheo-esophagoplasty cong
43320	C	Fuse esophagus & stomach
43324	C	Revise esophagus & stomach
43325	C	Revise esophagus & stomach
43326	C	Revise esophagus & stomach
43330	C	Repair of esophagus
43331	C	Repair of esophagus
43340	C	Fuse esophagus & intestine
43341	C	Fuse esophagus & intestine
43350	C	Surgical opening, esophagus
43351	C	Surgical opening, esophagus
43352	C	Surgical opening, esophagus
43360	C	Gastrointestinal repair
43361	C	Gastrointestinal repair
43400	C	Ligate esophagus veins
43401	C	Esophagus surgery for veins

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
43405	C	Ligate/staple esophagus
43410	C	Repair esophagus wound
43415	C	Repair esophagus wound
43420	C	Repair esophagus opening
43425	C	Repair esophagus opening
43460	C	Pressure treatment esophagus
43496	C	Free jejunum flap, microvasc
43500	C	Surgical opening of stomach
43501	C	Surgical repair of stomach
43502	C	Surgical repair of stomach
43520	C	Incision of pyloric muscle
43605	C	Biopsy of stomach
43610	C	Excision of stomach lesion
43611	C	Excision of stomach lesion
43620	C	Removal of stomach
43621	C	Removal of stomach
43622	C	Removal of stomach
43631	C	Removal of stomach, partial
43632	C	Removal of stomach, partial
43633	C	Removal of stomach, partial
43634	C	Removal of stomach, partial
43635	C	Removal of stomach, partial
43638	C	Removal of stomach, partial
43639	C	Removal of stomach, partial
43640	C	Vagotomy & pylorus repair
43641	C	Vagotomy & pylorus repair
43644	C	Lap gastric bypass/roux-en-y
43645	C	Lap gastr bypass incl smll i
43800	C	Reconstruction of pylorus
43810	C	Fusion of stomach and bowel
43820	C	Fusion of stomach and bowel
43825	C	Fusion of stomach and bowel
43832	C	Place gastrostomy tube
43840	C	Repair of stomach lesion
43842	C	Gastroplasty for obesity
43843	C	Gastroplasty for obesity
43845	C	Gastroplasty duodenal switch

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
43846	C	Gastric bypass for obesity
43847	C	Gastric bypass for obesity
43848	C	Revision gastroplasty
43850	C	Revise stomach-bowel fusion
43855	C	Revise stomach-bowel fusion
43860	C	Revise stomach-bowel fusion
43865	C	Revise stomach-bowel fusion
43880	C	Repair stomach-bowel fistula
44005	C	Freeing of bowel adhesion
44010	C	Incision of small bowel
44015	C	Insert needle cath bowel
44020	C	Explore small intestine
44021	C	Decompress small bowel
44025	C	Incision of large bowel
44050	C	Reduce bowel obstruction
44055	C	Correct malrotation of bowel
44110	C	Excise intestine lesion(s)
44111	C	Excision of bowel lesion(s)
44120	C	Removal of small intestine
44121	C	Removal of small intestine
44125	C	Removal of small intestine
44126	C	Enterectomy w/o taper, cong
44127	C	Enterectomy w/taper, cong
44128	C	Enterectomy cong, add-on
44130	C	Bowel to bowel fusion
44132	C	Enterectomy, cadaver donor
44133	C	Enterectomy, live donor

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
44135	C	Intestine transplnt, cadaver
44136	C	Intestine transplant, live
44137	C	Remove intestinal allograft
44139	C	Mobilization of colon
44140	C	Partial removal of colon
44141	C	Partial removal of colon
44143	C	Partial removal of colon
44144	C	Partial removal of colon
44145	C	Partial removal of colon
44146	C	Partial removal of colon
44147	C	Partial removal of colon
44150	C	Removal of colon
44151	C	Removal of colon/ileostomy
44152	C	Removal of colon/ileostomy
44153	C	Removal of colon/ileostomy
44155	C	Removal of colon/ileostomy
44156	C	Removal of colon/ileostomy
44160	C	Removal of colon
44202	C	Lap resect s/intestine singl
44203	C	Lap resect s/intestine, addl
44204	C	Laparo partial colectomy
44205	C	Lap colectomy part w/ileum
44210	C	Laparo total proctocolectomy
44211	C	Laparo total proctocolectomy
44212	C	Laparo total proctocolectomy
44300	C	Open bowel to skin
44310	C	Ileostomy/jejunostomy
44314	C	Revision of ileostomy
44316	C	Devise bowel pouch

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
44320	C	Colostomy
44322	C	Colostomy with biopsies
44345	C	Revision of colostomy
44346	C	Revision of colostomy
44602	C	Suture, small intestine
44603	C	Suture, small intestine
44604	C	Suture, large intestine
44605	C	Repair of bowel lesion
44615	C	Intestinal stricturoplasty
44620	C	Repair bowel opening
44625	C	Repair bowel opening
44626	C	Repair bowel opening
44640	C	Repair bowel-skin fistula
44650	C	Repair bowel fistula
44660	C	Repair bowel-bladder fistula
44661	C	Repair bowel-bladder fistula
44680	C	Surgical revision, intestine
44700	C	Suspend bowel w/prosthesis
44715	C	Prepare donor intestine
44720	C	Prep donor intestine/venous
44721	C	Prep donor intestine/artery
44800	C	Excision of bowel pouch
44820	C	Excision of mesentery lesion
44850	C	Repair of mesentery
44899	C	Bowel surgery procedure
44900	C	Drain app abscess, open
44950	C	Appendectomy
44955	C	Appendectomy add-on
44960	C	Appendectomy
45110	C	Removal of rectum
45111	C	Partial removal of rectum
45112	C	Removal of rectum
45113	C	Partial proctectomy
45114	C	Partial removal of rectum
45116	C	Partial removal of rectum
45119	C	Remove rectum w/reservoir
45120	C	Removal of rectum
45121	C	Removal of rectum and colon
45123	C	Partial proctectomy
45126	C	Pelvic exenteration

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
45130	C	Excision of rectal prolapse
45135	C	Excision of rectal prolapse
45136	C	Excise ileoanal reservior
45540	C	Correct rectal prolapse
45550	C	Repair rectum/remove sigmoid
45562	C	Exploration/repair of rectum
45563	C	Exploration/repair of rectum
45800	C	Repair rect/bladder fistula
45805	C	Repair fistula w/colostomy
45820	C	Repair rectourethral fistula
45825	C	Repair fistula w/colostomy
46705	C	Repair of anal stricture
46715	C	Repair of anovaginal fistula
46716	C	Repair of anovaginal fistula
46730	C	Construction of absent anus
46735	C	Construction of absent anus
46740	C	Construction of absent anus
46742	C	Repair of imperforated anus
46744	C	Repair of cloacal anomaly
46746	C	Repair of cloacal anomaly
46748	C	Repair of cloacal anomaly
46751	C	Repair of anal sphincter
47010	C	Open drainage, liver lesion
47015	C	Inject/aspirate liver cyst
47100	C	Wedge biopsy of liver
47120	C	Partial removal of liver
47122	C	Extensive removal of liver
47125	C	Partial removal of liver
47130	C	Partial removal of liver
47133	C	Removal of donor liver
47135	C	Transplantation of liver
47136	C	Transplantation of liver
47140	C	Partial removal, donor liver
47141	C	Partial removal, donor liver
47142	C	Partial removal, donor liver
47143	C	Prep donor liver, whole
47144	C	Prep donor liver, 3-segment

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
47145	C	Prep donor liver, lobe split
47146	C	Prep donor liver/venous
47147	C	Prep donor liver/arterial
47300	C	Surgery for liver lesion
47350	C	Repair liver wound
47360	C	Repair liver wound
47361	C	Repair liver wound
47362	C	Repair liver wound
47380	C	Open ablate liver tumor rf
47381	C	Open ablate liver tumor cryo
47400	C	Incision of liver duct
47420	C	Incision of bile duct
47425	C	Incision of bile duct
47460	C	Incise bile duct sphincter
47480	C	Incision of gallbladder
47550	C	Bile duct endoscopy add-on
47570	C	Laparo cholecystoenterostomy
47600	C	Removal of gallbladder
47605	C	Removal of gallbladder
47610	C	Removal of gallbladder
47612	C	Removal of gallbladder
47620	C	Removal of gallbladder
47700	C	Exploration of bile ducts
47701	C	Bile duct revision
47711	C	Excision of bile duct tumor
47712	C	Excision of bile duct tumor
47715	C	Excision of bile duct cyst
47716	C	Fusion of bile duct cyst
47720	C	Fuse gallbladder & bowel
47721	C	Fuse upper gi structures
47740	C	Fuse gallbladder & bowel
47741	C	Fuse gallbladder & bowel
47760	C	Fuse bile ducts and bowel
47765	C	Fuse liver ducts & bowel
47780	C	Fuse bile ducts and bowel
47785	C	Fuse bile ducts and bowel
47800	C	Reconstruction of bile ducts
47801	C	Placement, bile duct support
47802	C	Fuse liver duct & intestine

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
47900	C	Suture bile duct injury
48000	C	Drainage of abdomen
48001	C	Placement of drain, pancreas
48005	C	Resect/debride pancreas
48020	C	Removal of pancreatic stone
48100	C	Biopsy of pancreas, open
48120	C	Removal of pancreas lesion
48140	C	Partial removal of pancreas
48145	C	Partial removal of pancreas
48146	C	Pancreatectomy
48148	C	Removal of pancreatic duct
48150	C	Partial removal of pancreas
48152	C	Pancreatectomy
48153	C	Pancreatectomy
48154	C	Pancreatectomy
48155	C	Removal of pancreas
48180	C	Fuse pancreas and bowel
48400	C	Injection, intraop add-on
48500	C	Surgery of pancreatic cyst
48510	C	Drain pancreatic pseudocyst
48520	C	Fuse pancreas cyst and bowel
48540	C	Fuse pancreas cyst and bowel
48545	C	Pancreatorrhaphy
48547	C	Duodenal exclusion
48551	C	Prep donor pancreas
48552	C	Prep donor pancreas/venous
48556	C	Removal, allograft pancreas
49000	C	Exploration of abdomen
49002	C	Reopening of abdomen
49010	C	Exploration behind abdomen
49020	C	Drain abdominal abscess
49040	C	Drain, open, abdom abscess
49060	C	Drain, open, retrop abscess
49062	C	Drain to peritoneal cavity
49201	C	Remove abdom lesion, complex
49215	C	Excise sacral spine tumor
49220	C	Multiple surgery, abdomen

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
49255	C	Removal of omentum
49425	C	Insert abdomen-venous drain
49428	C	Ligation of shunt
49605	C	Repair umbilical lesion
49606	C	Repair umbilical lesion
49610	C	Repair umbilical lesion
49611	C	Repair umbilical lesion
49900	C	Repair of abdominal wall
49904	C	Omental flap, extra-abdom
49905	C	Omental flap
49906	C	Free omental flap, microvasc
50010	C	Exploration of kidney
50040	C	Drainage of kidney
50045	C	Exploration of kidney
50060	C	Removal of kidney stone
50065	C	Incision of kidney
50070	C	Incision of kidney
50075	C	Removal of kidney stone
50100	C	Revise kidney blood vessels
50120	C	Exploration of kidney
50125	C	Explore and drain kidney
50130	C	Removal of kidney stone
50135	C	Exploration of kidney
50205	C	Biopsy of kidney
50220	C	Remove kidney, open
50225	C	Removal kidney open, complex
50230	C	Removal kidney open, radical
50234	C	Removal of kidney & ureter
50236	C	Removal of kidney & ureter
50240	C	Partial removal of kidney
50280	C	Removal of kidney lesion
50290	C	Removal of kidney lesion
50300	C	Removal of donor kidney
50320	C	Removal of donor kidney
50323	C	Prep cadaver renal allograft
50325	C	Prep donor renal graft
50327	C	Prep renal graft/venous
50328	C	Prep renal graft/arterial
50329	C	Prep renal graft/ureteral

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
50340	C	Removal of kidney
50360	C	Transplantation of kidney
50365	C	Transplantation of kidney
50370	C	Remove transplanted kidney
50380	C	Reimplantation of kidney
50400	C	Revision of kidney/ureter
50405	C	Revision of kidney/ureter
50500	C	Repair of kidney wound
50520	C	Close kidney-skin fistula
50525	C	Repair renal-abdomen fistula
50526	C	Repair renal-abdomen fistula
50540	C	Revision of horseshoe kidney
50545	C	Laparo radical nephrectomy
50546	C	Laparoscopic nephrectomy
50547	C	Laparo removal donor kidney
50548	C	Laparo remove w/ ureter
50580	C	Kidney endoscopy & treatment
50600	C	Exploration of ureter
50605	C	Insert ureteral support
50610	C	Removal of ureter stone
50620	C	Removal of ureter stone
50630	C	Removal of ureter stone
50650	C	Removal of ureter
50660	C	Removal of ureter
50700	C	Revision of ureter
50715	C	Release of ureter
50722	C	Release of ureter
50725	C	Release/revise ureter
50727	C	Revise ureter
50728	C	Revise ureter
50740	C	Fusion of ureter & kidney
50750	C	Fusion of ureter & kidney
50760	C	Fusion of ureters
50770	C	Splicing of ureters
50780	C	Reimplant ureter in bladder
50782	C	Reimplant ureter in bladder
50783	C	Reimplant ureter in bladder
50785	C	Reimplant ureter in bladder
50800	C	Implant ureter in bowel

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
50810	C	Fusion of ureter & bowel
50815	C	Urine shunt to intestine
50820	C	Construct bowel bladder
50825	C	Construct bowel bladder
50830	C	Revise urine flow
50840	C	Replace ureter by bowel
50845	C	Appendico-vesicostomy
50860	C	Transplant ureter to skin
50900	C	Repair of ureter
50920	C	Closure ureter/skin fistula
50930	C	Closure ureter/bowel fistula
50940	C	Release of ureter
51060	C	Removal of ureter stone
51525	C	Removal of bladder lesion
51530	C	Removal of bladder lesion
51535	C	Repair of ureter lesion
51550	C	Partial removal of bladder
51555	C	Partial removal of bladder
51565	C	Revise bladder & ureter(s)
51570	C	Removal of bladder
51575	C	Removal of bladder & nodes
51580	C	Remove bladder/revise tract
51585	C	Removal of bladder & nodes
51590	C	Remove bladder/revise tract
51595	C	Remove bladder/revise tract
51596	C	Remove bladder/create pouch
51597	C	Removal of pelvic structures
51800	C	Revision of bladder/urethra
51820	C	Revision of urinary tract
51840	C	Attach bladder/urethra
51841	C	Attach bladder/urethra
51845	C	Repair bladder neck
51860	C	Repair of bladder wound

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
51865	C	Repair of bladder wound
51900	C	Repair bladder/vagina lesion
51920	C	Close bladder-uterus fistula
51925	C	Hysterectomy/bladder repair
51940	C	Correction of bladder defect
51960	C	Revision of bladder & bowel
51980	C	Construct bladder opening
53415	C	Reconstruction of urethra
53448	C	Remov/replc ur sphinctr comp
54125	C	Removal of penis
54130	C	Remove penis & nodes
54135	C	Remove penis & nodes
54332	C	Revise penis/urethra
54336	C	Revise penis/urethra
54390	C	Repair penis and bladder
54411	C	Remov/replc penis pros, comp
54417	C	Remv/replc penis pros, compl
54430	C	Revision of penis
54535	C	Extensive testis surgery
54560	C	Exploration for testis
54650	C	Orchiopexy (Fowler-Stephens)
55600	C	Incise sperm duct pouch
55605	C	Incise sperm duct pouch
55650	C	Remove sperm duct pouch
55801	C	Removal of prostate
55810	C	Extensive prostate surgery
55812	C	Extensive prostate surgery
55815	C	Extensive prostate surgery

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
55821	C	Removal of prostate
55831	C	Removal of prostate
55840	C	Extensive prostate surgery
55842	C	Extensive prostate surgery
55845	C	Extensive prostate surgery
55862	C	Extensive prostate surgery
55865	C	Extensive prostate surgery
55866	C	Laparo radical prostatectomy
56630	C	Extensive vulva surgery
56631	C	Extensive vulva surgery
56632	C	Extensive vulva surgery
56633	C	Extensive vulva surgery
56634	C	Extensive vulva surgery
56637	C	Extensive vulva surgery
56640	C	Extensive vulva surgery
57110	C	Remove vagina wall, complete
57111	C	Remove vagina tissue, compl
57112	C	Vaginectomy w/nodes, compl
57270	C	Repair of bowel pouch
57280	C	Suspension of vagina
57282	C	Repair of vaginal prolapse
57283	C	Colpopexy, intraperitoneal
57292	C	Construct vagina with graft
57305	C	Repair rectum-vagina fistula
57307	C	Fistula repair & colostomy
57308	C	Fistula repair, transperine
57311	C	Repair urethrovaginal lesion
57335	C	Repair vagina

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
57531	C	Removal of cervix, radical
57540	C	Removal of residual cervix
57545	C	Remove cervix/repair pelvis
58140	C	Removal of uterus lesion
58146	C	Myomectomy abdom complex
58150	C	Total hysterectomy
58152	C	Total hysterectomy
58180	C	Partial hysterectomy
58200	C	Extensive hysterectomy
58210	C	Extensive hysterectomy
58240	C	Removal of pelvis contents
58260	C	Vaginal hysterectomy
58262	C	Vag hyst including t/o
58263	C	Vag hyst w/t/o & vag repair
58267	C	Vag hyst w/urinary repair
58270	C	Vag hyst w/enterocele repair
58275	C	Hysterectomy/revise vagina
58280	C	Hysterectomy/revise vagina
58285	C	Extensive hysterectomy
58290	C	Vag hyst complex
58291	C	Vag hyst incl t/o, complex
58292	C	Vag hyst t/o & repair, compl
58293	C	Vag hyst w/uro repair, compl
58294	C	Vag hyst w/enterocele, compl
58400	C	Suspension of uterus
58410	C	Suspension of uterus
58520	C	Repair of ruptured uterus
58540	C	Revision of uterus
58605	C	Division of fallopian tube
58611	C	Ligate oviduct(s) add-on

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
58700	C	Removal of fallopian tube
58720	C	Removal of ovary/tube(s)
58740	C	Revise fallopian tube(s)
58750	C	Repair oviduct
58752	C	Revise ovarian tube(s)
58760	C	Remove tubal obstruction
58805	C	Drainage of ovarian cyst(s)
58822	C	Drain ovary abscess, percut
58825	C	Transposition, ovary(s)
58940	C	Removal of ovary(s)
58943	C	Removal of ovary(s)
58950	C	Resect ovarian malignancy
58951	C	Resect ovarian malignancy
58952	C	Resect ovarian malignancy
58953	C	Tah, rad dissect for debulk
58954	C	Tah rad debulk/lymph remove
58956	C	Bso, omentectomy w/tah
58960	C	Exploration of abdomen
59100	C	Remove uterus lesion
59120	C	Treat ectopic pregnancy
59121	C	Treat ectopic pregnancy
59130	C	Treat ectopic pregnancy
59135	C	Treat ectopic pregnancy
59136	C	Treat ectopic pregnancy
59140	C	Treat ectopic pregnancy
59325	C	Revision of cervix
59350	C	Repair of uterus
59514	C	Cesarean delivery only
59525	C	Remove uterus after cesarean
59620	C	Attempted vbac delivery only
59830	C	Treat uterus infection
59850	C	Abortion
59851	C	Abortion
59852	C	Abortion
59855	C	Abortion
59856	C	Abortion
59857	C	Abortion

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
60254	C	Extensive thyroid surgery
60270	C	Removal of thyroid
60271	C	Removal of thyroid
60502	C	Re-explore parathyroids
60505	C	Explore parathyroid glands
60520	C	Removal of thymus gland
60521	C	Removal of thymus gland
60522	C	Removal of thymus gland
60540	C	Explore adrenal gland
60545	C	Explore adrenal gland
60600	C	Remove carotid body lesion
60605	C	Remove carotid body lesion
60650	C	Laparoscopy adrenalectomy
61105	C	Twist drill hole
61107	C	Drill skull for implantation
61108	C	Drill skull for drainage
61120	C	Burr hole for puncture
61140	C	Pierce skull for biopsy
61150	C	Pierce skull for drainage
61151	C	Pierce skull for drainage
61154	C	Pierce skull & remove clot
61156	C	Pierce skull for drainage
61210	C	Pierce skull, implant device
61250	C	Pierce skull & explore
61253	C	Pierce skull & explore
61304	C	Open skull for exploration
61305	C	Open skull for exploration
61312	C	Open skull for drainage
61313	C	Open skull for drainage
61314	C	Open skull for drainage
61315	C	Open skull for drainage
61316	C	Implt cran bone flap to abdo
61320	C	Open skull for drainage
61321	C	Open skull for drainage
61322	C	Decompressive craniotomy
61323	C	Decompressive lobectomy
61332	C	Explore/biopsy eye socket
61333	C	Explore orbit/remove lesion

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
61334	C	Explore orbit/remove object
61340	C	Relieve cranial pressure
61343	C	Incise skull (press relief)
61345	C	Relieve cranial pressure
61440	C	Incise skull for surgery
61450	C	Incise skull for surgery
61458	C	Incise skull for brain wound
61460	C	Incise skull for surgery
61470	C	Incise skull for surgery
61480	C	Incise skull for surgery
61490	C	Incise skull for surgery
61500	C	Removal of skull lesion
61501	C	Remove infected skull bone
61510	C	Removal of brain lesion
61512	C	Remove brain lining lesion
61514	C	Removal of brain abscess
61516	C	Removal of brain lesion
61517	C	Implt brain chemotx add-on
61518	C	Removal of brain lesion
61519	C	Remove brain lining lesion
61520	C	Removal of brain lesion
61521	C	Removal of brain lesion
61522	C	Removal of brain abscess
61524	C	Removal of brain lesion
61526	C	Removal of brain lesion
61530	C	Removal of brain lesion
61531	C	Implant brain electrodes
61533	C	Implant brain electrodes
61534	C	Removal of brain lesion
61535	C	Remove brain electrodes
61536	C	Removal of brain lesion
61537	C	Removal of brain tissue
61538	C	Removal of brain tissue
61539	C	Removal of brain tissue
61540	C	Removal of brain tissue
61541	C	Incision of brain tissue
61542	C	Removal of brain tissue
61543	C	Removal of brain tissue
61544	C	Remove & treat brain lesion

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
61545	C	Excision of brain tumor
61546	C	Removal of pituitary gland
61548	C	Removal of pituitary gland
61550	C	Release of skull seams
61552	C	Release of skull seams
61556	C	Incise skull/sutures
61557	C	Incise skull/sutures
61558	C	Excision of skull/sutures
61559	C	Excision of skull/sutures
61563	C	Excision of skull tumor
61564	C	Excision of skull tumor
61566	C	Removal of brain tissue
61567	C	Incision of brain tissue
61570	C	Remove foreign body, brain
61571	C	Incise skull for brain wound
61575	C	Skull base/brainstem surgery
61576	C	Skull base/brainstem surgery
61580	C	Craniofacial approach, skull
61581	C	Craniofacial approach, skull
61582	C	Craniofacial approach, skull
61583	C	Craniofacial approach, skull
61584	C	Orbitocranial approach/skull
61585	C	Orbitocranial approach/skull
61586	C	Resect nasopharynx, skull
61590	C	Infratemporal approach/skull
61591	C	Infratemporal approach/skull
61592	C	Orbitocranial approach/skull
61595	C	Transtemporal approach/skull
61596	C	Transcochlear approach/skull
61597	C	Transcondylar approach/skull
61598	C	Transpetrosal approach/skull

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
61600	C	Resect/excise cranial lesion
61601	C	Resect/excise cranial lesion
61605	C	Resect/excise cranial lesion
61606	C	Resect/excise cranial lesion
61607	C	Resect/excise cranial lesion
61608	C	Resect/excise cranial lesion
61609	C	Transect artery, sinus
61610	C	Transect artery, sinus
61611	C	Transect artery, sinus
61612	C	Transect artery, sinus
61613	C	Remove aneurysm, sinus
61615	C	Resect/excise lesion, skull
61616	C	Resect/excise lesion, skull
61618	C	Repair dura
61619	C	Repair dura
61624	C	Occlusion/embolization cath
61680	C	Intracranial vessel surgery
61682	C	Intracranial vessel surgery
61684	C	Intracranial vessel surgery
61686	C	Intracranial vessel surgery
61690	C	Intracranial vessel surgery
61692	C	Intracranial vessel surgery
61697	C	Brain aneurysm repr, complx
61698	C	Brain aneurysm repr, complx
61700	C	Brain aneurysm repr, simple
61702	C	Inner skull vessel surgery
61703	C	Clamp neck artery
61705	C	Revise circulation to head
61708	C	Revise circulation to head
61710	C	Revise circulation to head
61711	C	Fusion of skull arteries
61720	C	Incise skull/brain surgery
61735	C	Incise skull/brain surgery

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
61750	C	Incise skull/brain biopsy
61751	C	Brain biopsy w/ ct/mr guide
61760	C	Implant brain electrodes
61770	C	Incise skull for treatment
61850	C	Implant neuroelectrodes
61860	C	Implant neuroelectrodes
61863	C	Implant neuroelectrode
61864	C	Implant neuroelectrde, add'l
61867	C	Implant neuroelectrode
61868	C	Implant neuroelectrde, add'l
61870	C	Implant neuroelectrodes
61875	C	Implant neuroelectrodes
62000	C	Treat skull fracture
62005	C	Treat skull fracture
62010	C	Treatment of head injury
62100	C	Repair brain fluid leakage
62115	C	Reduction of skull defect
62116	C	Reduction of skull defect
62117	C	Reduction of skull defect
62120	C	Repair skull cavity lesion
62121	C	Incise skull repair
62140	C	Repair of skull defect
62141	C	Repair of skull defect
62142	C	Remove skull plate/flap
62143	C	Replace skull plate/flap
62145	C	Repair of skull & brain
62146	C	Repair of skull with graft
62147	C	Repair of skull with graft
62148	C	Retr bone flap to fix skull
62160	C	Neuroendoscopy add-on
62161	C	Dissect brain w/scope
62162	C	Remove colloid cyst w/scope
62163	C	Neuroendoscopy w/fb removal
62164	C	Remove brain tumor w/scope
62165	C	Remove pituit tumor w/scope
62180	C	Establish brain cavity shunt
62190	C	Establish brain cavity shunt
62192	C	Establish brain cavity shunt

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
62200	C	Establish brain cavity shunt
62201	C	Establish brain cavity shunt
62220	C	Establish brain cavity shunt
62223	C	Establish brain cavity shunt
62256	C	Remove brain cavity shunt
62258	C	Replace brain cavity shunt
63043	C	Laminotomy, add'l cervical
63044	C	Laminotomy, add'l lumbar
63050	C	Cervical laminoplasty
63051	C	C-laminoplasty w/graft/plate
63075	C	Neck spine disk surgery
63076	C	Neck spine disk surgery
63077	C	Spine disk surgery, thorax
63078	C	Spine disk surgery, thorax
63081	C	Removal of vertebral body
63082	C	Remove vertebral body add-on
63085	C	Removal of vertebral body
63086	C	Remove vertebral body add-on
63087	C	Removal of vertebral body
63088	C	Remove vertebral body add-on
63090	C	Removal of vertebral body
63091	C	Remove vertebral body add-on
63101	C	Removal of vertebral body
63102	C	Removal of vertebral body
63103	C	Remove vertebral body add-on
63170	C	Incise spinal cord tract(s)
63172	C	Drainage of spinal cyst
63173	C	Drainage of spinal cyst
63180	C	Revise spinal cord ligaments
63182	C	Revise spinal cord ligaments
63185	C	Incise spinal column/nerves
63190	C	Incise spinal column/nerves
63191	C	Incise spinal column/nerves
63194	C	Incise spinal column & cord
63195	C	Incise spinal column & cord
63196	C	Incise spinal column & cord
63197	C	Incise spinal column & cord

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
63198	C	Incise spinal column & cord
63199	C	Incise spinal column & cord
63200	C	Release of spinal cord
63250	C	Revise spinal cord vessels
63251	C	Revise spinal cord vessels
63252	C	Revise spinal cord vessels
63265	C	Excise intraspinal lesion
63266	C	Excise intraspinal lesion
63267	C	Excise intraspinal lesion
63268	C	Excise intraspinal lesion
63270	C	Excise intraspinal lesion
63271	C	Excise intraspinal lesion
63272	C	Excise intraspinal lesion
63273	C	Excise intraspinal lesion
63275	C	Biopsy/excise spinal tumor
63276	C	Biopsy/excise spinal tumor
63277	C	Biopsy/excise spinal tumor
63278	C	Biopsy/excise spinal tumor
63280	C	Biopsy/excise spinal tumor
63281	C	Biopsy/excise spinal tumor
63282	C	Biopsy/excise spinal tumor
63283	C	Biopsy/excise spinal tumor
63285	C	Biopsy/excise spinal tumor
63286	C	Biopsy/excise spinal tumor
63287	C	Biopsy/excise spinal tumor
63290	C	Biopsy/excise spinal tumor
63295	C	Repair of laminectomy defect
63300	C	Removal of vertebral body
63301	C	Removal of vertebral body
63302	C	Removal of vertebral body
63303	C	Removal of vertebral body
63304	C	Removal of vertebral body

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
63305	C	Removal of vertebral body
63306	C	Removal of vertebral body
63307	C	Removal of vertebral body
63308	C	Remove vertebral body add-on
63700	C	Repair of spinal herniation
63702	C	Repair of spinal herniation
63704	C	Repair of spinal herniation
63706	C	Repair of spinal herniation
63707	C	Repair spinal fluid leakage
63709	C	Repair spinal fluid leakage
63710	C	Graft repair of spine defect
63740	C	Install spinal shunt
64752	C	Incision of vagus nerve
64755	C	Incision of stomach nerves
64760	C	Incision of vagus nerve
64763	C	Incise hip/thigh nerve
64766	C	Incise hip/thigh nerve
64804	C	Remove sympathetic nerves
64809	C	Remove sympathetic nerves
64818	C	Remove sympathetic nerves
64866	C	Fusion of facial/other nerve
64868	C	Fusion of facial/other nerve
65273	C	Repair of eye wound
69155	C	Extensive ear/neck surgery
69535	C	Remove part of temporal bone
69554	C	Remove ear lesion
69950	C	Incise inner ear nerve
69970	C	Remove inner ear lesion
75900	C	Arterial catheter exchange
75952	C	Endovasc repair abdom aorta
75953	C	Abdom aneurysm endovas rpr
75954	C	Iliac aneurysm endovas rpr
92970	C	Cardioassist, internal
92971	C	Cardioassist, external
92975	C	Dissolve clot, heart vessel

CPT/ HCPCS	CY 2005 Final Status Indicator	Description
92992	C	Revision of heart chamber
92993	C	Revision of heart chamber
99190	C	Special pump services
99191	C	Special pump services
99192	C	Special pump services
99251	C	Initial inpatient consult
99252	C	Initial inpatient consult
99253	C	Initial inpatient consult
99254	C	Initial inpatient consult
99255	C	Initial inpatient consult
99261	C	Follow-up inpatient consult
99262	C	Follow-up inpatient consult
99263	C	Follow-up inpatient consult
99293	C	Ped critical care, initial
99294	C	Ped critical care, subseq
99295	C	Neonatal critical care
99296	C	Neonatal critical care
99298	C	Neonatal critical care
99299	C	Ic, lbw infant 1500-2500 gm
99356	C	Prolonged service, inpatient
99357	C	Prolonged service, inpatient
99433	C	Normal newborn care/hospital
G0341	C	Percutaneous islet cell trans
G0342	C	Laparoscopy Islet cell Trans
G0343	C	Laparotomy Islet cell tranp

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Part III

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 403, 405, 410, et al.
Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 403, 405, 410, 411, 414, 418, 424, 484, and 486

[CMS–1429–FC]

RIN 0938–AM90

Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule with comment period.

SUMMARY: This final rule refines the resource-based practice expense relative value units (RVUs) and makes other changes to Medicare Part B payment policy. These policy changes concern: supplemental survey data for practice expense; updated geographic practice cost indices for physician work and practice expense; updated malpractice RVUs; revised requirements for supervision of therapy assistants; revised payment rules for low osmolar contrast media; changes to payment policies for physicians and practitioners managing dialysis patients; clarification of care plan oversight requirements; revised requirements for supervision of diagnostic psychological testing services; clarifications to the policies affecting therapy services; revised requirements for assignment of Medicare claims; addition to the list of telehealth services; and, several coding issues. We are making these changes to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services.

This final rule also addresses the following provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–17) (MMA): coverage of an initial preventive physical examination; coverage of cardiovascular (CV) screening blood tests; coverage of diabetes screening tests; incentive payment improvements for physicians in shortage areas; payment for covered outpatient drugs and biologicals; payment for renal dialysis services; coverage of routine costs associated with certain clinical trials of category A devices as defined by the Food and Drug Administration; hospice consultation service; indexing the Part B deductible to inflation; extension of coverage of intravenous immune globulin (IVIG) for the treatment in the home of primary immune deficiency diseases; revisions to reassignment provisions; and, payment for diagnostic mammograms, physicians' services associated with drug administration services and coverage of religious nonmedical health care institution items and services to the beneficiary's home.

In addition, this rule updates the codes subject to the physician self-referral prohibition, discusses payment for set-up of portable x-ray equipment, discusses the third five-year refinement of work RVUs, and solicits comments on potentially misvalued work RVUs.

We are also finalizing the calendar year (CY) 2004 interim RVUs and are issuing interim RVUs for new and revised procedure codes for CY 2005.

As required by the statute, we are announcing that the physician fee schedule update for CY 2005 is 1.5 percent, the initial estimate for the sustainable growth rate for CY 2005 is 4.3, and the conversion factor for CY 2005 is $37.8975.

DATES: *Effective Date:* These regulations are effective on January 1, 2005.

Applicability Date: Section 623 of the MMA, that is, the case-mix portion of the revised composite payment methodology and the budget neutrality adjustment required by the MMA, is applicable on April 1, 2005.

Comment Date: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on January 3, 2005.

ADDRESSES: In commenting, please refer to file code CMS–1429–FC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of three ways (no duplicates, please):

1. *Electronically.* You may submit electronic comments on specific issues in this regulation to *http://www.cms.hhs.gov/regulations/ecomments.* (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. *By mail.* You may mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1429–FC, P.O. Box 8012, Baltimore, MD 21244–8012.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number 800–743–3951 in advance to schedule your arrival with one of our staff members. Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244–1850.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by mailing your comments to the addresses provided at the end of the ''Collection of Information Requirements'' section in this document.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT:

Pam West (410) 786–2302 (for issues related to Practice Expense, Respiratory Therapy Coding, and Therapy Supervision).

Rick Ensor (410) 786–5617 (for issues related to Geographic Practice Cost Index (GPCI) and malpractice RVUs).

Craig Dobyski (410) 786–4584 (for issues related to list of telehealth services or payments for physicians and practitioners managing dialysis patients).

Bill Larson or Tiffany Sanders (410) 786–7176 (for issues related to coverage of an initial preventive physical examination).

Cathleen Scally (410) 786–5714 (for issues related to payment of an initial preventive physical examination).

Joyce Eng (410) 786–7176 (for issues related to coverage of cardiovascular screening tests).

Betty Shaw (410) 786–7176 (for issues related to coverage of diabetes screening tests).

Anita Greenberg (410) 786–0548 (for issues related to payment of cardiovascular and diabetes screening tests).

David Worgo (410) 786–5919, (for issues related to incentive payment

improvements for physicians practicing in shortage areas).

Angela Mason or Jennifer Fan (410) 786–0548 (for issues related to payment for covered outpatient drugs and biologicals).

David Walczak (410) 786–4475 (for issues related to reassignment provisions).

Henry Richter (410) 786–4562 (for issues related to payments for ESRD facilities).

Steve Berkowitz (410) 786–7176 (for issues related to coverage of routine costs associated with certain clinical trials of category A devices).

Terri Deutsch (410) 786–9462 (for issues related to hospice consultation services).

Karen Daily (410) 786–7176 (for issues related to clinical conditions for payment of covered items of durable medical equipment).

Dorothy Shannon (410) 786–3396 (for issues related to outpatient therapy services performed ''incident to'' physicians' services).

Roberta Epps (410) 786–5919 (for issues related to low osmolar contrast media or supervision of diagnostic psychological testing services).

Gail Addis (410) 786–4522 (for issues related to care plan oversight).

Jean-Marie Moore (410) 786–3508 (for issues related to religious nonmedical health care institution services).

Diane Milstead (410) 786–3355 or Gaysha Brooks (410) 786–9649 (for all other issues).

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on the following issues: interim RVUs for selected procedure codes identified in Addendum C; zip code areas for Health Professional Shortage Areas (HPSAs); the coverage of religious nonmedical health care institution items and services to the beneficiary's home; the physician self referral designated health services listed in tables 20 and 21; the third five-year refinement of work RVUs for services furnished beginning January 1, 2007; and, potentially misvalued work RVUs for all services in the CY 2005 physician fee schedule. You can assist us by referencing the file code CMS–1429–FC and the specific ''issue identifier'' that precedes the section on which you choose to comment.

Inspection of Public Comments: Comments received timely will be available for public inspection as they are processed, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, call 800–743–3951.

Copies: To order copies of the **Federal Register** containing this document, send your request to: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250–7954. Specify the date of the issue requested and enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or Master Card number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 512–1800 (or toll-free at 1–888–293–6498) or by faxing to (202) 512–2250. The cost for each copy is $10. As an alternative, you can view and photocopy the **Federal Register** document at most libraries designated as Federal Depository Libraries and at many other public and academic libraries throughout the country that receive the **Federal Register**.

This **Federal Register** document is also available from the **Federal Register** online database through *GPO Access,* a service of the U.S. Government Printing Office. The web site address is: *http://www.access.gpo.gov/nara/index.html.*

Information on the physician fee schedule can be found on the CMS homepage. You can access this data by using the following directions:

1. Go to the CMS homepage (*http://www.cms.hhs.gov*).

2. Place your cursor over the word ''Professionals'' in the blue area near the top of the page. Select ''physicians'' from the drop-down menu.

3. Under ''Policies/Regulations'' select ''Physician Fee Schedule.''

To assist readers in referencing sections contained in this preamble, we are providing the following table of contents. Some of the issues discussed in this preamble affect the payment policies but do not require changes to the regulations in the Code of Federal Regulations. Information on the regulation's impact appears throughout the preamble and is not exclusively in section VII.

Table of Contents

In addition, because of the many organizations and terms to which we refer by acronym in this final rule, we are listing these acronyms and their corresponding terms in alphabetical order below:

AAA Abdominal aortic aneurysm
AAFP American Academy of Family Physicians
AAKP American Association of Kidney Patients
AANA American Association of Nurse Anesthetists
ABI Ankle brachial index
ABN Advanced beneficiary notice
ACC American College of Cardiology
ACLA American Clinical Laboratory Association
ACP American College of Physicians
ACPM American College of Preventative Medicine
ACR American College of Radiology
ADLs Activities of daily living
AFROC Association of Freestanding Radiation Oncology Centers
AGS American Geriatric Society
AHA American Heart Association
AMA American Medical Association
AOA American Osteopathic Association
APA Administrative Procedures Act
APTA American Physical Therapy Association
ASA American Society of Anesthesiologists
ASCP American Society for Clinical Pathology
ASN American Society of Nephrology
ASP Average sales price
ASTRO American Society for Therapeutic Radiation Oncology
ATA American Telemedicine Association
AWP Average wholesale price
BBA Balanced Budget Act of 1997
BBRA Balanced Budget Refinement Act of 1999
BIPA Benefits Improvement and Protection Act of 2000
BLS Bureau of Labor Statistics
BMI Body mass index
BSA Body surface area
CAH Critical access hospital
CAP College of American Pathologists
CAPD Continuous ambulatory peritoneal dialysis
CCPD Continuous cycling peritoneal dialysis
CDC Centers for Disease Control and Prevention
CF Conversion factor
CFR Code of Federal Regulations
CLIA Clinical Laboratory Improvement Amendment
CMA California Medical Association
CMS Centers for Medicare & Medicaid Services
CNMs Certified nurse midwives
CNS Clinical nurse specialist
COPD Chronic obstructive pulmonary disease
CORF Comprehensive outpatient rehabilitation facilities
CPEP Clinical Practice Expert Panel
CPI Consumer Price Index
CPO Care Plan Oversight
CPT [Physicians'] Current Procedural Terminology [4th Edition, 2002, copyrighted by the American Medical Association]
CRNAs Certified Registered Nurse Anesthetists
CT Computed tomography
CV Cardiovascular
CY Calendar year
DEXA Dual energy x-ray absorptiometry
DHS Designated health services
DME Durable medical equipment
DMEPOS Durable medical equipment, prosthetics, orthotics, and supplies
DMERC Durable medical equipment regional carrier
DOI Departments of Insurance
DRE Digital rectal exam
DRG Diagnosis-related groups
DVT Deep venous thrombosis
EKG Electrocardiogram
E/M Evaluation and management
EPO Erythropoeitin
ESRD End-stage renal disease
FAX Facsimile
FMR Fair market rental
FQHC Federally qualified healthcare center
FR Federal Register
FY Fiscal year
GAF Geographic adjustment factor
GPCI Geographic practice cost index
GTT Glucose tolerance test
HBO Hyperbaric oxygen
HCPAC Health Care Professional Advisory Committee
HCPCS Healthcare Common Procedure Coding System
HHA Home health agency
HHS [Department of] Health and Human Services
HIPAA Health Insurance Portability and Accountability Act of 1996
HOCM High osmolar contrast media
HPSA Health professional shortage area
HRSA Health Resources and Services Administration
HsCRP high sensitivity C-reactive protein
HUD Housing and Urban Development
IDTFs Independent diagnostic testing facilities
IMRT Intensity modulated radiation therapy
IOM Internet Only Manual
IPD Intermittent peritoneal dialysis
IPPE Initial preventive physical examination
IPPS Inpatient prospective payment system
ISO Insurance Services Office
IVIG Intravenous immune globulin
JUAs Joint underwriting associations
KCP Kidney Care Partners
KECC Kidney Epidemiology and Cost Center
LCD Local coverage determination
LMRP Local medical review policies
LOCM Low osmolar contrast media
LUPA Low utilization payment adjustment
MCM Medicare Carrier Manual
MCP Monthly capitation payment
MedPAC Medicare Payment Advisory Commission
MEI Medicare Economic Index
MGMA Medical Group Management Association
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MPFS Medicare physician fee schedule
MSA Metropolitan statistical area
NAMCS National Ambulatory Medical Care Survey
NCD National coverage determination
NCIPC National Center for Injury Prevention and Control
NDC National drug code
NIH National Institutes of Health
NP Nurse practitioner
NPP Nonphysician practitioners
OASIS Outcome and Assessment Information Set
OBRA Omnibus Budget Reconciliation Act
OIG Office of Inspector General
OMB Office of Management and Budget
OPPS Outpatient prospective payment system
OT Occupational therapy
OTA Occupational therapist assistant
OTPP Occupational therapists in private practice
PA Physician assistant
PAD Peripheral arterial disease
PC Professional component
PCF Patient compensation fund
PD Peritoneal dialysis
PEAC Practice Expense Advisory Committee
PET Positron emission tomography
PFS Physician Fee Schedule
PHSA Public Health Services Act
PIAA Physician Insurers Association of America
PIN Provider identification number
PLI Professional liability insurance
POS Prosthetics, orthotics and supplies
PPI Producer price index
PPS Prospective payment system
PRA Paperwork Reduction Act
PSA Physician scarcity area
PT Physical therapy
PTA Physical therapist assistant
PTPP Physical therapists in private practice
PVD Peripheral vascular disease
RFA Regulatory Flexibility Act

RHC Rural health clinic
RHHI Regional home health intermediary
RIA Regulatory impact analysis
RN Registered nurse
RNHCI Religious nonmedical health care institution
RPA Renal Physicians Association
RT Respiratory therapy
RTs Respiratory therapists
RUC [AMA's Specialty Society] Relative [Value] Update Committee
RUCA Rural-Urban commuting area
RVU Relative value unit
SAF Standard analytic file
SCHIP State Child Health Insurance Program
SGR Sustainable growth rate
SHIPs State Health Insurance Assistance Programs
SIR Society for Interventional Radiology
SLP Speech language pathology
SMR Standardized mortality ratio
SMS [AMA's] Socioeconomic Monitoring System
SNF Skilled nursing facility
TC Technical component
UAF Update adjustment factor
URR Urea reduction ratios
USPSTF U.S. Preventive Services Task Force

I. Background

A. Legislative History

Medicare has paid for physicians' services under section 1848 of the Social Security Act (the Act), ''Payment for Physicians' Services'' since January 1, 1992. The Act requires that payments under the fee schedule be based on national uniform relative value units (RVUs) reflecting the resources used in furnishing a service. Section 1848(c) of the Act requires that national RVUs be established for physician work, practice expense, and malpractice expense. Section 1848(c)(2)(B)(ii)(II) of the Act provides that adjustments in RVUs may not cause total physician fee schedule payments to differ by more than $20 million from what they would have been had the adjustments not been made. If adjustments to RVUs cause expenditures to change by more than $20 million, we must make adjustments to ensure that they do not increase or decrease by more than $20 million.

B. Published Changes to the Fee Schedule

The July 2000 and August 2003 proposed rules ((65 FR 44177) and (68 FR 49030), respectively), include a summary of the final physician fee schedule rules published through February 2003.

In the November 7, 2003 final rule, we refined the resource-based practice expense RVUs and made other changes to Medicare Part B payment policy. The specific policy changes concerned: the Medicare Economic Index; practice expense for professional component services; definition of diabetes for diabetes self-management training; supplemental survey data for practice expense; geographic practice cost indices; and several coding issues. In addition, this rule updated the codes subject to the physician self-referral prohibition. We also made revisions to the sustainable growth rate and the anesthesia conversion factor. Additionally, we finalized the CY 2003 interim RVUs and issued interim RVUs for new and revised procedure codes for CY 2004.

As required by the statute, we announced that the physician fee schedule update for CY 2004 was −4.5 percent; that the initial estimate of the sustainable growth rate for CY 2004 was 7.4 percent; and that the conversion factor for CY 2004 was $35.1339.

Subsequent to the November 7, 2003 final rule, the Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–17) (MMA). On January 7, 2004, an interim final rule was published to implement provisions of the MMA applicable in 2004 to Medicare payment for covered drugs and physician fee schedule services. These provisions included—

- Revising the current payment methodology for Medicare Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis;
- Making changes to Medicare payment for furnishing or administering drugs and biologicals;
- Revising the geographic practice cost indices;
- Changing the physician fee schedule conversion factor. (Note: The 2004 physician fee schedule conversion factor is $37.3374); and
- Extending the ''opt-out'' provisions of section 1802(b)(5)(3) of the Act to dentists, podiatrists, and optometrists.

The information contained in the January 7, 2004 interim final rule concerning payment under the physician fee schedule superceded information contained in the November 7, 2003 final rule to the extent that the two are inconsistent.

C. Components of the Fee Schedule Payment Amounts

Under the formula set forth in section 1848(b)(1) of the Act, the payment amount for each service paid under the physician fee schedule is the product of three factors: (1) A nationally uniform relative value unit (RVU) for the service; (2) a geographic adjustment factor (GAF) for each physician fee schedule area; and (3) a nationally uniform conversion factor (CF) for the service. The CF converts the relative values into payment amounts.

For each physician fee schedule service, there are three relative values: (1) An RVU for physician work; (2) an RVU for practice expense; and (3) an RVU for malpractice expense. For each of these components of the fee schedule, there is a geographic practice cost index (GPCI) for each fee schedule area. The GPCIs reflect the relative costs of practice expenses, malpractice insurance, and physician work in an area compared to the national average for each component.

The general formula for calculating the Medicare fee schedule amount for a given service in a given fee schedule area can be expressed as:

Payment = [(RVU work × GPCI work) + (RVU practice expense × GPCI practice expense) + (RVU malpractice x GPCI malpractice)] × CF

The CF for calendar year (CY) 2005 appears in section X. The RVUs for CY 2005 are in Addendum B. The GPCIs for CY 2005 can be found in Addendum D.

Section 1848(e) of the Act requires us to develop GAFs for all physician fee schedule areas. The total GAF for a fee schedule area is equal to a weighted average of the individual GPCIs for each of the three components of the service. In accordance with the statute, however, the GAF for the physician's work reflects one-quarter of the relative cost of physician's work compared to the national average.

D. Development of the Relative Value System

1. Work Relative Value Units

Approximately 7,500 codes represent services included in the physician fee schedule. The work RVUs established for the implementation of the fee schedule in January 1992 were developed with extensive input from the physician community. A research team at the Harvard School of Public Health developed the original work RVUs for most codes in a cooperative agreement with us. In constructing the vignettes for the original RVUs, Harvard worked with expert panels of physicians and obtained input from physicians from numerous specialties.

The RVUs for radiology services were based on the American College of Radiology (ACR) relative value scale, which we integrated into the overall physician fee schedule. The RVUs for anesthesia services were based on RVUs from a uniform relative value guide. We established a separate CF for anesthesia services, and we continue to recognize

time as a factor in determining payment for these services. As a result, there is a separate payment system for anesthesia services.

2. Practice Expense and Malpractice Expense Relative Value Units

Section 1848(c)(2)(C) of the Act requires that the practice expense and malpractice expense RVUs equal the product of the base allowed charges and the practice expense and malpractice percentages for the service. Base allowed charges are defined as the national average allowed charges for the service furnished during 1991, as estimated using the most recent data available. For most services, we used 1989 charge data aged to reflect the 1991 payment rules, because those were the most recent data available for the 1992 fee schedule.

Section 121 of the Social Security Act Amendments of 1994 (Pub. L. 103–432), enacted on October 31, 1994, required us to develop a methodology for a resource-based system for determining practice expense RVUs for each physician's service. As amended by the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33), enacted on August 5, 1997, section 1848(c) required the new payment methodology to be phased in over 4 years, effective for services furnished in 1999, with resource-based practice expense RVUs becoming fully effective in 2002. The BBA also required us to implement resource-based malpractice RVUs for services furnished beginning in 2000.

II. Provisions of the Proposed Rule Related to the Physician Fee Schedule

In response to the publication of the August 5, 2004 proposed rule (69 FR 47488), we received approximately 9,302 comments. We received comments from individual physicians, health care workers, professional associations and societies, and beneficiaries. The majority of the comments addressed the proposals related to ''incident to'' therapy services, GPCI, diagnostic psychological testing, and drug issues including average sales price (ASP).

The proposed rule discussed policies that affected the number of RVUs on which payment for certain services would be based. The proposed rule also discussed policies related to implementation of the MMA. RVU changes implemented through this final rule are subject to the $20 million limitation on annual adjustments contained in section 1848(c)(2)(B)(ii)(II) of the Act.

After reviewing the comments and determining the policies we would implement, we have estimated the costs and savings of these policies and discuss in detail the effects of these changes in the Regulatory Impact Analysis in section XIV.

For the convenience of the reader, the headings for the policy issues correspond to the headings used in the August 5, 2004 proposed rule. More detailed background information for each issue can be found in the August 5, 2004 proposed rule.

A. Resource-Based Practice Expense Relative Value Units

1. Resource-Based Practice Expense Legislation

Section 121 of the Social Security Act Amendments of 1994 (Pub. L. 103–432), enacted on October 31, 1994, amended section 1848(c)(2)(C)(ii) of the Social Security Act (the Act) and required us to develop a methodology for a resource-based system for determining practice expense RVUs for each physician's service beginning in 1998. Until that time, physicians' practice expenses were established based on historical allowed charges.

In developing the methodology, we were to consider the staff, equipment, and supplies used in providing medical and surgical services in various settings. The legislation specifically required that, in implementing the new system of practice expense RVUs, we apply the same budget-neutrality provisions that we apply to other adjustments under the physician fee schedule.

Section 4505(a) of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33), enacted on August 5, 1997, amended section 1848(c)(2)(C)(ii) of the Act and delayed the effective date of the resource-based practice expense RVU system until January 1, 1999. In addition, section 4505(b) of the BBA provided for a 4-year transition period from charge-based practice expense RVUs to resource-based RVUs.

Further legislation affecting resource-based practice expense RVUs was included in the Medicare, Medicaid and State Child Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113) enacted on November 29, 1999. Section 212 of the BBRA amended section 1848(c)(2)(C)(ii) of the Act by directing us to establish a process under which we accept and use, to the maximum extent practicable and consistent with sound data practices, data collected or developed by entities and organizations. These data would supplement the data we normally collect in determining the practice expense component of the physician fee schedule for payments in CY 2001 and CY 2002. (The 1999 and 2003 final rules (64 FR 59380 and 68 FR 63196, respectively, extended the period during which we would accept supplemental data.)

2. Current Methodology for Computing the Practice Expense Relative Value Unit System

In the November 2, 1998 final rule (63 FR 58910), effective with services furnished on or after January 1, 1999, we established at 42 CFR 414.22(b)(5) a new methodology for computing resource-based practice expense RVUs that used the two significant sources of actual practice expense data we have available—the Clinical Practice Expert Panel (CPEP) data and the American Medical Association's (AMA) Socioeconomic Monitoring System (SMS) data. The CPEP data were collected from panels of physicians, practice administrators, and nonphysicians (for example registered nurses) nominated by physician specialty societies and other groups. The CPEP panels identified the direct inputs required for each physicians service in both the office setting and out-of-office setting. The AMA's SMS data provided aggregate specialty-specific information on hours worked and practice expenses. The methodology was based on an assumption that current aggregate specialty practice costs are a reasonable way to establish initial estimates of relative resource costs for physicians' services across specialties. The methodology allocated these aggregate specialty practice costs to specific procedures and, thus, can be seen as a ''top-down'' approach.

Also in the November 2, 1998 final rule, in response to comments, we discussed the establishment of the Practice Expense Advisory Committee (PEAC) of the AMA's Specialty Society Relative Value Update Committee (RUC), which would review code'specific CPEP data during the refinement period. This committee would include representatives from all major specialty societies and would make recommendations to us on suggested changes to the CPEP data.

As directed by the BBRA, we also established a process (*see* 65 FR 65380) under which we would accept and use, to the maximum extent practicable and consistent with sound data practices, data collected by entities and organizations to supplement the data we normally collect in determining the practice expense component of the physician fee schedule.

a. Major Steps

A brief discussion of the major steps involved in the determination of the practice expense RVUs follows. (Please see the November 1, 2001 final rule (66 FR 55249) for a more detailed explanation of the top-down methodology.)

- *Step 1*—Determine the specialty specific practice expense per hour of physician direct patient care. We used the AMA's SMS survey of actual aggregate cost data by specialty to determine the practice expenses per hour for each specialty. We calculated the practice expenses per hour for the specialty by dividing the aggregate practice expenses for the specialty by the total number of hours spent in patient care activities.
- *Step 2*—Create a specialty-specific practice expense pool of practice expense costs for treating Medicare patients. To calculate the total number of hours spent treating Medicare patients for each specialty, we used the physician time assigned to each procedure code and the Medicare utilization data. The primary sources for the physician time data were surveys submitted to the AMA's RUC and surveys done by Harvard for the establishment of the work RVUs. We then multiplied the physician time assigned per procedure code by the number of times that code was billed by each specialty, and summed the products for each code, by specialty, to get the total physician hours spent treating Medicare patients for that specialty. We then calculated the specialty-specific practice expense pools by multiplying the specialty practice expenses per hour (from step 1) by the total Medicare physician hours for the specialty.
- *Step 3*—Allocate the specialty-specific practice expense pool to the specific services (procedure codes) performed by each specialty. For each specialty, we divided the practice expense pool into two groups based on whether direct or indirect costs were involved and used a different allocation basis for each group.

(i) Direct costs—For direct costs (which include clinical labor, medical supplies, and medical equipment), we used the procedure-specific CPEP data on the staff time, supplies, and equipment as the allocation basis. For the separate practice expense pool for services without physician work RVUs, we have used, on an interim basis, 1998 practice expense RVUs to allocate the direct cost pools.

(ii) Indirect costs—To allocate the cost pools for indirect costs, including administrative labor, office expenses, and all other expenses, we used the total direct costs, or the 1998 practice expense RVUs, in combination with the physician fee schedule work RVUs. We converted the work RVUs to dollars using the Medicare CF (expressed in 1995 dollars for consistency with the SMS survey years).

- *Step 4*—The direct and indirect costs are then added together to attain the practice expense for each procedure, by specialty. For procedures performed by more than one specialty, the final practice expense allocation was a weighted average of practice expense allocations for the specialties that perform the procedure, based on the frequency with which each specialty performs the procedure on Medicare patients.

b. Other Methodological Issues

i. Nonphysician Work Pool

As an interim measure, until we could further analyze the effect of the top-down methodology on the Medicare payment for services with physician work RVUs equal to zero (including the technical components of radiology services and other diagnostic tests), we created a separate practice expense pool. We first used the average clinical staff time from the CPEP data and the ''all physicians'' practice expense per hour to create the pool. In the December 2002 final rule, we changed this policy and now use the total clinical staff time and the weighted average specialty-specific practice expense per hour for specialties with services in this pool. In the next step, we used the adjusted 1998 practice expense RVUs to allocate this pool to each service. Also, for all radiology services that are assigned physician work RVUs, we used the adjusted 1998 practice expense RVUs for radiology services as an interim measure to allocate the direct practice expense cost pool for radiology.

A specialty society may request that its services be removed from the nonphysician work pool. We have removed services from the nonphysician work pool if the requesting specialty predominates utilization of the service.

ii. Crosswalks for Specialties Without Practice Expense Survey Data

Since many specialties identified in our claims data did not correspond exactly to the specialties included in the SMS survey data, it was necessary to crosswalk these specialties to the most appropriate SMS specialty.

iii. Physical Therapy Services

Because we believe that most physical therapy services furnished in physicians' offices are performed by physical therapists, we crosswalked all utilization for therapy services in the CPT 97000 series to the physical and occupational therapy practice expense pool.

3. Practice Expense Proposals for Calendar Year 2005

a. Supplemental Practice Expense Surveys

i. Survey Criteria and Submission Dates

As required by the BBRA, we established criteria to evaluate survey data collected by organizations to supplement the SMS survey data used in the calculation of the practice expense component of the physician fee schedule. The deadline for submission of supplemental data to be considered in CY 2006 is March 1, 2005.

ii. Survey by the College of American Pathologists (CAP)

In the August 5, 2004 rule, we proposed to incorporate the CAP survey data into the practice expense methodology and to implement a change to the practice expense methodology to calculate the technical component RVUs for pathology services as the difference between the global and professional component RVUs. (This technical change was proposed in the June 28, 2002 **Federal Register** (67 FR 43849), but, at the specialty's request, we delayed implementation of this change for pathology services to permit evaluation of the combined effects of the use of the new survey data along with this technical change to the methodology.) We proposed to use the following practice expense per hour figures for specialty 69—Independent Laboratory.

TABLE 1: Practice Expense Per Hour Figures for Specialty 69--Independent Laboratory

Specialty	Clinical Staff	Admin. Staff	Office Expense	Medical Supplies	Medical Equipment	Other	Total
Independent Laboratory	$66.5	$20.2	$15.0	$15.8	$6.9	$16.9	$141.1

Comment: Specialty organizations representing clinical laboratories and pathologists expressed support for the use of the CAP supplemental survey data and urged us to finalize this proposal.

Response: We will incorporate the CAP survey data into the practice expense methodology and implement the proposed change to the practice expense methodology to calculate the technical component RVUs for pathology services as the difference between the global and professional component RVUs.

iii. Submission of Supplemental Surveys

We received surveys from the American College of Cardiology (ACC), the American College of Radiology (ACR), and the American Society for Therapeutic Radiation Oncology (ASTRO). Our contractor, The Lewin Group, evaluated the data and recommended that we accept the data from the ACC and the ACR, but indicated that the survey from ASTRO did not meet the precision criteria established for supplemental surveys and, thus, did not recommend using the ASTRO survey results at this time. We agreed with these recommendations. However, as explained in the August 5, 2004 proposed rule, the ACR and the ACC requested that we not use the data until we have a stable and global solution that is workable for all specialties that are currently paid using the nonphysician work pool. We agreed with these requests and proposed delaying use of these supplemental surveys until issues related to the nonphysician work pool can be addressed.

Comment: The ACR expressed appreciation for our acceptance of the supplemental data and for our proposal to delay implementation until next year, as they had requested, to allow further time to examine the issue of the nonphysician work pool. The Society for Interventional Radiology (SIR) also expressed support for the use of the ACR data and the delay in implementation.

Response: We look forward to working with these and other specialties as we seek a permanent solution to practice expense issues associated with the nonphysician work pool.

Comment: ASTRO stated that they appreciate the opportunity to submit data and, that they understand we will not be using the data in 2005. ASTRO further commented that, due to the specific practice patterns and practice environment of radiation oncology, new data, regardless of the response rate, may not meet the criteria. ASTRO further stated that they will continue to work with CMS and with the Lewin Group as this issue is analyzed. The Association of Freestanding Radiation Oncology Centers (AFROC) expressed concern that freestanding centers that have higher costs than hospital-based centers were underrepresented by the ASTRO survey. They also expressed concern about the reference in the Lewin Group report to crosswalking radiation oncology costs from another specialty. In addition, AFROC argued that we should not average costs associated with freestanding centers with those that are hospital-based, because the costs would be understated. They urged us to ensure that any assumption regarding representativeness of any survey data is justified.

Response: We will take these comments into consideration as we continue to work with these groups concerning the supplemental survey data. We currently have no plans to propose a practice expense crosswalk for radiation oncology.

Comment: The ACC expressed appreciation that we are not eliminating the nonphysician workpool until methodologic issues are addressed. While they support the delay in implementing their supplemental survey data, they believe that the contractor's suggestion that the ACC survey data could be blended with the existing SMS survey data is invalid for two reasons: (1) The suggestion that similar changes to physician practice (for example, increased use of technology) may have occurred throughout all physician services is an unfounded speculation because few other specialties are as technologically driven as cardiology; and (2) other supplemental data has not been blended and all specialties must be treated consistently.

Response: We will take these comments into consideration as part of the evaluation and discussion of the cardiology survey data in next year's proposed rule.

Comment: The American Urological Association requested that, as we explore alternate sources of data and consider how to incorporate new practice expense data into the methodology, we find a way to incorporate recently collected specialty supplemental data into the new efforts. They also requested that we clarify whether we would apply the budget neutrality exemption to any increases in drug administration PE RVUs that result from the use of urology survey data that will be submitted under the supplemental survey process.

Response: We anticipate that we would incorporate all accepted supplemental survey data into any comprehensive changes to the nonphysician work pool.

As we explained in the January 7, 2004 **Federal Register** (69 FR 1093 through 1094), section 303(a)(1) of the MMA modifies section 1848(c)(2)(B) of the Act to provide an exemption from the budget neutrality requirements in 2006 for further increases in the practice expense RVUs for drug administration that may result from using survey data from specialties meeting certain criteria. The survey must include expenses for the administration of drugs and biologicals and be submitted by a specialty that receives more than 40 percent of its 2002 Medicare revenues from drugs. Urology received more than 40 percent of its 2002 Medicare revenues from drugs. Therefore, if we were to receive a practice expense survey of urologists by March 1, 2005

that included expenses for the administration of drugs and biologicals and the survey met the criteria we have established (and those of section 1848(c)(2)(I)(ii) of the Act), we would exempt the change in the practice expense RVUs for drug administration services from the budget neutrality requirements of section 1848(c)(2)(B) of the Act.

b. Practice Expense Advisory Committee (PEAC)

Recommendations on CPEP Inputs for 2005

- CPEP Refinement Process.

In the August 5, 2004 proposed rule, we included the PEAC recommendations from meetings held in March and August 2003 and January and March 2004, which accounted for over 2,200 codes from many specialties. We also stated that future practice expense issues, including the refinement of the remaining codes not addressed by the PEAC, would be handled by the RUC.

Comment: We received comments from the AMA that future practice expense issues, including the refinement of the remaining codes not addressed by the PEAC, would be handled by the RUC with the help of a new ad hoc committee, now termed the Practice Expense Review Committee (PERC), comprised of former PEAC members. The RUC also noted that their Practice Expense Subcommittee remains committed to reviewing improvements to the practice expense methodology.

The AMA and the RUC, as well as the specialty society representing neurological surgeons, noted their appreciation of our continued efforts to improve the direct practice expense data and to establish a reasonable methodology for determining practice expense relative values.

Response: We look forward to our continuing work with the AMA, the RUC and all the specialty societies on the refinement of the remaining codes and with ongoing practice expense issues.

Comment: The National Association for the Support of Long Term Care expressed concern about the dissolution of the PEAC and requested that we require the RUC to expand its membership to include a broad array of providers who are reimbursed under the physician fee schedule.

Response: Because the RUC is an independent committee, we are not in a position to set the requirements for RUC membership. However, we are confident that the RUC and the Health Care Professional Advisory Committee, which also sends practice expense recommendations directly to us, together represent two broad ranges of practitioners, both physician and nonphysician.

Comment: A specialty society suggested that there should be a process for fixing minor errors that are identified outside of the refinement process. The commenter also suggested that there should be a system to address individual exceptions to PEAC standard packages.

Response: If we have made errors, major or minor, in any part of our calculation of practice expense RVUs in this final rule, inform us as soon as possible so that we are able to correct them in the physician fee schedule correction notice. Any other revisions would have to be made in the next physician fee schedule rule. If a specialty society believes that a RUC decision is not appropriate, the society can always request that the decision be revisited or can discuss the issue with us at any time. For the concern with the standard packages adopted by the PEAC, it is our understanding that all presenters at the RUC have the opportunity to demonstrate that something other than the standard would be more appropriate.

- PEAC Recommendations.

We proposed to adopt nearly all of the PEAC recommendations. However, we disagreed with the PEAC recommendation for clinical labor time for CPT code 99183, Physician attendance and supervision of hyperbaric oxygen therapy, per session, and proposed a total clinical labor time of 112 minutes for this service.

Comment: Specialty societies representing interventional radiology and neurological surgeons, as well as the AMA, expressed appreciation for our acceptance of well over 2,000 PEAC refinements in this rule. However, the specialty society representing orthopaedic surgeons commented that some of our proposals appeared to be circumventing the PEAC process, in that we changed the PEAC recommendation for hyperbaric oxygen (HBO) therapy and proposed in-office inputs for two services rather than referring these to the RUC.

Response: We appreciate the hard work and perseverance on the part of the PEAC and the specialty societies that produced the recommended refinements for so many services. In addition, we do not believe that we circumvented the PEAC process in any way. We have the greatest respect for the PEAC and RUC recommendations that we received. However, we do have the final responsibility for all payments made under the physician fee schedule, and this can lead to disagreement with a specific recommendation. The RUC itself has always demonstrated its understanding and respect for our responsibility in this regard. With regard to the two services that we priced in the office, we stated explicitly in the proposed rule that we were requesting that the RUC review the practice expense inputs.

Comment: The specialty society representing family physicians disagreed with our proposed changes to the PEAC recommendations for the clinical labor time for CPT code 99183, *Physician attendance and supervision of hyperbaric oxygen therapy, per session.* The commenter contended that a physician providing this service would probably have multiple hyperbaric oxygen chambers; therefore, staff would not be in constant attendance. However, the specialty society representing podiatrists supported this change in clinical staff time.

Response: Based on our concern that the PEAC recommendation of 20 minutes of clinical staff time during the intra-service period undervalued the clinical staff time, we proposed increasing this time to 90 minutes in the proposed rule. This was, of course, subject to comment. We believe there is some merit to the claim that the clinical staff may be monitoring more than one chamber at a time. Therefore, we are adjusting the time for the intra-service period from the proposed 90 minutes to 60 minutes in recognition of this point. We will continue our examination of this issue and entertain ongoing dialog with all interested organizations and individuals familiar with this service to assure the accuracy of the intra-service time.

Comment: The Cardiac Event Monitoring Provider Group Coalition expressed concern about the PEAC recommendations that would substantially reduce the clinical staff time associated with cardiac monitoring services. Of particular concern to the Coalition was the 70 percent reduction in time for CPT code 93271, the code for cardiac event monitoring, receipt of transmissions, and analysis. Although all these services are currently priced in the nonphysician work pool and this decrease in the staff times has no immediate impact, the commenter was concerned that, when the nonphysician work pool is eliminated, these services will be undervalued. The commenter also believed that the PEAC recommendations may not have reflected all the supplies and equipment utilized in these services and included a complete list of necessary supplies

and equipment. The American College of Cardiology (ACC) presented these services at the PEAC meeting and commented they had been unable to collect sufficient data so that the PEAC could make an appropriate recommendation.

Response: It is clear from the Coalition and ACC comments that more information is needed in order to ensure that the appropriate practice expense inputs are assigned to these services in the event that they are removed from the nonphysician work pool. We would be glad to work with the Coalition and the specialty society so that they can make a new presentation to the RUC this coming year.

• Adjustments To Conform With PEAC Standards

We also reviewed those codes that are currently unrefined or that were refined early in the PEAC process to apply some of the major PEAC-agreed standards. For the unrefined 10-day global services, we proposed to substitute for the original CPEP times the PEAC-agreed standard post-service office visit clinical staff times used for all 90-day and refined 10-day global services. We also proposed to eliminate the discharge day management clinical staff time from all but the 10 and 90-day global codes, substituting one post-service phone call if not already in the earlier data. Lastly, we proposed to delete any extra clinical staff time for post-visit phone calls for 10 and 90-day global service because that time is already included in the time allotted for the visits.

Comment: A specialty society representing family physicians supported the elimination of the discharge day management time assigned in the facility setting for all 0-day global services, as well as all the other adjustments we made to apply PEAC standards. However, several specialty societies representing gastroenterology and orthopaedics, as well as the American College of Physicians, did not agree with the deletion of the discharge day management time. These groups requested restoration of the six minutes allocated to the discharge day management for 0-day global services and argued that most 0-day services require as much staff time as do many 10-day global services performed in the outpatient setting. One of these commenters did not believe a rationale was provided for this change. Another commenter, although recommending that any future refinements take into account all of the PEAC standards, expressed concern regarding all of the above changes, suggesting that this could lead to additional anomalies and recommending that the revisions should be reviewed by the RUC.

Response: The PEAC recommended that the discharge day management time apply only to 10-day and 90-day global services and we were complying with this recommendation. We also believe that this PEAC recommendation is reasonable; it is hard to imagine what tasks a physician's clinical staff back in the office is performing for a patient during the period that the patient is undergoing a same-day procedure in the hospital outpatient department. However, the point made about 10-day global procedures is pertinent. We would suggest that the RUC reconsider whether the discharge day management clinical staff time should apply only to services that are typically performed in the inpatient setting. We also believe that it was appropriate to apply the PEAC standards to codes that were not refined or that were refined before the standards were developed. The application of these standards is not only fair, but can also help to avoid the possible rank order anomalies cited by the commenter.

Methacholine Chloride

The PEAC recommendations for CPT codes 91011 and 91052 included a supply input for methacholine chloride as the injected stimulant for these two services. In discussions with representatives from the gastroenterology specialty society subsequent to receipt of the PEAC recommendations, we learned this is incorrect. For the esophageal motility study, CPT code 91011, we proposed to include edrophonium as the drug typically used in this procedure. For the gastric analysis study, CPT code 91052, we were unable to identify the single drug that is most typically used with this procedure. We requested that commenters provide us with information on the drug that is most typically used for CPT code 91052, including drug dosage and price, so that it could be included in the practice expense database.

Comment: Several specialty societies representing allergists, pulmonologists and chest physicians, as well as the AMA, requested that the additional cost of methacholine be reflected in the RVUS for the bronchial challenge test, CPT code 95070. As an alternative, the specialty society representing allergists suggested that a HCPCS code could be created so that methacholine could be billed separately.

In response to our request for information about the supply inputs for CPT codes 91011 and 91052, the American Gastroenterological Association (AGA) indicated that edrophonium may be an appropriate supply proxy for CPT code 91011, but, in practice, other agents are more commonly used. However, they provided no additional information regarding these other agents. AGA also stated that the most commonly used drug for CPT code 91052 is pentagastrin, but betazole or histamine may also be used. Again, they did not provide further specific information.

Response: Because CPT code 95070 is valued in the nonphysician work pool, the PEAC's addition of methacholine to this procedure could not be captured by the practice expense RVUs. However, a J-code was established, J7674, *Methacholine chloride administered as inhalation solution through nebulizer, per 1mg,* so that this drug can be billed separately. Accordingly, we have deleted methacholine from the practice expense database.

For CPT code 91011, we have retained the drug edrophonium, and our proposed price of $4.67 per ml, as a supply in the practice expense database. However, we were not able to include a price for pentagastrin in the supply practice expense database for CPT code 91052. We will be happy to work with the specialty societies involved with both of these procedures to obtain accurate drug pricing for the 2006 fee schedule.

• Nursing Facility and Home Visits.

We proposed to adopt the direct practice expense input recommendations from the March 2003 PEAC meeting for CPT codes 99348 and 99350, two E/M codes for home visits, as well as the March 2004 PEAC recommendations for E/M codes for nursing home services (CPT codes 99301 through 99316).

Comment: A specialty group representing family physicians supported the acceptance of the PEAC recommendations for nursing facility visits, even though this resulted in a decrease for these services. The commenter stated that the decrease occurred because the original CPEP data was flawed and the clinical staff times were too high. The commenter also stated that the payments in the facility setting will increase for these services and that setting has the higher volume of visits. Other commenters representing long term care physicians, geriatricians and podiatrists expressed disappointment in these PEAC recommendations and stated that, while the PEAC did consider the views of long term care physicians, the PEAC failed to accept these views even though they were supported by data. These commenters believe the PEAC did not

recommend an appropriate increase based on a false assumption that the nursing home provides the staff. Another commenter contended that the new values do not adequately account for work performed by the physician's clinical staff. The commenter stated that the pre- and post-times for these codes are less than for the comparable office visit codes, even though it is clear that more clinical staff time is required for the nursing facility resident. One commenter suggested that these concerns would need to be addressed within the framework of the 5-year review. The specialty society representing homecare physicians also commented that, rather than challenging a flawed system, they will use the 5-year review process to have work and practice expense re-valuated for the home visit codes.

Response: While sympathetic to the concerns expressed by the long-term care physicians regarding the overall decrease in clinical staff time in the nursing facility E/M procedures, we believe the PEAC recommendations for these services to be reasonable. We also agree with commenters regarding the upcoming 5-year review process as a means to address the physician work component of these codes. To the extent that there is overlap between the physician time and the clinical labor practice expenses involved in a particular procedure, the 5-year review process can be utilized to address these issues. We encourage the home care physicians and the long-term care physicians to consider using the 5-year review process for these codes.

• Suggested Corrections to the CPEP Data.

Comment: The RUC and American Podiatric Medical Association identified a number of PEAC refinements from the August 2003 meeting that were not reflected in the practice expense database and asked that these be implemented. The RUC also asked us to correct the equipment times for all of the 90-day global services to correspond with the PEAC-refined clinical staff times for these codes.

Response: We have made the recommended corrections to our practice expense database.

Comment: The specialty society representing hematology noted the supply items missing from the practice expense database for CPT codes 36514 through 36516 that had been included in the CMS-accepted PEAC refinements.

Response: We regret the error. These items are incorporated into the practice expense database.

Comment: The specialty society representing pediatrics as well as the RUC commented that the PEAC recommendations also included a recommendation for a change in the global period for CPT code 54150, *Circumcision, using clamp or other device; newborn,* from a 10-day global to an ''xxx'' designation, which would mean the global period does not apply. This issue was not discussed in the proposed rule and the commenters requested that this change be reflected in the final rule.

Response: As stated by the commenters, this request was included in the PEAC recommendations but was inadvertently omitted from the proposed rule. We agree that the 10-day global period currently assigned to this procedure may not be appropriate because the physician performing the procedure most likely does not see the infant for a post-procedure visit. However, we believe that a 0-day global period rather than ''xxx'' should be assigned to this procedure. We generally use the ''xxx'' designation for diagnostic tests and no surgical procedure currently is designated as an ''xxx'' global service. We believe this will accomplish the same end because most any other service performed at the same time as the circumcision could be billed with the appropriate modifier. We are adjusting the practice expense database to delete any staff time, supplies and equipment associated with the post-procedure office visit.

Comment: Specialty societies representing dermatology stated that there was an error in the nonfacility practice expense RVUS for the Mohs micrographic surgery service, CPT code 17307, due to the omission of clinical staff time from the practice expense database.

Response: We have corrected the practice expense database to reflect the appropriate clinical staff time.

Comment: We received comments from the American College of Radiology (ACR) and Society of Nuclear Medicine noting that some of the codes used by their specialty were omitted from the listing of PEAC-refined codes that appeared in Addendum C in our proposed rule. They submitted a complete list of the codes that had gone through PEAC refinement, beginning at the first PEAC meeting in April 1999, and asked that we include these codes on the Addendum.

Response: We appreciate the specialty societies bringing to our attention that some of their codes were omitted from Addendum C and we have reviewed the codes on their submitted list. Addendum C was meant to list only those codes that were refined in this year's rule, and thus, only listed those refined by the PEAC from March and August 2003 and January and March 2004. However, it does appear that there is some confusion regarding what codes were refined during this period, particularly from the March 2004 meeting. We will work with all medical societies and the RUC to clarify the status of all the codes in question.

• Other Issues.

Comment: The RUC requested that we publish practice expense RVUs for all Medicare noncovered services for which the RUC has recommended direct inputs. We also received a request from the American Academy of Pediatrics to publish work and practice expense RVUs for the noncovered nasal or oral immunization services (CPT codes 90473 and 90474) and the visual acuity test (CPT code 99173).

Response: In the past, we have published the practice expense RVUs for only a small number of noncovered codes which are listed in our national payment files that can be accessed via our physician web page under ''Medicare Payment Systems'' as part of the public use files at *www.cms.hhs.gov/physicians/.* Because we have not yet established a consistent policy regarding the publication of RVUs for noncovered services, we will need to examine this issue further to carefully weigh the pros and cons of publishing these RVUs for noncovered services.

Comment: The American Speech-Language Hearing Association (ASHA) and the American Academy of Audiology (AAA), expressed concern about the reduction of practice expense RVUs for CPT code 92547, *Use of vertical electrodes (List separately in addition to code for primary procedure),* which resulted after the PEAC refinement. The commenters asked for our assistance to clarify a CPT instruction regarding this procedure because they believe it prevents the multiple billings of CPT 92547 in a given patient encounter.

Response: While we are sympathetic to the concerns expressed by ASHA and AAA, we also want to note that CPT code descriptors and accompanying coding instructions are proprietary to CPT. We would encourage these organizations to discuss this issue directly with the CPT editorial committee.

Comment: A specialty society representing vascular surgery expressed concern about the wide variations in practice expense RVUs that are sometimes derived under the current methodology. The commenter suggested that some outliers require additional focus to determine whether these are errors in the direct inputs or if they

reflect problems inherent in the methodology. According to the commenter, it would appear that some of the extreme variation is due to the high costs of certain disposable supplies in the office setting as well as high scaling factors. A few examples of outlier codes were provided. The commenter suggested that we consider an alternative methodology for payment of high-priced single-use items in the nonfacility setting.

Response: We agree with the commenter that the issue raised is one worth study and analysis. Unfortunately, this is not a task that can be accomplished in time for discussion in this final rule. We will be very willing to work with the specialty society and with the Practice Expense Subcommittee of the RUC, as well as any other interested parties, to work further on this issue that will only be magnified as more complex procedures are moved into the office setting.

Comment: A provider of radiology services questioned the reductions in practice expense for CPT code 77370, *Special medical radiation physics consultation.*

Response: The practice expense RVUs for CPT code 77370 decreased by 0.02 RVUs between last year's final rule and this year's proposed rule. This small decrease is due to the normal fluctuations resulting from updating our practice expense data.

c. Repricing of Clinical Practice Expense Inputs—Equipment

We use the practice expense inputs (the clinical staff, supplies, and equipment assigned to each procedure) to allocate the specialty-specific practice expense cost pools to the procedures performed by each specialty. The costs of the original equipment inputs assigned by the CPEP panels were determined in 1997 by our contractor, Abt Associates, based primarily on list prices from equipment suppliers. Subsequent to the CPEP panels, equipment has also been added to the CPEP data, with the costs of the inputs provided by the relevant specialty society. We only include equipment with costs equal to or exceeding $500 in our practice expense database because the cost per use for equipment costing less than $500 would be negligible. We also consider the useful life of the equipment in establishing an equipment cost per minute of use.

We contracted with a consultant to assist in obtaining the current price for each equipment item in our CPEP database. The consultant was able to determine the current prices for most of the equipment inputs and clarified the specific composition of each of the various packaged and standardized rooms or ophthalmology ''lanes'' currently identified in the equipment practice expense database (for example, mammography room or exam lane). We proposed to delete the current ''room'' designation for the radiopharmaceutical receiving area and, in its place, list separately the equipment necessary for each procedure as individual line items.

Also, we proposed to replace all surgical packs and trays in the practice expense database with the appropriate standardized packs that were recommended by the PEAC, either the basic instrument pack or the medium pack.

The useful life for each equipment item was also updated as necessary, primarily based on the AHA's ''Estimated Useful Lives of Depreciable Hospital Assets'' (1998 edition). We noted in the August 5, 2004 proposed rule that AHA would be publishing updated guidelines this summer and that we would reflect any updates in our final rule.

In addition, we proposed the following database revisions:

Assignment of Equipment Categories

We proposed that equipment be assigned to one of the following six categories: documentation, laboratory, scopes, radiology, furniture, rooms-lanes, and other equipment. These categories would also be used to establish a new numbering system for equipment that would more clearly identify them for practice expense purposes.

Consolidation and Standardization of Item Descriptions

We proposed combining items that appeared to be duplicative. For example, for two cervical endoscopy procedures, our contractor identified that the price of the LEEP system includes a smoke evacuation system but that system is also listed separately. We proposed to merge these two line items and reflect both prices in the price of the LEEP system.

These changes were reflected in Addendum D of the proposed rule.

Additionally, there were specific equipment items for which a source was not identified or for which pricing information was not found that were included in Table 2 of the August 5 proposed rule. Items that we proposed to delete from the database were also identified in this table. We requested that commenters, particularly the relevant specialty groups, provide us with the needed pricing information, including appropriate documentation. Also, we stated that if we were not able to obtain any verified pricing information for an item, we might eliminate it from the database.

Comment: The Society of Nuclear Medicine agreed with the deletion of the current room designation for radiopharmaceutical area and designation of categories for equipment. However, the society recommended that the category designation of ''radiology'' be changed to ''imaging equipment'' and ''other equipment'' be changed to ''non-imaging equipment'' to be inclusive of these modalities. The American College of Radiology also concurred with the elimination of the current room designation for radiopharmaceutical area.

Response: We agree that the term ''imaging equipment'' rather than the term ''radiology'' more accurately reflects current practice and have changed the practice expense database accordingly. However, it would be inappropriate to change the ''other equipment'' category to ''non-imaging equipment'' because there are items in other categories that would not be encompassed in the proposed title change.

Comment: The Society of Nuclear Medicine supplied information on the equipment item E51076 with the requested documentation.

Response: We have revised the practice expense database to reflect the information provided.

Comment: The American Society for Therapeutic Radiology and Oncology (ASTRO) submitted information and the requested documentation for fifteen items, often supplying two or more pricing sources.

Response: We greatly appreciate the information and have revised the practice expense database to reflect the information provided.

Comment: Commenters representing manufacturers and providers expressed concern about the reduction in payment (9 percent) for external counterpulsation (ECP), G0166. The commenters questioned the proposed change made to the life of the ECP equipment, from seven to five years, used for this service. Commenters did not believe this was supported by the AHA information (which indicated that similar diagnostic cardiovascular equipment has an equipment life of five years) and requested that this timeframe be applied to the ECP equipment for this service. The American College of Cardiology also questioned the change to the ECP equipment life. The commenters also questioned the allocation for maintenance and indirect costs applied under the practice expense methodology

as well as the time allocated for this service. As a final point, some of the commenters requested that we adjust the work RVUs assigned to this G-code to that of an echocardiogram (CPT code 93307) and include it in the nonphysician work pool.

Response: Based upon review of the information provided we have revised the equipment life to five years. The methodology used for the allocation for maintenance and indirect costs is consistent with our methodology. For the request to adjust the work RVUs for this service, we refer the commenters to section VI of this final rule where we are soliciting comments on services where the physician work may be misvalued.

Comment: The College of American Pathologists provided information on items listed in table 2: the DNA image analyzer (ACIS), and image analyzer (CAS system) code E13652. They noted that the CAS system is no longer marketed and that the ACIS system would be used in its place. Thus, they provided documentation on the price for the ACIS system.

Response: We appreciate the information and have made the necessary changes to the database.

Comment: The American College of Cardiology (ACC) agreed with the pricing for the ambulatory blood pressure monitor, provided prices for the ECG signal averaging system (E55035), but provided no documentation for these prices. They stated that the echocardiography digital acquisition ultrasound referenced in table 2 was no longer in the marketplace and that a digital workstation was now typically used. They requested that an appropriate equipment code be available for this item and provided a price range for this item (although without the supporting documentation). ACC also recommended that the pacemaker programmer (E55013) be removed from the equipment list because it is provided at no cost to the physician. Removal of this item from the PE database was also supported by a manufacturer that commented on the rule.

Response: We have removed the pacemaker programmer from the practice expense database. We will temporarily retain other items and prices for the 2005 physician fee schedule and request that ACC forward the documentation as soon as possible.

Comment: The American College of Radiology (ACR) provided partial information for the CAD processor unit and software. ACR also submitted information regarding the computer workstation for MRA and the mammography reporting software, but with insufficient documentation. For the various equipment items ACR listed for the mammography room, updated information was provided for a few of the items. ACR noted that they would submit documentation for all outstanding pieces of equipment when it is available. ACR did not agree with the room price for MRI and CT that was referenced in Addendum D and requested an extension so that they can work with us to accurately price these items.

Response: We will maintain current pricing for all equipment items and the mammography room on an interim basis, until sufficient documentation is provided.

Comment: The American Ophthalmology Association (AOA) and American Optometric Association both supplied pricing information along with the requested documentation for the computer, VDT, and software (E71013) listed in table 2. AOA also provided pricing information for the ophthalmology drill listed in this table, indicating a cost of $57. They expressed their appreciation for the recategorization and standardization of descriptions for equipment and supplies.

Response: We appreciate the documentation forwarded by these two organizations and have incorporated into the practice expense database the pricing information provided for the computer, VDT, and software. Because the ophthalmology drill is less than $500 (the standard established for equipment), we are removing it from the equipment list for the practice expense database.

Comment: The American Gastroenterological Association (AGA) expressed concern about the reduction in RVUs for CPT code 91065, a breath hydrogen test. They believe that the newer equipment listed in the practice expense database does not reflect the analyzer that is typically used, which is more expensive, and noted that the costs for the reagents have also increased.

Response: We are sympathetic to the concerns of the AGA regarding the typical equipment used for CPT code 91065 and would like to work with them to ascertain updated pricing information about the equipment most physicians utilize for this service. However, the majority of the decrease (76 percent) in practice expense RVUs for this procedure is due to the PEAC refinement for the clinical labor time that was reduced by nearly 50 percent.

Comment: The American Academy of Sleep Medicine indicated that most typical CPAP/BiPAP remote unit is a bilevel positive airway pressure unit and provided documentation for the price of this item.

Response: This price is reflected in the practice expense database.

Comment: The Society for Vascular Surgery (SVS), Society for Vascular Ultrasound and Society of Diagnostic Medical Sonography all expressed appreciation for the refinement to the inputs that apply to vascular ultrasound services. However, the commenters requested that we incorporate the requested refinements for the other ancillary equipment present in a vascular ultrasound room into other similar procedures. SVS specifically listed the following CPT codes: 93875–9 and 93990.

Response: In addition to the three new CPT codes for cerebrovascular arterial studies CPT 93890, 93892 and 93893, we have added the vascular ultrasound room to the codes indicated in the SVS comment noted above.

Comment: The American Psychiatric Association provided documentation for the cost of the ECT machine and the American Psychological Association provided information on the neurobehavioral status exam and testing, as well as the biofeedback equipment listed in table 2, along with the requested documentation.

Response: We appreciate this information. The practice expense database was revised to reflect this cost information.

Comment: The American Society of Clinical Oncology requested that the biohazard hood be substituted for the ventilator and hood blower as a practice expense input for the chemotherapy codes.

Response: We revised the database to reflect this change.

Comment: American Academy of Neurology supplied information and the necessary documentation on several equipment items listed in table 2 associated with neurology services.

Response: We have made the revisions to the prices for the ambulatory EEG recorder (E54008), ambulatory review station (E54009), and portable digital EEG monitor based on the documentation provided. Based on the documentation provided, we note that the price for the ambulatory review station was substantially reduced ($44,950 to $7,950).

Comment: The American Clinical Neurophysiology Society (ACNS) stated that the payment for CPT code 95819, an EEG service, was substantially reduced. The Society believes it is due to a price reduction for the EEG equipment (E54006) used in this service that was listed in Addendum D of the

proposed rule. The commenter indicated that the proposed price does not include the review station and software which is needed for this service and provided documentation for appropriately pricing this item.

Response: Based on the documentation provided, we have changed, on an interim basis for the 2005 fee schedule, the price for this item and note that this equipment price is associated only with CPT code 95819. We would be happy to work with ACNS in order to resolve any issues surrounding the RVUs for CPT code 95819. Reviewing the direct inputs for this code, we note that the largest contributor to the reduction of practice expense RVUs is the PEAC's refinement of this code's supply items.

Comment: The National Association for Medical Direction of Respiratory Care and the American College of Chest Physicians were in agreement with the proposed prices for equipment except for the pulse oximeter (including printer), E55003. The commenters referenced a price that is $83 more than that listed in the table, but provided no documentation.

Response: We appreciate the comments from these organizations regarding the repricing of the equipment items in the practice expense database. We have retained our price of $1,207 for the pulse oximeter and note that it is an average from two different available sources.

Comment: We received a comment from a consumer regarding the price of the electromagnetic therapy machine for HCPCS code G0329 with concerns about the low payment for this modality. While no documentation was submitted, the commenter noted that the cost for this equipment ranged from $25,000 to $35,000.

Response: We appreciate the commenter's remarks about the price of the electromagnetic therapy equipment, Diapulse. We have retained our price of $25,000 in the practice expense database because we do not have documentation that any higher-priced equipment is typically used. Similar to other modalities used in rehabilitation, including those used in wound care, we note that this procedure reflects comparable practice expense values.

Comment: Several specialty organizations questioned our substitution of the two standardized packs for previously PEAC-approved packs and trays, as discussed in our proposed rule. One specialty society suggested we consult with the AMA before proceeding on this point.

Response: We uniformly applied the PEAC-approved values for the packs and trays to all packs and trays, regardless of whether the codes had previously been refined by the PEAC. To the extent that a specialty society feels that it was disadvantaged by this policy, we would encourage them to bring the specific codes that should be excluded from this policy to the newly formed PERC (formerly PEAC) at the next RUC meeting in February 2005.

Comment: Several specialty organizations indicated that they were in the process of obtaining pricing information on equipment items and would provide it as soon as possible. One commenter also asked that we retain the items proposed for deletion as they are necessary in providing their services, but provided no documentation.

Response: In the proposed rule, we noted that we might eliminate those items from the database for which documented pricing information was not received. Due to the number of outstanding equipment prices, and the number of societies that are underway in their search for this data, we have decided to extend the submission deadline. We would encourage specialty societies to submit price information soon to help ensure that it can be used to establish practice expense RVUs in next year's proposed rule.

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Table 2

Equipment Items Needing Specialty Input for Pricing and Proposed Deletions

2005 Description	2004 Price	Primary specialties associated with item	*CPT code(s) associated with item	Prior status of equipment item	Commenter response	CMS action taken
ambulatory blood pressure monitor	3,000.00	cardiology	93784, 93786, 93788	See Note A	No/Insufficient documentation received	See Note D.
biofeedback equipment		psychology	90875	See Note A	Submitted price of $9,925	See Note F.
CAD processor unit (mammography)	210,000.00	radiology	76082, 76083, 76085	See Note A (Need system components)	No/Insufficient documentation received	See Note D.
camera system, cardiac, nuclear	675,000.00	anesthesia, IM, cardiology	78414	See Note A	Submitted price of $406,817	See Note F.
collimator, cardiofocal set	29,990.00	radiology	78206, 78607, 78647, 78803, 78807	See Note A	No/Insufficient documentation received	See Note D.
computer and VDT and software	9,000.00	ophthalmology, optometry	92060, 92065	See Notes A and C	Submitted price of $7,100	See Note F.
computer software, MR/PET/CT fusion	60,000.00	radiation oncology	77301	See Note A	Sumitted price of $60,000	See Note F.
computer system, record and verify	60,000.00	radiation oncology	77418	See Note A	Submitted prices from 2 sources, average of $163,593	See Note F.
computer workstation, 3D teletherapy treatment planning	221,500.00	radiation oncology	77300, 77305, 77310, 77315, 77321, 77331	See Note A	Submitted prices from 4 sources, average of $256,224	See Note F.
computer workstation, MRA post processing		radiology	71555, 72159, 72198, 73225, 73725, 74185	See Note A	No/Insufficient documentation received	See Note E.

2005 Description	2004 Price	Primary specialties associated with item	*CPT code(s) associated with item	Prior status of equipment item	Commenter response	CMS action taken
computer, server		radiation oncology	77301	See Note A (Need system components)	Submitted prices from 3 sources, average of $22,567	See Note F.
cortical bipolar-biphasic stimulating equipment		neurosurgery, neurology	95961, 95962	See Note A	No/Insufficient documentation received	See Note E.
CPAP/BiPAP remote clinical unit		pulmonary disease, neurology	95811	See Note A	Submitted price of $3,100	See Note F.
cryo-thermal unit		anesthesia	64620	See Notes A and C	No/Insufficient documentation received	See Note E.
densitometry unit, whole body, DPA	65,000.00	radiology	78351	See Notes A and C	No/Insufficient documentation received	See Note D.
densitometry unit, whole body, SPA	22,500.00	radiology	78350	See Notes A and C	No/Insufficient documentation received	See Note D.
Detector (Probe)	14,000.00	radiology, cardiology	78455	See Notes A and C	No/Insufficient documentation received	See Note D.
dialysis access flow monitor	10,000.00	nephrology	90940	See Note A	No/Insufficient documentation received	See Note D.
diathermy, microwave		anesthesia, GP, podiatry	97020	See Notes A and C	No/Insufficient documentation received	See Note D.
DNA image analyzer (ACIS)	200,000.00	lab, pathology	88358, 88361	See Note A	Submitted price of $195,000	See Note F.
drill, ophthalmology		ophthalmology	65125	See Note A	Submitted price of $57, less than $500	See Note G.
ECG signal averaging system	8,250.00	cardiology, IM	93278	See Note A	No/Insufficient documentation received	See Note D.
EEG monitor, digital, portable		neurology	95953	See Note A	Submitted price of $17,500	See Note F.
EEG recorder, ambulatory	6,940.00	neurology	95950	See Note A	Submitted price of $12,500	See Note F.
EEG review station, ambulatory	44,950.00	neurology	95950	See Note A	Submitted price of $7,950	See Note F.

2005 Description	2004 Price	Primary specialties associated with item	*CPT code(s) associated with item	Prior status of equipment item	Commenter response	CMS action taken
electroconvulsive therapy machine		psychiatry	90870	See Note A	Submitted price of $13,995	See Note F.
Electromagnetic therapy machine	25,000.00	physical therapy	G0329	See Note A	No/Insufficient documentation received	See Note D.
EMG botox	1,500.00	critical care, pulmonary, ophthalmology	92265	See Note A	No/Insufficient documentation received	See Note D.
fetal monitor software	35,000.00	ob-gyn, radiology	76818, 76819	See Note A	No/Insufficient documentation received	See Note D.
film alternator (motorized film viewbox)	27,500.00	radiology	329 codes	See Note B	No/Insufficient documentation received	See Note D.
generator, constant current	950.00	neurology, NP	95923	See Note A	No/Insufficient documentation received	See Note D.
HDR Afterload System, Nucletron - Oldelft	375,000.00	radiation oncology	77781-84	See Note A	Submitted prices from 2 sources, average of $375,9665	See Note F.
hyperbaric chamber	125,000.00	FP, IM, EM	99183	See Note A	No/Insufficient documentation received	See Note D.
hyperthermia system, ultrasound, external	360,000.00	radiation oncology	77600	See Note A	Submitted price of $360,000	See Note F.
hyperthermia system, ultrasound, intracavitary	250,000.00	radiation oncology	77620	See Note A	No/Insufficient documentation received	See Note D.
hysteroscopy ablation system	19,500.00	ob-gyn	58563	See Note A	No/Insufficient documentation received	See Note D.
image analyzer (CAS system)	92,000.00	pathology, neurology	88355, 88356	See Note A	No longer available	See Note H.
IMRT physics tools	55,485.00	radiation oncology	77301, 77418	See Note A	Submitted prices from 3 sources, average of $78,600	See Note F.
IVAC Injection Automatic Pump	2,500.00	radiology	78206, 78607, 78647, 78803, 78807	See Note A	No/Insufficient documentation received	See Note D.

2005 Description	2004 Price	Primary specialties associated with item	*CPT code(s) associated with item	Prior status of equipment item	Commenter response	CMS action taken
mammography reporting software		radiology	76090, 76091, 76092	See Note A	No/Insufficient documentation received	See Note E.
neurobehavioral status instrument-average	717.00	psychology, IM	96115, 96117	See Note A	Submitted price of $1,136.25	See Note F.
orthovoltage radiotherapy system	140,000.00	radiation oncology	77401	See Note A	No/Insufficient documentation received	See Note D.
OSHA ventilated hood	5,000.00	radiation oncology	77334	See Note B	No/Insufficient documentation received	See Note D.
plasma pheresis machine w/UV light source	37,900.00	radiology, dermatology	36481, 36510, 36522	See Note A	No/Insufficient documentation received	See Note D.
programmer, pacemaker	10,000.00	cardiology, cardiothoracic surgery, general surgery	33200-01, 33206-08, 33212-18, 33220, 33222, 33240, 33245-46, 33249, 33282	See Note A	Supplied without cost to physician offices, IDTFs, etc	See Note G.
pulse oxymetry recording software (prolonged monitoring)	3,660.00	pulmonary disease, IM	94762	See Note A	No/Insufficient documentation received	See Note D.
radiation treatment vault	550,670.00	radiation oncology	774XX	See Note B	Submitted prices from 3 sources, average $773,104	See Note F.
radiation virtual simulation system		radiation oncology	77280, 77285, 77290, 77402-16	See Note A	Submitted price of $967,000	See Note F.
remote monitoring service (neurodiagnostics)	9,500.00	neurology	95955	See Note A	No/Insufficient documentation received	See Note D.

2005 Description	2004 Price	Primary specialties associated with item	*CPT code(s) associated with item	Prior status of equipment item	Commenter response	CMS action taken
review master	23,500.00	pulmonary disease, neurology	95805, 95807-11, 95816, 95822, 95955-56	See Note A	No/Insufficient documentation received	See Note D.
room, basic radiology	150,000.00	radiology	103 codes	See Note A	No/Insufficient documentation received	See Note D.
room, mammography	130,000.00	radiology	19030, 19290-91, 19295, 76086-92, 76096	See Note A	No/Insufficient documentation received	See Note D.
room, radiographic-fluoroscopic	475,000.00		123 codes	See Note A	No/Insufficient documentation received	See Note D.
room, ultrasound, vascular		vascular		New-Added 10/04	Submitted price of $466,492	See Note F.
source, 10 Ci Ir 192	22,000.00	radiation oncology	77781-84	See Note A	Submitted prices from 2 sources, average $45,326	See Note F.
strontium-90 applicator	8,599.00	radiation oncology	77789	See Note A	Submitted prices from 3 sources, average $6,705	See Note F.
table, cystoscopy		urology	52204-24, 52265-75, 52310-17, 52327-32	See Note A	No/Insufficient documentation received	See Note E.
ultrasound color doppler, transducers and vaginal probe	155,000.00	ob-gyn	59070, 59074, 76818-19	See Note A	No/Insufficient documentation received	See Note D.
ultrasound, echocardiography digital acquisition (Novo Microsonics, TomTec)	29,900.00	ob-gyn, cardiology, pediatrics	76825-28, 93303-12, 93314, 93320, 93325, 93350	See Note A	No/Insufficient documentation received	See Note D.
vacuum cart		anesthesia	64620	See Notes A and C	No/Insufficient documentation received	See Note E.

2005 Description	2004 Price	Primary specialties associated with item	*CPT code(s) associated with item	Prior status of equipment item	Commenter response	CMS action taken
video camera	1,000.00	radiation oncology	77418	See Note A	Submitted price of $1,000	See Note F.
water chiller (radiation treatment)	28,000.00	radiation oncology	77402-16	See Note B	Submitted prices from 2 sources, average $25,565	See Note F.
well counter		radiology	78160-72, 78282	See Note A	Submitted price of $3,450	See Note F.

Notes:
A. Additional information required. Need detailed description, source, and current pricing information.
B. Proposed deletion as indirect expense.
C. Item may no longer be available.
D. No/Insufficient documentation. Current price retained on an interim basis. Forward documentation promptly.
E. No/Insufficient documentation. No price in database. Forward documentation promptly.
F. Submitted price accepted.
G. Equipment deleted, per comment.
H. No longer available/marketed. Item deleted.

BILLING CODE 4120–01–C

d. Miscellaneous Practice Expense Issues

- Pricing for Seldinger Needle.

We proposed to average two prices of this supply item to reflect a cost of $5.175. We requested that, if commenters disagreed with this change in price, the comment should provide documentation to support the recommended price, as well as the specific type of needle that is most commonly used.

Comment: Commenters were in agreement with the proposed pricing of the seldinger needle.

Response: We will use the proposed price of $5.175 for this supply item in the practice expense database.

• Hysteroscopic Endometrial Ablation.

We proposed to assign, on an interim basis, the following direct practice expense inputs in the nonfacility setting for CPT code 58563, *Hysteroscopy, surgical; with endometrial ablation.* (**Note:** In the August 5, 2004 proposed rule this code was erroneously identified as 56853, which does not exist.) We also stated we would request that the RUC review these inputs as part of the practice expense refinement process.

+ *Clinical Staff:* RN/LPN/MTA—72 minutes (18 pre-service and 54 service)

+ *Supplies:* PEAC multispecialty visit supply package, pelvic exam package, irrigation tubing, sterile impervious gown, surgical cap, shoe cover, surgical mask with face shield, 3x3 sterile gauze (20), cotton tip applicator, cotton balls (4), irrigation 0.9 percent sodium chloride 500–1000 ml (3), maxi-pad, mini-pad, 3-pack betadine swab (4), Monsel's solution (10 ml), lidocaine jelly (1000 ml), disposable speculum, spinal needle, 18–24 g needle, 20 ml syringe, bupivicaine 0.25 percent (10 ml), 1 percent xylocaine (20 ml), cidex (10 ml), Polaroid film-type 667 (2), endosheath, and hysteroscopic ablation device kit.

+ *Equipment:* power table, fiberoptic exam light, endoscopic-rigid hysteroscope, endoscopy video system, and hysteroscopic ablation system.

Comment: Commenters, including many individual practitioners, were supportive of this proposed change. The specialty society also stated that they plan to present the inputs for this service at the RUC meeting in February 2005

Response: With the exception of the post incision care kit that we deleted because this procedure does not require an incision, we will finalize these inputs as proposed.

• Photopheresis.

We proposed to assign, on an interim basis, the following nonfacility practice expense inputs for the photopheresis service, CPT code 36522:

+ *Clinical Staff:* RN—223 minutes (treatment is for approximately 4 hours)

+ *Supplies:* multispecialty visit supply package, photopheresis procedural kit, blood filter (filter iv set), IV blood administration set, 0.9 percent irrigation sodium chloride 500–1000 ml (2), heparin 1,000 units-ml (10), povidone solution-betadine, methoxsalen (UVADEX) sterile solution-10 ml vial, 1 percent-2 percent lidocaine-xylocaine, paper surgical tape (12), 2x3 underpad (chux), nonsterile drapesheet 40 inches x 60 inches, nonsterile Kling bandage, bandage strip, 3x3 sterile gauze, 4x4 sterile gauze, alcohol swab pad (3), impervious staff gown, 19–25 g butterfly needle, 14–24g angiocatheter, 18–27 g needle, 20 ml syringe, 10–12 ml syringe, 1 ml syringe, 22–26 g syringe needle-3 ml.

+ *Equipment:* plasma pheresis machine with ultraviolet light source, medical recliner.

We also stated we would request that the RUC review these inputs.

Comment: One commenter supplied information on practice expense inputs for this code and indicated that an oncology nurse should be used, instead of an RN, to perform the procedure. A specialty society also stated that they would be providing information on this service at the September RUC meeting.

Response: We appreciate the information submitted by the commenters. This code was discussed at the September RUC meeting and recommended practice expense inputs for this service were provided to us. We do not agree with the RUC recommended clinical staff procedure (intra) time of 90 minutes. We believe that this time, which is half of the proposed intra time, does not accurately reflect the total time involved in performing this procedure. Our understanding is that the filtration rate and the procedures performed by the nurse for photopheresis are similar to those that are reflected in the selective apheresis services, CPT code 36516, with a PEAC-approved intra time of 240 minutes. Based on this, and the absence of specialty representation at the RUC familiar with the process, we are assigning 180 minutes for the intra time, as proposed. We are also assigning the RN/LPN staff type to this procedure, because we believe it is similar to other apheresis procedures. We will continue our examination of this issue and entertain ongoing dialog with all interested organizations and individuals, including the AMA and the RUC, the industry, and those physicians and individuals familiar with the photopheresis procedure in order to assure the accuracy of the intra time.

• Pricing of New Supply Items.

As part of last year's rulemaking process, we reviewed and updated the prices for supply items in our practice expense database. During subsequent meetings of both the PEAC and the RUC, supply items were added that were not included in the supply pricing update. The August 5, 2004 proposed rule included Table 3 Proposed Practice Expense Supply Item Additions for 2005, which listed supply items added as a result of PEAC or RUC recommendations subsequent to last year's update of the supply items and the proposed associated prices that we will use in the practice expense calculation.

We also identified certain supply items for which we were unable to verify the pricing information (*see* Table 4, Supply Items Needing Specialty Input for Pricing, in the August 5, 2004 proposed rule). We requested that commenters provide pricing information on these items along with documentation to support the recommended price. In addition, we also requested information on the specific contents of the listed kits, so that we do not duplicate any supply items.

Comment: Several commenters representing providers of these services stated that table 3 incorrectly associated ''gold markers'' with the brachtherapy intracavity codes. They were all in agreement that these markers are typically used in external beam treatments and payment is associated with unlisted procedure codes and should be paid for at cost.

Response: We have deleted the gold markers from CPT codes 77761–77763 and removed this supply from the practice expense database.

Comment: The American Urology Association noted that we should exclude the vasotomy kit from CPT codes 55200 and 55250.

Response: We have deleted the vasotomy kit from CPT codes 55200 and 55250.

Comment: The American College of Chest Physicians agreed with pricing of items used in their practices in table 3 and stated that the bronchogram tray does not need to be included in the practice expense database, as the procedure is seldom performed and, when it is, the procedure is performed in a facility.

Response: We have deleted the bronchogram tray from the practice expense database and corrected the direct inputs for CPT code 31708 accordingly.

Comment: We received comments from the American College of Cardiology (ACC) that included price quotes and names of sources for supply items listed on table 3.

Response: Unfortunately, ACC did not include the requested sufficient documentation, such as invoices or catalog web page links. We have asked ACC to forward this pricing documentation to us as soon as possible because it will be required for supplies to remain valued in the practice expense database. In the interim, for the 2005 fee schedule, we will maintain the prices currently in the practice expense database for the following supplies:

blood pressure recording form at $0.31, pressure bag (infuser) 500cc or 1000cc at $8.925, sterile, non-vented, tubing at $1.99.

Comment: Noting that a $15 supply item, needle-wire for localization of lesions in the breast (used preoperatively in CPT codes 19290 and 19291) was no longer used, a manufacturer requested that we replace this supply with an anchor-guide device valued at $245. The commenters also stated that this device is used in over 70 offices and imaging centers.

Response: We appreciate the comments from the manufacturer. However, during last year's rulemaking process we repriced all of our supplies, and the needle-wire price of $15 was an average of prices from two different sources ($17 and $13). This price was proposed and accepted by the medical specialty societies that we depend on to verify typical items in our practice expense database. We have retained the $15 needle-wire for localization because we believe it is typically used for this procedure.

The following table lists the items on which we requested input, the comments received, and the action taken.

BILLING CODE 4120–01–P

Table 3: Supplies Needing Specialty Input

2005 Description	Unit	Unit Price	Primary specialties associated with item	Prior status of item	Commenter response	CMS action taken
antibodies - detection	slide	30.90	lab, pathology	See Note A.	Deleted, CPEP refinement	See Note D.
blood pressure recording form, average	item	0.31	cardiology	See Note A.	No/Insufficient documentaion received	See Note B.
catheter, hyperthermia, closed-end	item		radiation oncology	See Note A.	Submitted price of $20	See Note C.
catheter, hyperthermia, open-end	item		radiation oncology	See Note A.	Submitted price of $20	See Note C.
Edrophonium	ml	4.67	gastroenterology	See Note A	No/Insufficient documentaion received	See Note B.
hysteroscope, ablation device	item	1,146.00	ob-gyn	See Note A	No/Insufficient documentaion received	See Note B.
kit, BCR/ABL DNA probe	kit	42.65	pathology	See Note A.	Submitted price of $42.65	See Note C.
kit, Her-2/Neu DNA probe	kit		pathology	New-Added 10/04	Submitted price of $105	See Note C.
kit, detection	slide	8.50	pathology, neurology	See Note A.	Refinement scheduled 2/05	See Note B.
kit, photopheresis procedure	kit	809.00	dermatology, ob-gyn	See Note A.	Submitted price of $858	See Note C.
kit, vasotomy	kit		urology	See Note A.	Delete, per comment	See Note D.
methoxsalen, sterile solution (UVADEX) 10 ml vial	ml	49.50	dermatology, radiation oncology	See Note A.	Submitted price of $49.50	See Note C.
pressure bag	item		cardiology	See Note A.	No/Insufficient documentaion received	See Note E.

2005 Description	Unit	Unit Price	Primary specialties associated with item	Prior status of item	Commenter response	CMS action taken
primary antibodies	slide	3.52	pathology, neurology	See Note A.	Refinement scheduled 2/05	See Note B.
tray, bronchogram	tray		pulmonary disease	See Note A.	Delete, per comment	See Note D.
tubing, sterile, non-vented (fluid administration)	item		cardiology	See Note A.	No/Insufficient documentaion received	See Note E.

*CPT codes and descriptions only are copyright 2004 American Medical Association. All rights reserved. Applicable FARS/DFARS apply.

Notes:
A. Additional information required. Need detailed description (including kit contents), source, and current pricing information.
B. No/Insufficient documentation. Retained price in database, on interim basis. Forward documentation promptly.
C. Submitted price accepted.
D. Deleted per comment.
E. 2004 price retained on an interim basis. Forward documentation promptly.

BILLING CODE 4120–01–C

- Addition of Supply Item to CPT 88365, Tissue In Situ Hybridization.

We proposed to add, on an interim basis, a DNA probe to the CPEP database for CPT 88365, tissue in situ hybridization, with the understanding that the inclusion of the item would be subject to forthcoming RUC review.

Comment: Commenters were supportive of this proposal. The College of American Pathologists also encouraged us to include updated information on practice expense inputs from the September RUC meeting, while another commenter suggested that we run the information by the specialty society.

Response: The direct practice expense inputs for this code and two other codes in the same family were discussed at the September RUC after a presentation made by the specialty society. We have reviewed and accepted the RUC recommendations, and these practice expense inputs will be included in the practice expense database.

• Ophthalmology Equipment.

In cases where both the screening and exam lanes are included in the equipment list for the same ophthalmology service, we proposed to include only one lane because the patient could only be in one lane at a time. We proposed defaulting to the exam lane and, thus, we proposed deleting the screening lane from the practice expense inputs for these procedures. For the services where a lane change was made, time values were assigned to the exam lane in accordance with our established standard procedure.

Comment: The American Academy of Ophthalmology requested that we specifically identify the codes for which we deleted the screening lane, so that they can ensure that the correct lane was deleted.

Response: This information can be obtained by comparing the direct inputs in the practice expense database files for the 2004 and 2005 fee schedules that are posted on our Web site (*http://www.cms.hhs.gov/physicians/pfs*). However, we would be happy to work with the specialty organization to verify the accuracy of the information.

• Parathyroid Imaging, CPT code 78070.

Based on comments received from the RUC and the specialty society representing nuclear medicine, we proposed to crosswalk the charge-based RVUs from CPT 78306, *Bone and/or joint imaging; whole body,* to CPT 78070, *Parathyroid imaging.*

Comment: Several specialty societies expressed appreciation for this proposed change.

Response: We will finalize our proposal and crosswalk the charge-based RVUs from CPT code 78306 to CPT code 78070.

• Additional PE concerns.

Comment: We received information from the American Academy of Ophthalmology that two biometry devices (a-scan ultrasonic biometry unit and an optical coherence biometer) were listed as equipment for the ophthalmic biometry service, CPT code 92136. Only the optical coherence biometer should be included for this code.

Response: As requested by the specialty society, we have deleted the a-scan biometry unit from the equipment list for CPT code 92136.

Comment: We received comments from manufacturers, specialty societies representing renal physicians and vascular surgeons, and individual providers questioning the decrease in nonfacility practice expense RVUS for CPT code 36870, *Percutaneous thrombectomy, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis.* Some commenters believe this reduction occurred because the supplies listed in the database for this service reflect only one method of providing this service. While commenters acknowledged that the database includes the supplies used in approximately 50 percent of the instances this procedure is performed, the commenters claimed that other supplies may be used in the remaining occasions. Commenters requested that we add these other specific supplies to the database.

Response: Because there are a variety of supplies and equipment that can be used in performing a service, under the practice expense methodology, the supplies and equipment that are used in determining payment are those that are most typical for the procedure. Although there may be alternative supplies used, the inputs in the database reflect what is typically used (which is acknowledged by the commenters) and thus we are not adding the requested supplies to the practice expense database. However, we did note that the list of equipment did not reflect the cost of the angiography room that is used during the procedure, and this has been added to our database for this code.

Comment: Societies representing dermatologic specialties expressed concern about the reduction in practice expense RVUs for a photodynamic therapy service, CPT code 96567. The commenters believe that this reduction is due to the application of the dermatology scaling factor based on updated practice expense utilization and requested that this be reconsidered. These commenters also expressed appreciation that there is now a separate HCPCS code to bill for levulan that is needed for this procedure, but stated that there are two medical supplies that need to be included in the practice expense database: bacitracin, and a topical anesthetic cream.

Response: The practice expense RVUs for photodynamic therapy decreased only slightly in this year's proposed rule due to the proposed repricing of equipment. The decrease referred to by the commenter occurred after the first year that the code was established. At that time we obtained the utilization data that demonstrated that dermatologists performed the service and we then applied the same scaling factors to the code that we do for all dermatology services. Therefore, the scaling factor we now apply is correct. We will add the requested amount of bacitracin to the supply list for the code. Unfortunately, the topical anesthetic requested is not in our database and the commenters did not include pricing information so we are not able to include the item in our practice expense calculation.

Comment: A society representing interventional pain physicians expressed concern that the practice expense RVUs for CPT code 95990, *Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular)*, are understated when compared to the RVUs for CPT code 95991, the same service administered by a physician. According to the commenter, CPT code 95991 includes a total of 47 minutes of nonphysician labor and 37 minutes of physician labor or total professional time of 84 minutes. This is the total time spent with the patient before, during and after the refill. The commenter requested that the number of minutes of direct labor for CPT code 95990 should be a minimum of 84 minutes, since the nonphysician practitioner would be performing all the services associated with CPT code 95991 that are performed by both the physician and clinical staff. In addition, the commenter stated that CPT code 95990 should also be assigned physician work RVUs because there is physician oversight of the service even when performed by clinical staff. Two other commenters stated that both CPT codes 95990 and 95991 should be valued the same as the chemotherapy implanted pump refill service, CPT code 96530. The commenters state that this was the code originally used to report the above services, that CPT codes 95990 and 95991 originally were assigned higher RVUs than CPT code 96530 and that the MMA adjustments that increased the payment for CPT code 96530 should be applied to CPT codes 95990 and 95991.

Response: The commenter is correct that the clinical staff times for CPT codes 95990 and 95991 are the same (50 minutes of clinical staff time), although the clinical staff is performing the procedure in one case and assisting the physician in the other. However, the assumption underlying these times is that, in the cases where it is necessary for the physician to personally perform the procedure, the nurse is assisting for the entire time. If this assumption is not correct, then the clinical staff time for CPT code 95991 is overstated. Because CPT codes 95990 and 95991 are not considered drug administration codes under section 303 of the MMA, we will not apply the adjustments made for CPT code 96530 to these services. Therefore, we will not be revising the staff time for either code at this time, but would suggest that the RUC look further at this issue. We would also suggest that the society bring CPT code 95990 to the 5-year review, if they wish to make the case that work RVUs should be assigned.

Comment: The society representing interventional pain physicians questioned the ''professional component only'' designation we assigned to the codes for the analysis of an implanted intrathecal pump, CPT codes 62367 and 62368, and the subsequent low RVUs for these services. The commenter stated that if the payment is left as proposed, more physicians would stop offering intrathecal pumps to patients.

Response: This was an inadvertent error on our part that we have corrected for the final rule. These services are physicians' services that do not have separate professional and technical components. We thank the commenter for pointing out this error.

Comment: The Joint Council of Allergy, Asthma and Immunology expressed concern about the reduction in the proposed rule in practice expense RVUs for a number of allergy codes, in particular the venom therapy CPT codes, 95145 through 95149. The commenter stated that Medicare reimbursement for these services does not cover the physician's supply expense, due to the expensive venom antigens that are part of the service, and believes this is a result of the scaling factor being used.

Response: We are sympathetic to the commenter's concern about the high cost of the venom antigens and the specialty's low scaling factor. We would be happy to work with JCAAI further to see if a remedy can be identified regarding this subset of the allergy codes.

Comment: Two commenters stated that the practice expense RVUs for HCPCS code G0329, Electromagnetic Therapy for ulcers, were too low and supplied information on the supplies, equipment and clinical staff time for this service.

Response: Based on the information provided by the commenters, we added diapulse asetips and chux to the supplies in the practice expense database for this service. We also increased the equipment time to 30 minutes.

Comment: We received comments from the North American Spine Society (NASS) stating that the specific needle used for CPT codes 22520 and 22522, which was originally recommended by NASS, is the most expensive needle and may not be the most typical. The specialty noted that available needles range from $26 to $1,295, which represent the needle (termed vertebroplasty kit) in the practice expense database. NASS indicated that the specialties involved in performing these procedures are conducting a survey to determine the most commonly used needles and their costs.

Response: We appreciate the comments from NASS and look forward to receiving the survey results. In the interim, we have averaged the needle costs for the range indicated above by the specialty and have entered this figure, $660.50, as a placeholder for the 2005 fee schedule. Because of the large disparity between the lowest and highest needle costs, it is not reasonable to consider $660.50 as a true average cost for this supply item. We will continue to work with the specialty organizations in order to ensure that the 2006 fee schedule practice expense database reflects the value for the most typical needle used in these procedures.

Comment: We received comments from two medical societies with concerns about a decrease in practice expense RVUs for CPT code 95819, which is part of the EEG sleep study series of codes. These two organizations noted their willingness to bring this code to the February 2005 RUC meeting in order to rectify the direct practice expense inputs for this procedure.

Response: We have reviewed the family of EEG sleep-study codes and believe that a rank order anomaly exists relating primarily to the 2004 PEAC recommendation to delete the 25 reusable electrodes from CPT code 95819. We support and encourage these organizations to bring the entire EEG family of codes to the February 2005 RUC to ensure that this rank order anomaly can be resolved and the correct direct inputs can be identified for these procedures.

Comment: The Coalition for Advancement of Prosthetic Urology expressed concern about the continuing decline in practice expense RVUs for prosthetic urology procedures. They believe that this is due in part to the number of post service visits assigned to these services. They stated that information from a survey they conducted shows there are typically four to five post service visits rather than three as reflected in the database. The commenter also provided a copy of the survey information.

Response: The number of post service visits for these services was established based on recommendations from the RUC or by using the Harvard data. If they believe that the information regarding the number of post service visits for specific procedures is incorrect, the Coalition must request that the codes be examined as part of the 5-year refinement of work RVUs. An explanation of this process and the information that must be provided is found in section VI. of this rule.

B. Geographic Practice Cost Indices (GPCIs)

We are required by section 1848(e)(1)(A) of the Act to develop separate GPCIs to measure resource cost differences among localities compared to the national average for each of the three fee schedule components. While requiring that the practice expense and malpractice GPCIs reflect the full relative cost differences, section 1848(e)(1)(A)(iii) of the Act requires that the physician work GPCIs reflect only one-quarter of the relative cost differences compared to the national average.

Section 1848(e)(1)(C) of the Act requires us to review and, if necessary, to adjust the GPCIs at least every 3 years. This section of the Act also requires us to phase-in the adjustment over 2 years and to implement only one-half of any adjustment if more than 1 year has elapsed since the last GPCI revision. The GPCIs were first implemented in 1992. The first review and revision was implemented in 1995, the second review was implemented in 1998, and the third review was implemented in 2001. We reviewed and revised the malpractice GPCIs as part of the November 7, 2003 (68 FR 63196) physician fee schedule final rule. We were unable to revise the work and practice expense GPCIs at the time of the publication of the November 2003 final rule because the U.S. Census data, upon which the work and practice expense GPCIs are based, were not yet available.

In addition, section 412 of the MMA amended section 1848(e)(1) of the Act and established a floor of 1.0 for the work GPCI for any locality where the GPCI would otherwise fall below 1.0. This 1.0 work GPCI floor is used for purposes of payment for services furnished on or after January 1, 2004 and before January 1, 2007. Section 602 of the MMA further amended section 1848(e)(1) of the Act for purposes of payment for services furnished in Alaska under the physician fee schedule on or after January 1, 2004 and before January 1, 2006, and sets the work, practice expense, and malpractice expense GPCIs at 1.67 if any GPCI would otherwise be less than 1.67.

In the August 5, 2004 proposed rule, we proposed to revise the work and practice expense GPCIs for 2005 through 2007 based on updated U.S. Census data and Department of Housing and Urban Development (HUD) fair market rental (FMR) data. The same data sources and methodology used for the development of the 2001 through 2003 GPCIs were used for the proposed 2005 through 2007 work and practice expense GPCIs.

The relative respective weights for the 2004 work, practice expense and malpractice GPCIs, as well as the proposed 2005 through 2007 GPCI revisions, were derived using the same weights that were used in the Medicare Economic Index (MEI) revision discussed in the November 2003 physician fee schedule final rule (68 FR 63245).

1. Work Geographic Practice Cost Indices

As explained in the August 5, 2004 proposed rule, we used data from the 2000 decennial U.S. Census, by county, of seven professional occupations (architecture and engineering; computer, mathematical, and natural sciences; social scientists, social workers, lawyers; education, library, training; registered nurses; pharmacists; writers, artists, editors) in the development of the proposed work GPCIs. Physicians' wages are not included because Medicare payments are determinant of the physicians' earnings. Including physician wages in the physician work GPCI would, in effect, make the index dependent upon Medicare payments. Based on analysis performed by Health Economics Research, we believe that, in the majority of instances, the earnings of physicians will vary among areas to the same degree that the earnings of other professionals vary.

The U.S. Census Bureau has very specific criteria that tabulations must meet in order to be released to the public. To maximize the accuracy and availability of the data collection, the nonphysician professional wage data were aggregated by county and a median wage by county was calculated for each occupational category. These median wages were then weighted by the total RVUs associated with a given county to ultimately arrive at locality-specific work GPCIs. This geographic aggregation of Census data is the same methodology that was used in previous updates to the GPCIs.

The proposed work GPCIs reflected one-fourth of the relative cost differences, as required by statute, with the exception of those areas where MMA requires that the GPCI be set at no lower than 1.00 and that the Alaska GPCIs be set at 1.67.

2. Practice Expense GPCIs

As in the past, we proposed that the practice expense GPCI would be comprised of several factors that represent the major expenses incurred in operating a physician practice. The impact of each individual factor on the calculation of the practice expense GPCI is based on the relative weight for that factor consistent with the calculation of the MEI. The specific factors included:

- *Employee Wage Indices*—The employee wage index is based on special tabulations of 2000 Census data and is designed to capture the median wage by county of the professional labor force. The employee wage index uses the median wages of four labor categories that are most commonly present in a physician's private practice (administrative support, registered nurses, licensed practical nurses, and health technicians). Median wages for these occupations were aggregated by county in the same manner as the data for the work GPCI.
- *Office Rent Indices*—The HUD FMR data for the residential rents were again used as the proxy for physician office rents as they are in the current practice expense GPCIs. The proposed 2005 through 2007 practice expense GPCIs reflect the final fiscal year 2004 HUD FMR data. We believe that the FMR data remain the best available source for constructing the office rent index. The FMR data are available for all areas, are updated annually, and retain consistency from area-to-area and from year-to-year. A reduction in an area's rent index does not necessarily mean that rents have gone down in that area since the last GPCI update. Since the GPCIs measure area costs compared to the national average, a decrease in an area's rent index means that that area's rental costs are lower relative to the national average rental costs. Addendum X illustrates the changes in the rental index based upon the new FMR data.
- *Medical Equipment, Supplies, and other Miscellaneous Expenses*—The GPCIs assume that items such as medical equipment and supplies have a national market and that input prices do not vary among geographic areas. We were again unable to find any data sources that demonstrated price differences by geographic areas. As mentioned in previous updates, some price differences may exist, but these differences are more likely to be based on volume discounts rather than on geographic areas. The medical equipment, supplies, and miscellaneous expense portion of the practice expense geographic index will continue to be 1.000 for all areas in the proposed GPCIs, except for Alaska which will have an overall practice expense GPCI set at 1.67 for 2005 and 2006.

3. Fee Schedule Payments

All three of the indices for a specific fee schedule locality are based on the indices for the individual counties within the respective fee schedule localities. As in the past, fee schedule RVUs are again used to weight the county indices (to reflect volumes of services within counties) when mapping to fee schedule areas and in constructing the national average indices.

Fee schedule payments are the product of the RVUs, the GPCIs, and the conversion factor. Updating the GPCIs changes the relative position of fee schedule areas compared to the national average. Because the changes represented by the GPCIs could result in total payments either greater than or less than what would have been paid if the GPCIs were not updated, it is necessary to apply scaling factors to the proposed GPCIs to ensure budget neutrality (prior to applying the provisions of MMA that change the work GPCIs to a minimum of 1.0 and increase the Alaska GPCIs to 1.67 because these provisions are exempted from budget neutrality). We determined that the proposed work and practice expense GPCIs would have resulted in slightly higher total national payments. Because the law requires that each individual component of the fee schedule—work, practice expense, and malpractice expense—be separately adjusted by its respective GPCI, we proposed to scale each of the GPCIs separately. To ensure budget neutrality prior to applying the MMA provisions, we have made the following adjustments:

- Decreased the proposed work GPCI by 0.9965;

• Decreased the proposed practice expense GPCI by 0.9930; and

• Increased the malpractice GPCIs that were published in the November 7, 2003 final rule by 1.0021.

Because all geographic payment areas will receive the same percentage adjustments, the adjustments do not change the new relative positions among areas indicated by the proposed GPCIs. After the appropriate scaling factors are applied, the MMA provision setting a 1.0 floor has been applied to all work GPCIs falling below 1.0. Additionally, the GPCIs for Alaska have been set to 1.67 in accordance with MMA.

Comment: A specialty society representing family physicians recommended that we work with the Congress to eliminate the GPCIs or set them all at 1.00. The society stated that they understand the statutory requirement to apply the GPCIs, but that all geographic adjustment factors should be eliminated from the physician fee schedule, except for those designed to achieve a specific policy good, such as adjustment to encourage physicians to practice in underserved areas. The commenter contended that elimination of the GPCIs would have a positive effect on the availability of medical care to rural beneficiaries. Other commenters suggested that we should no longer apply the work GPCI to the work RVUs.

We also received numerous comments on the subject of the source of the data we use in the development of the GPCIs. Commenters suggested that we find data sources other than Census Bureau data. They believe the census data become obsolete very quickly and want us to use data that reflect up-to-date prices for inputs. This would, they argue, make the GPCI values more realistic.

A medical specialty group commented that the index is flawed because—

• It is based on the tenuous assumption that the relative differences in the prices of the input proxies accurately reflect relative changes in prices of corresponding physician practice cost components; and,

• It applies uniform weights to practice cost components, despite evidence of geographic variation in component shares.

Several commenters had specific concerns about the proxies used for the work and practice expense GPCIs, for example—

• Using data for four employee classes to measure relative compensation differences for all physicians' office staff which does not reflect the changes in medical practice that have occurred since the index was developed;

• Using residential real estate prices to reflect relative differences in physicians' office costs; and

• Using nationally uniform prices for supplies, equipment, and other expenses.

Another particular concern among commenters is the use of HUD apartment rental data as the source of costs for physicians' rents. Instead, they argue, we should find, or carry out, a national study of retail and business rents.

Another commenter asserts that these indices have not been verified by peer-reviewed published research since they were instituted and that we should replace the indices with data from nationwide studies that validate and update actual cost of practice data.

Response: As noted by a commenter, we are required by the Congress to adjust for geographic differences in the operational cost of physicians' practices by applying geographic price indices to each component of the Physician Fee Schedule. However, we also believe it appropriate in our resource based payment system to account for real differences in physicians' costs in different geographical areas. We share the concern about access to care for our rural beneficiaries and, in this rule, we are finalizing our proposals on payment adjustments to physicians in underserved areas through the HPSA Incentive Payment Program. For the commenters who object to the GPCI adjustment to the work RVUs, we would note that for 2005 and 2006 the floor for the work GPCI will be 1.00.

With reference to the issue of the GPCI data source, we are always open to suggestions about possible data sources; however, we believe the most reliable source of national, comparable data at the county level is the Census Bureau. Other data sources that we have examined either fail to produce the data at the county level, cannot be compared nationally, or offer no means of comparability over time.

We believe that the proxies, while not perfect, are the best tools available for the development of the GPCIs. For example, if we were to eliminate all proxies, we would have to collect actual physicians' office data from a sufficiently large sample in each locality to calculate the GPCIs. This would place a substantial burden on the office staff and would be prohibitively expensive. Also, the benefits from that approach would be uncertain.

The question of applying uniform weights to practice components is an area where more research could lead to better information about the variation attributable to case mix and the availability of other health resources, input prices, and practice styles. However, it is important to note that much of the variation associated with case and specialty mix is accounted for by the varying RVUs for different services. However, we are open to exploring this issue.

On the issue of which employee categories are included in the employee wage index component of the practice expense GPCI calculation, we included those that have been determined in the past to be most commonly present in a physician's private practice. We are considering the suggestion that we include a broader group of employment categories in the future.

While we recognize that apartment rents are not a perfect proxy for physician office rents, there are no existing national studies that present reliable retail and business rentals data. We would welcome any nationally consistent data that could be used for this purpose.

We noted in the proposed rule that we were unable to find any data sources that demonstrate price differences by geographic areas for medical equipment and supplies. Once again, however, we welcome any nationally consistent data for this purpose.

We appreciate the concern expressed by the commenter who suggested our GPCI methodology has not been subjected to peer-review validation since its inception, but we are not aware of any currently available data that could replace our methodology. Furthermore, we believe the process of updating the GPCIs periodically through notice and comment rulemaking affords an opportunity for a thorough review of the GPCI calculation methodology.

Comment: A member of a medical society suggested that we make the floor of 1.00 permanent for the work GPCI and incrementally increase both the practice expense GPCI and the professional liability insurance GPCI to 1.00 over the next ten years.

Response: We have no authority to extend the floor of the work GPCI, or to create a 1.00 floor for the practice expense and professional liability insurance GPCIs. Section 1848(c)(1)(A) of the Act requires that the index reflect resource costs relative to the national average, indicating that, aside from the MMA provision establishing a floor on the work GPCI through 2006, localities with costs below the national average have GPCIs below 1.00.

Comment: A specialty organization representing the long term care industry suggested that we phase in the new

GPCI values over a three-year period to minimize the impact of the changes.

Response: We are required by section 1848(e)(1)(C) of the Act to review and adjust the GPCIs every 3 years. This section of the Act also requires us to phase in the adjustment over 2 years and implement only one-half of any adjustment if more than 1 year has elapsed since the last GPCI revision. We believe this phase-in appropriately balances any negative impacts of the changes with the positive impacts on those localities where the GPCIs increase.

4. Payment Localities

As discussed in the August 5, 2004 proposed rule, we have considered, and are continuing to examine, alternatives to the composition of the current 89 Medicare physician payment localities to which the GPCIs are applied.

While we have considered alternatives, we have been unable to establish a policy and criteria that would satisfactorily apply to all situations. Any policy that we would propose would have to apply to all States and payment localities. If, for example, we were to establish a policy that when adjacent county geographic indices exceeded a threshold amount the lower county could be moved to the higher county or that a separate locality could be created, redistributions would be caused within a State.

Because there will be both winners and losers in any locality reconfiguration, the State medical associations should be the impetus behind these changes. The support of State medical associations has been the basis for previous changes to statewide areas, and continues to be equally important in our consideration of other future locality changes.

Comment: We received numerous comments from physicians and individuals, including members of the Congress, living in and around Santa Cruz County, California. Their comments uniformly expressed the opinion that Santa Cruz be taken out of the ''Rest of California'' payment locality and placed in a separate payment locality.

Additionally, the California Medical Association (CMA) submitted a ''placeholder'' proposal to move any county with a county-specific geographic adjustment factor (GAF) that is 5 percent greater than its locality GAF to its own individual county payment locality. Under their proposal, any reductions in payments to maintain budget neutrality in light of the higher payments to physicians in the counties that are moved into the new independent county localities would be divided equally among all payment localities within the State of California. Additionally, for 2005 and 2006, the GAFs in localities from which the high-cost counties are removed would not be reduced as a result of removing the counties.

Response: We greatly appreciate the efforts of the CMA and many others toward addressing this difficult issue. We also recognize the concerns expressed by the residents of Santa Cruz County about the impact of the current payment disparities upon physicians in their community. Our consistent position has been that we will be responsive to requests for locality changes when there is a demonstrated consensus within the State medical association for the change. Due to the re-distributive impacts of these types of changes, we believe this approach helps ensure the appropriateness of any such change.

We are required, however, to publish the final 2005 GPCIs and GAFs in this rule, and we have applied the current definitions for all California localities.

On October 21, 2004, the CMA Board of Trustees voted without objection to support the placeholder proposal submitted in the CMA's comment with the amendment to limit the time period to the years 2005 through 2006. However, we have determined that we do not have the authority under section 1848(e) of the Act to reduce the GPCIs of some localities in a State to offset higher payments to other localities. Nonetheless, we are eager to work with CMA and its Congressional Representatives to resolve this difficult problem as quickly and fairly as possible.

Comment: We received comments from physicians, individuals and the Texas Medical Association regarding locality payments. These commenters request that we regard all counties in a metropolitan statistical area (MSA) as being in a single payment locality. This would, they argue, equalize payments in those areas where growth has expanded city boundaries across county lines.

Response: As noted above, we will be responsive to requests for locality changes when there is a demonstrated consensus within the State medical association for the change.

Result of Evaluation of Comments

We will finalize the GPCIs as proposed.

C. Malpractice Relative Value Units (RVUs)

1. Proposed Methodology for the Revision of Resource-based Malpractice RVUs

The methodology used in calculating the proposed resource-based malpractice RVUs is the same methodology that was used in the initial development of resource-based RVUs, the only difference being the use of more current data. The proposed resource-based malpractice expense RVUs are based upon:

- Actual 2001 and 2002 malpractice premium data;
- Projected 2003 premium data; and
- 2003 Medicare payment data on allowed services and charges.

As in the initial development of resource-based malpractice expense RVUs in the November 2, 1999 final rule, we proposed to revise resource-based malpractice expense RVUs using specialty-specific malpractice premium data because they represent the actual malpractice expense to the physician. In addition, malpractice premium data are widely available. We proposed using actual 2001 and 2002 malpractice premium data and projected 2003 malpractice premium data for three reasons:

- These are the most current national claims-made premium data available.
- These data capture the highly publicized and most recent trends in the specialty-specific costs of professional liability insurance.
- These are the same malpractice premium data that were used in the development of revised malpractice GPCIs in the November 7, 2003 final rule.

We were unable to obtain a nationally representative sample of 2003 malpractice premium data for the following two reasons:

- The premium data that we collected from the private insurance companies had to ''match'' the market share data that were provided by the respective State Departments of Insurance (DOI). Because none of the State DOI had 2003 market share information at the time of this data collection, 2003 premium data were not usable; and
- The majority of private insurers were not amenable to releasing premium data to us. In the majority of instances, the private insurance companies would release their premium data only to the State Department of Insurance.

Discussions with the industry led us to conclude that the primary determinants of malpractice liability costs remain physician specialty, level

of surgical involvement, and the physician's malpractice history. Malpractice premium data were collected for the top 20 Medicare physician specialties measured by total payments. Premiums were for a $1 million/$3 million mature claims-made policy (a policy covering claims made, rather than services provided during the policy term). We attempted to collect premium data from all 50 States, Washington, DC, and Puerto Rico. Data were collected from commercial and physician-owned insurers and from joint underwriting associations (JUAs). A JUA is a State government-administered risk pooling insurance arrangement in areas where commercial insurers have left the market. Adjustments were made to reflect mandatory patient compensation funds (PCFs) (funds to pay for any claim beyond the statutory amount, thereby limiting an individual physician's liability in cases of a large suit) surcharges in States where PCF participation is mandatory. The premium data collected represent at least 50 percent of physician malpractice premiums paid in each State.

For 2001, we collected premium data from 48 States (for purposes of this discussion, State counts include Washington, DC and Puerto Rico). We were unable to obtain premium data from Kentucky, New Hampshire, New Mexico, and Washington, DC. To calculate a proxy for the malpractice premium data for these four areas in 2001, we began with the most current malpractice premium data collected for these areas, 1996 through 1998 (the last premium data collection that was undertaken). We calculated an average premium price (using 1996 through 1998 data) for all States except Kentucky, New Hampshire, New Mexico, and Washington, DC. Similarly, we calculated an average premium price for the 1999 through 2001 period for all States except Kentucky, New Hampshire, New Mexico, and Washington, DC. We calculated the percentage change in these premium prices as the percent difference between the 1999 to 2001 calculated average premium price and the 1996 to 1998 calculated average premium price. We then applied this percentage change to the weighted average 1996 to 1998 malpractice premium price for these four areas to arrive at a comparable 1999 to 2001 average premium price.

For 2002, we were able to obtain malpractice premium data from 33 States. Many State Departments of Insurance had not yet obtained premium data from the primary insurers within their States at the time of this data collection. For those States for which we were unable to obtain malpractice premium data, we calculated a national average rate of growth for 2002 and applied this national rate of growth to the weighted average premium for 2001 to obtain an average premium for 2002 for each county for which we were unable to obtain malpractice premium data for 2002.

We projected premium values for 2003 based on the average of historical year-to-year changes for each locality (when locality level data were available) or by State (when only statewide premium data projections were available). First, we calculated the percentage changes in the premiums from the 1999 through 2000, 2000 through 2001, and 2001 through 2002 periods for each payment locality. Next, we calculated the geometric mean of these three percentages and applied the mean to the 2002 premium to obtain the forecasted 2003 malpractice premium. We used the geometric mean to calculate the forecasted 2003 premium data because the geometric mean is commonly used to derive the mean of a series of values that represent rates of change. Because the geometric mean is based on the logarithmic scale, it is less impacted by outlying data. Alternative methods, such as linear extrapolation tended to yield more extreme values that were the result of outlying data.

Malpractice insurers generally use five-digit codes developed by the Insurance Services Office (ISO), an advisory body serving property and casualty insurers, to classify physician specialties into different risk classes for premium rating purposes. ISO codes classify physicians not only by specialty, but in many cases also by whether or not the specialty performs surgical procedures. A given specialty could thus have two ISO codes, one for use in rating a member of that specialty who performs surgical procedures and another for rating a member who does not perform surgery. We use our own system of specialty classification for payment and data purposes. It was therefore necessary to map Medicare specialties to ISO codes and insurer risk classes. Different insurers, while using ISO codes, have their own risk class categories. To ensure consistency, we used the risk classes of St. Paul Companies, one of the oldest and largest malpractice insurers. Although St. Paul Companies have recently terminated writing professional liability insurance policies at the time of this data collection they were still the largest and most nationally representative writer of professional liability insurance policies in the nation. The crosswalks for Medicare specialties to ISO codes and to the St. Paul risk classes used are reflected in Table 4.

Some physician specialties, nonphysician practitioners, and other entities (for example, independent diagnostic testing facilities) paid under the physician fee schedule could not be assigned an ISO code. We crosswalked these specialties to similar physician specialties and assigned an ISO code and a risk class. These crosswalks are reflected in Table 5.

In the development of the proposed resource-based malpractice RVU methodology, we considered two malpractice premium-based alternatives for resource-based malpractice RVUs: the dominant specialty approach and the specialty-weighted approach.

Dominant Specialty Approach

The dominant specialty approach bases the malpractice RVUs upon the risk factor of only the dominant specialty performing a given service as long as the dominant specialty accounted for at least 51 percent of the total utilization for a given service. When 51 percent of the total utilization does not comprise the dominant specialty, this approach uses a modified specialty-weighted approach. In this modified specialty-weighted approach, two or more specialties are collectively defined as the dominant specialty. Starting with the specialty with the largest percentage of allowed services, the modified specialty-weighted approach successively adds the next highest specialty in terms of percentage of allowed services until a 50 percent threshold is achieved. The next step is to sum the risk factors of those specialties (weighted by utilization) in order to achieve at least 50 percent of the total utilization of a given service and then to use the factors in the calculation of the final malpractice RVU.

The dominant specialty approach produces modest increases for some specialties and modest decreases for other specialties. The largest increase for any given specialty, over the specialty-weighted approach, is less than 1.5 percent of total RVUs, while the largest decrease for any given specialty is less than 0.5 percent of total RVUs. The dominant specialty approach also fails to account for as much as 49 percent of the utilization associated with a given procedure.

Specialty-Weighted Approach

The approach that we adopted in the November 1999 final rule and proposed

to use for 2005 bases the final malpractice RVUs upon a weighted average of the risk factors of all specialties performing a given service. The specialty-weighted approach ensures that all specialties performing a given service are accounted for in the calculation of the final malpractice RVU. Under the proposed methodology, we—

• *Compute a national average premium for each specialty.* Insurance rating area malpractice premiums for each specialty are mapped to the county level. The specialty premium for each county is then multiplied by the total county RVUs (as defined by Medicare claims data), which were divided by the malpractice GPCI applicable to each county to standardize the relative values for geographic variations. If the malpractice RVUs were not normalized for geographic variation, the locality cost differences (as reflected by the GPCIs) would be counted twice. The product of the malpractice premiums and standardized RVUs is then summed across specialties for each county. This calculation is then divided by the total RVUs for all counties, for each specialty, to yield a national average premium for each specialty. As stated previously, we used an average of the 3 most current years, 2001 to projected 2003 malpractice premiums, in our calculation of the proposed malpractice RVUs. See Table 6 for a display of the average premiums for the top 20 Medicare specialties;

• *Calculate a risk factor for each specialty.* Differences among specialties in malpractice premiums are a direct reflection of the malpractice risk associated with the services performed by a given specialty. The relative differences in national average premiums between various specialties can be expressed as a specialty risk factor. These risk factors are an index calculated by dividing the national average premium for each specialty by the national average premium for the specialty with the lowest average premium, nephrology. The risk factors used in the development of the resource-based malpractice RVUs are displayed in Table 7;

• *Calculate malpractice RVUs for each code.* Resource-based malpractice RVUs were calculated for each procedure. In order to calculate malpractice RVUs for each code, we identified the percentage of services performed by each specialty for each respective procedure code. This percentage was then multiplied by each respective specialty's risk factor as calculated in Step 2. The products for all specialties for the procedure were then summed, yielding a specialty-weighted malpractice RVU reflecting the weighted malpractice costs across all specialties for that procedure. This number was then multiplied by the procedure's work RVUs to account for differences in risk-of-service. Since we were unable to find an acceptable source of data to be used in determining risk-of-service, work RVUs were used. We welcome any suggestions at any time for alternative data sources to be used in determining risk-of-service.

Certain specialties may have more than one ISO rating class and risk factor. The surgical risk factor for a specialty was used for surgical services and the nonsurgical risk factor for evaluation and management services. Also, for obstetrics/gynecology, the lower gynecology risk factor was used for all codes except those obviously surgical services, in which case the higher, surgical risk factor was used.

Certain codes have no physician work RVUs. The overwhelming majority of these codes are the technical components (TCs) of diagnostic tests, such as x-rays and cardiac catheterization, which have a distinctly separate technical component (the taking of an x-ray by a technician) and professional component (the interpretation of the x-ray by a physician). Examples of other codes with no work RVUs are audiology tests and injections. Nonphysicians, in this example, audiologists and nurses, respectively, usually furnish these services. In many cases, the nonphysician or entity furnishing the TC is distinct and separate from the physician ordering and interpreting the test. We believe it is appropriate for the malpractice RVUs assigned to TCs to be based on the malpractice costs of the nonphysician or entity, not the professional liability of the physician.

Our proposed methodology, however, would result in zero malpractice RVUs for codes with no physician work, since we proposed the use of physician work RVUs to adjust for risk-of-service. We believe that zero malpractice RVUs would be inappropriate because nonphysician health practitioners and entities such as independent diagnostic testing facilities (IDTFs) also have malpractice liability and carry malpractice insurance. Therefore, we proposed to retain the current charge-based malpractice RVUs for all services with zero work RVUs. We also solicited comments and suggestions for constructing resource-based malpractice RVUs for codes with no physician work.

• *Rescale for budget neutrality.* The law requires that changes to fee schedule RVUs be budget neutral. The current resource-based malpractice RVUs and the proposed resource-based malpractice RVUs were constructed using entirely different malpractice premium data. Thus, the last step in this process is to adjust for budget neutrality by rescaling the proposed malpractice RVUs so that the total proposed resource-based malpractice RVUs equal the total current resource-based malpractice RVUs. The proposed resource-based malpractice RVUs for each procedure were then multiplied by the frequency count for that procedure to determine the total resource-based malpractice RVUs for each procedure. The total resource-based malpractice RVUs for each procedure were summed for all procedures to determine the total fee schedule proposed resource-based malpractice RVUs. The total fee schedule *proposed* resource-based malpractice RVUs were compared to the total *current* resource-based malpractice RVUs. The total current and proposed malpractice RVUs were equal and, therefore, budget neutral. Thus, no adjustments were needed to ensure that expenditures remained constant for the malpractice RVU portion of the physician fee schedule payment.

The proposed resource-based malpractice RVUs were shown in Addendum B of the August 5, 2004 proposed rule. The values did not reflect any final budget-neutrality adjustment, which we stated would be made in the final rule based upon the more current Medicare claims data. The malpractice RVUs identified in this final rule did not require the application of a scaling factor to retain budget neutrality.

Because of the differences in the sizes of the three fee schedule components, the implementation of the updated resource-based malpractice RVUs has a smaller payment effect than the previous implementation of resource-based practice expense RVUs. On average, work represents about 52.5 percent of the total payment for a procedure, practice expense about 43.6 percent of the total payment, and malpractice expense about 3.9 percent of the total payment. Thus, a 20 percent change in practice expense or work RVUs would yield a change in payment of about 8 to 11 percent. In contrast, a corresponding 20 percent change in malpractice values would yield a change in payment of only about 0.6 percent.

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TABLE 4:

Medicare Code	Medicare Description	ISO code		Risk Class		St. Paul's Description
		Surgery	Other	Surgery	Other	
1	General practice	80117	80420	4	1	Family/Gen. Practitioners - No Obstetrical
2	General surgery	80143	80143	5	5	Surgery General
3	Allergy/Immunology	80254	80254	1A	1A	Allergy
4	Otolaryngology	80159	80265	3	1	Otarhinolaryngology
5	Anesthesiology	80151	80151	5A	5A	Anesthesiology
6	Cardiology	80281	80255	2	1	Cardiovascular Disease
7	Dermatology	80472	80256	5	1A	Dermatology
8	Family practice	80117	80420	4	1	Family/Gen. Practitioners - No Obstetrical
10	Gastroenterology	80104	80241	3	1	Gastroenterology
11	Internal medicine	80284	80257	2	1	Internal medicine
13	Neurology	80288	80261	2	2	Neurology
14	Neurosurgery	80152	80152	8	8	Surgery Neurology
16	Obstetrics/Gynecology	80167	80244	4	1	Gynecology
18	Ophthalmology	80114	80263	2	1	Ophthalmology
20	Orthopedic surgery	80501	80501	5	5	Surgery Orthopedic - excluding Spinal Surgery
20	Orthopedic surgery	80154	80154	6	6	Surgery Orthopedic - including Spinal Surgery
22	Pathology	80292	80266	2	1A	Pathology
24	Plastic and reconstructive surgery	80156	80156	5	5	Surgery Plastic
25	Physical medicine and rehab	80235	80235	1	1	Physical medicine and rehab
26	Psychiatry *	80492, 80431	80249	2	1A	Psychiatry
28	Colorectal surgery	80115	80115	3	3	Surgery Colon and Rectal
29	Pulmonary Disease	80269	80269	1	1	Pulmonary Disease
30	Diagnostic radiology **	80280	80253	2	2	Radiology
33	Thoracic surgery	80144	80144	6	6	Surgery Thoracic
34	Urology	80145	80145	2	2	Surgery Urological
36	Nuclear medicine	80262	80262	1	1	Nuclear medicine

Medicare Code	Medicare Description	ISO code		Risk Class		St. Paul's Description
		Surgery	Other	Surgery	Other	
37	Pediatric medicine	80293	80267	2	1	Pediatrics
38	Geriatric medicine ***	80276	80243	2	1	Geriatrics
39	Nephrology ***	80287	80260	2	1	Nephrology
40	Hand surgery	80169	80169	5	5	Surgery Hand
44	Infectious disease	80279	80246	2	1	Infectious disease
46	Endocrinology ***	80272	80238	2	1	Endocrinology
65	Physical therapist (independent)	80235	80235	1	1	Physical medicine and rehab
66	Rheumatology	80252	80252	1	1	Rheumatology
67	Occupational therapist (independent)	80235	80235	1	1	Occupational Medicine
77	Vascular surgery	80146	80146	6	6	Surgery Vascular
78	Cardiac surgery	80141	80141	6	6	Surgery Cardiac
82	Hematology	80278	80245	2	1	Hematology
83	Hematology/oncology	80473	80473	1	1	Oncology
84	Preventive medicine	80231	80231	1	1	General Preventive Medicine
92	Radiation Oncology ****	80425	80425	2	2	Radiation Therapy
93	Emergency medicine	80157	80102	5	4	Emergency Medicine
98	Gynecologist/oncologist	80167	80244	4	1	Gynecology

Note: For specialties with multiple risk classifications depending on the level of surgical involvement, the highest level of surgery for each specialty was selected for the "surgery" ISO and risk class; and the lowest level of surgery was selected for the "nonsurgery" ISO and risk class.

Note: If a specialty has only one risk classification the same classification was used for both surgery and nonsurgery..*The ISO codes for surgery for Psychiatry represents Psychiatry - shock therapy.

**St. Paul's is the only one of the five companies that has a "major invasive" procedures ISO Code for Radiology; therefore, the "minor invasive procedures" ISO Code is being used as the highest level of surgery.

***St. Paul's is the only one of the five companies that has a "major surgery" ISO Code for Geriatrics, Nephrology, and Endocrinology; therefore, the minor Surgery" ISO Code is being used as the highest level of surgery.

****Medical Protective's Description was used as St. Paul's does not provide specific medical malpractice insurance for Radiation Therapy.

TABLE 5:

Medicare Code	Unassigned Medicare Specialty	Crosswalk Specialty
12	Osteopathic Manipulative Therapy	Family Practice
32	Anesthesiologist Assistant	Anesthesiology
35	Chiropractic	Physical medicine and rehab
41	Optometry	Ophthalmology
43	Certified Registered Nurse Assistant	All Physicians
47	Physiological Laboratory (independent)	All Physicians
48	Podiatry	All Physicians
50	Nurse Practitioner	All Physicians
62	Psychologist	Psychiatry
68	Clinical Psychologist	Psychiatry
69	Clinical Laboratory	All Physicians
70	Multi-Specialty Clinic or Group Practice	All Physicians
74	Radiation Therpay Center	Radiation Oncology
76	Peripheral Vascular Disease	Vascular Surgery
79	Addiction Medicine	Psychiatry
80	Licensed Clinical Social Worker	Psychiatry
81	Critical Care (Intensivists)	All Physicians
85	Maxillofacial Surgery	Plastic Surgery
86	Neuropsychiatry	Psychiatry
89	Certified Clinical Nurse Specialist	All Physicians
90	Medical Oncology	Internal Medicine
91	Surgical Oncology	General Surgery
94	Interventional Radiology	Radiology
96	Optician	Ophthalmology
97	Physician Assistant	All Physicians

TABLE 6:

ISO	Specialty	2001 Average	2002 Average	2003 Average	1996-1998 Average	2001-2003 Average[1]	Annual Trend[2]	Specialty MGPCI[3]	Normalized 2001-2003 Premium[4]	Risk Factor[5]
80269	Pulmonary disease	12,574	13,456	14,541	9,508	13,524	7.30%	1.027	13,168	2.14
80280	Diagnostic radiology	15,807	16,783	17,997	12,372	16,862	6.39%	0.997	16,913	2.75
80284	Internal medicine	14,395	15,714	16,985	11,836	15,698	5.81%	1.028	15,270	2.48
80274	Gastroenterology	14,347	15,398	16,643	11,745	15,463	5.65%	1.017	15,204	2.47
80143	General surgery	33,163	36,004	39,059	27,825	36,075	5.33%	0.957	37,696	6.13
80423	General practice	13,325	14,479	15,731	11,234	14,512	5.25%	0.943	15,389	2.50
80288	Neurology	16,206	17,330	18,629	13,726	17,388	4.84%	1.032	16,849	2.74
80114	Ophthalmology	13,064	14,103	15,317	11,209	14,161	4.79%	0.997	14,204	2.31
80152	Neurosurgery	64,724	70,125	76,060	57,701	70,303	4.03%	0.952	73,848	12.00
80281	Cardiology	14,798	15,836	17,085	13,204	15,906	3.79%	1.021	15,579	2.53
80145	Urology	18,701	20,253	21,931	16,958	20,295	3.66%	0.999	20,315	3.30
80159	Otolaryngology	21,720	23,127	24,794	19,990	23,214	3.04%	0.997	23,284	3.78
80154	Orthopedic w/ spinal	40,384	43,758	47,321	38,584	43,821	2.58%	0.955	45,886	7.46
80144	Thoracic surgery	39,538	43,200	47,249	38,812	43,329	2.23%	1.020	42,479	6.91
80282	Dermatology	11,046	11,549	12,375	10,650	11,657	1.82%	1.020	11,428	1.86
80260	Nephrology [6]	8,408	9,290	10,142	n/a	9,280	n/a	0.999	9,289	1.51
80146	Vascular surgery	39,391	42,660	46,211	n/a	42,754	n/a	1.014	42,164	6.85
80141	Cardiac surgery	37,802	40,498	43,722	n/a	40,674	n/a	0.921	44,163	7.18
80425	Radiation oncology	13,800	14,755	15,976	n/a	14,844	n/a	0.995	14,918	2.43
80102	Emergency medicine	20,671	22,672	24,733	n/a	22,692	n/a	0.974	23,298	3.79

[1] A simple average of figures for 2001, 2002, and 2003.
[2] Annualized average growth rate between 1996 - 1998 and 2001 - 2003.

[3] An average of locality malpractice GPCIs using specialty-specific malpractice RVUs as weights.
[4] 2001 - 2003 premium divided by specialty MGPCI.
[5] (Normalized 2001 - 2003 Premium, .9289) x 1.51.
[6] Nephrology is set to 1.51 to be consistent with the risk factor taken from the rating manuals.
n/a siginifies that the premium data was not available.

TABLE 7:

Medicare Code	Medicare Description	Nonsurgical Risk Factor	Surgical Risk Factor
01	General practice	1.79	4.26
02	General surgery	6.13	6.13
03	Allergy/Immunology	1.00	1.00
04	Otolaryngology	1.45	3.78
05	Anesthesiology	2.84	2.84
06	Cardiology	1.45	2.53
07	Dermatology	1.00	1.86
08	Family practice	1.79	4.26
10	Gastroenterology	2.05	3.49
11	Internal medicine	2.05	2.48
12	Osteopathic Manipulative Therapy	1.79	4.26
13	Neurology	2.52	2.74
14	Neurosurgery	12.00	12.00
16	Obstretics/Gynecology	2.15	5.63
18	Ophthalmology	1.24	2.31
20	Orthopedic surgery w/o Spinal	8.06	8.06
20	Orthopedic surgery with Spinal	8.89	8.89
22	Pathology	1.72	2.09
24	Plastic Surgery	6.92	6.92

Medicare Code	Medicare Description	Nonsurgical Risk Factor	Surgical Risk Factor
25	Physical Med & Rehab	1.26	1.26
26	Psychiatry	1.11	3.08
28	Colorectal surgery	4.08	4.08
29	Pulmonary disease	2.14	2.14
30	Diagnostic radiology	2.07	2.75
32	Anesthesiologist Assistant	2.84	2.84
33	Thoracic surgery	6.91	6.91
34	Urology	3.30	3.30
35	Chiropractic	1.26	1.26
36	Nuclear medicine	1.66	1.66
37	Pediatric medicine	1.76	2.42
38	Geriatric medicine	1.35	2.17
39	Nephrology	1.51	1.96
40	Hand surgery	4.71	4.71
41	Optometry	1.24	2.31
43	Certified Registered Nurse Assistant	3.04	3.71
44	Infectious disease	1.55	2.09
46	Endocrinology	2.03	2.09
47	Physiological Laboratory (independent)	3.04	3.71
48	Podiatry	3.04	3.71
50	Nurse Practitioner	3.04	3.71
62	Psychologist	1.11	3.08
65	Physical therapist (independent)	1.26	1.26
66	Rheumatology	2.11	2.11
67	Occupational therapist	1.11	1.11
68	Clinical Psychologist	1.11	3.08

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Medicare Code	Medicare Description	Nonsurgical Risk Factor	Surgical Risk Factor
69	Clinical Laboratory	3.04	3.71
70	Multi-Specialty Clinic or Group Practice	3.04	3.71
74	Radiation Therapy Center	2.43	2.43
76	Peripheral Vascular Disease	6.85	6.85
77	Vascular surgery	6.85	6.85
78	Cardiac surgery	7.18	7.18
79	Addiction Medicine	1.11	3.08
80	Licensed Clinical Social Worker	1.11	3.08
81	Critical Care (Intensivists)	3.04	3.71
82	Hematology	1.77	2.26
83	Hematology/oncology	2.05	2.11
84	Preventive medicine	1.26	1.26
85	Maxillofacial Surgery	6.92	6.92
86	Neuropsychiatry	1.11	3.08
89	Certified Clinical Nurse Specialist	3.04	3.71
90	Medical Oncology	2.05	2.48
91	Surgical Oncology	6.13	6.13
92	*Radiation oncology/therapy	2.43	2.43
93	Emergency medicine	3.79	4.55
94	Interventional Radiology	2.07	2.75
96	Optician	1.24	2.31
97	Physician Assistant	3.04	3.71
98	Gynecologist/oncologist	2.15	5.63

Note: If a specialty has only one risk classification, the same classification was used for both surgery and nonsurgery.

Note: For specialties with multiple risk classifications depending on the level of surgical involvement, the highest level of surgery was selected for surgery risk factor and the lowest level of surgery was selected for nonsurgery risk factor.

Note: CPT codes 59000-59899 were assigned the obstetrics risk factor (11.30) while all other OB/GYN procedures were assigned the gynecology surgical risk factor.

Comments and Responses

We received public comments on several malpractice issues. The comments and our responses are stated below.

Comment: Several comments were received that requested revisions to the data sources utilized in the development of resource-based malpractice RVUs. Specifically, commenters requested that we remove utilization for assistant-at-surgery claims from the calculation of resource-based malpractice RVUs because the utilization of assistant-at-surgery services artificially lowers the average risk associated with surgical services. Additionally, we also received comments that raised questions related to the ISO crosswalks and resulting risk factors that we used.

Response: We agree that assistants at surgery should not be reflected in the malpractice RVUs because they are not primarily responsible for performing the surgical procedures, and we are removing the assistant-at-surgery utilization, and associated risk factors, from the data that are used to calculate the resource-based malpractice RVUs. The inclusion of the lower assistant-at-surgery risk factors into the overall determination of some complex surgical services artificially lowers the average risk factor and resulting resource-based malpractice RVUs of these services.

Regarding the ISO Classifications and resulting risk factors that were applied to specialties, the majority of comments received did not offer substantive reasons or alternative methodologies for the proposed ISO crosswalks. We derived the ISO crosswalks, and resulting risk factors, based upon the review by both our contractor and CMS medical officers. Due to the lack of substantive alternatives in the comments received, we will retain the crosswalks that were proposed in the August 4, 2004 proposed rule (see Table 7) with the exception of orthopedic surgery and dermatology.

Comment: Several commenters believed that the August 2004 proposed rule that established risk factors of 7.46 for orthopedic surgery with spinal and 8.06 for orthopedic surgery without spinal were counterintuitive and needed revision.

Response: We agree with these comments and have revised the orthopedic surgery with spinal risk factor to reflect the risk factor identified in the rating manuals (8.89). In the proposed rule, the risk factors for orthopedic surgery with spinal and without spinal were taken from two separate sources (premium data and rating manuals, respectively) thus causing the anomalous result. See Table 7 for the revised orthopedic surgery risk factors.

Comment: Two commenters, including the American College of Dermatology believe that the use of the higher risk class of major surgery is inappropriate for dermatological services as the typical dermatological practice does not encompass major surgery but instead focuses on minor surgery in the office setting.

Response: We agree with these comments and will use the minor surgery and no-surgery risk classifications for dermatological services. See Table 7 for the revised dermatology risk factors. The impact of removing the assistant at surgery claims and revising the risk factor associated with orthopedic surgery with spinal is a 0.9 percent increase for neurosurgery and a 0.4 percent increase for orthopedic surgery over the malpractice RVUs shown in proposed rule. The effect of replacing the major surgery risk factor with the minor surgery risk factor for dermatology is a 0.9 percent decrease in total payments relative to the proposed rule.

Comment: One commenter states that the resource-based malpractice RVU methodology underestimates the cost of PLI for physicians who perform obstetric and gynecologic services. According to the commenter, eighty percent of OB/GYNs perform both obstetric and gynecologic services yet the risk factor for most services these physicians provide to Medicare beneficiaries is based on the much lower premiums paid by physicians who offer only gynecologic services.

Response: Although obstetricians and gynecologists' malpractice premiums can be appreciably different, most Medicare OB/GYN services are gynecological. Therefore, all Medicare OB/GYN procedures will be assigned a gynecology risk factor except in those instances where the service provided is clearly obstetrical in nature. CPT codes in the range of 59000–59899 are clearly obstetrical services and use the obstetrics risk factor (11.30).

Comment: One commenter felt that it was inappropriate to assign 0.00 malpractice RVUs to services that have physician work and have historically had a small amount of malpractice RVUs associated with them.

Response: We agree with this comment and will adjust these services in the final rule. All payable fee schedule services have some amount of PLI associated with their performance.

Comment: One commenter requested that we consider the implementation of the resource-based malpractice expense RVUs interim until the agency has worked with the medical community to ensure that the data and methodology utilized to calculate the malpractice RVUs are appropriate.

Response: We are continuing to work with the medical community to ensure that the methodology and data used to calculate the malpractice RVUs appropriately reflect the actual resource costs associated with professional liability insurance for physicians. Section 1848(c)(2)(B)(i) of the Act states that the Secretary is required to review the relative values not less often than every 5 years. If substantive information becomes available subsequent to the publication of the final malpractice RVUs, the statute allows us flexibility to review that information for possible inclusion in future malpractice RVU updates.

Comment: Several commenters requested that we use a methodology that would only account for the dominant specialty in the calculation of the service-specific resource-based malpractice RVUs. Commenters stated that a dominant specialty approach would be consistent with the ''typical'' service approach that we use throughout the resource-based physician payment system. Commenters also feel that a dominant specialty approach would more appropriately reflect the actual premium resource costs associated with the performance of individual services.

Response: We continue to believe that accounting for all specialties that perform a given service is the more appropriate and equitable methodology in establishing resource-based malpractice RVUs. Basing payment upon all specialties that perform a given service ensures that the actual professional liability insurance resource costs of all specialties are included in the calculation of the final malpractice RVUs. Using only the dominant specialty does not capture the true resource costs associated with a given service and under a relative value based system, results in the redistribution of RVUs based upon only partial data.

The dominant specialty approach is particularly vulnerable for calculating resource-based malpractice RVUs in services that are multi-disciplinary in nature. An example that illustrates the potentially distorting effect of the dominant specialty approach on multi-disciplinary services is the specialty utilization associated with a level III established office visit. Although over 35 different specialties perform a significant number of these services, a dominant specialty approach would base the malpractice RVUs on

approximately 2 specialties. High risk specialties such as neurosurgery, thoracic surgery, general surgery, and obstetrics and gynecology, which account for a small percentage of the total utilization but a large amount of total dollars, would no longer factor into the calculation of the malpractice RVU for this service. These four specialties alone account for nearly $300 million of the total dollars associated with a level III established office visit. The effect of removing these four high-cost, high-risk specialties from the calculation of the malpractice RVUs for this service would be an overall decrease in the malpractice RVUs, because the calculation would be based upon lower-cost, lower-risk specialties.

We disagree that a dominant specialty approach is consistent with the typical service approach used in the RUC survey process. Irrespective of the specialty performing a given service, we require that the typical service be the measurement tool for the calculation of final payments. The typical service approach utilized in the RUC survey process has never referred to the typical specialty performing a service, but instead to the typical type of service furnished. This typical service would encompass such things as the condition of the patient, the extent of the work, the staff needed to accomplish the service, and the respective resource inputs associated with the typical service.

We will continue to work with the RUC PLI Workgroup to identify alternatives to the dominant specialty approach. One alternative that we are currently exploring with the RUC PLI Workgroup is removing aberrant data from low utilization services.

Comment: One commenter suggested that we determine the exponential rate of growth in the PLI premium data from 2001 through 2003 to predict the 2004 premium data. This commenter believes that we should use only this predicted 2004 premium data in the calculation of resource-based malpractice RVUs.

Response: We disagree with the commenter's recommendation that predicted 2004 professional liability insurance premium data be utilized in the calculation of resource-based malpractice RVUs. The data sources that are currently used in the calculation of the 2005 resource-based malpractice RVUs consist of actual 2001 and 2002 premium data (when available) and projected 2003 premium data. Professional liability insurance has proven to be the most volatile data source that is used in the calculation of resource-based physician fee schedule RVUs. For this reason, we believe that it is inappropriate to use only one year of projected premium data.

Comment: Various specialty organizations request that we work with the RUC's Professional Liability Insurance (PLI) Workgroup to ensure that the medical community has input into the refinement of the malpractice RVUs.

Response: Over the course of the past year, we have been working with the RUC PLI Workgroup to solicit input on the methodology and data sources utilized to calculate resource-based malpractice RVUs. We continue to actively participate in the PLI Workgroup to keep both the workgroup and the various specialty organizations aware of our progress in the development and refinement of resource-based malpractice RVUs. We have forwarded all requested contractor reports, which outline both our methodology and data sources, to the RUC for review and comment. We agree with these comments and plan to continue our cooperative relationship with the RUC PLI Workgroup and various specialty organizations to ensure that the necessary specialty organizations are involved with both the premium collection efforts and the development and refinement of resource-based malpractice RVUs.

Comment: Tail coverage is designed to cover any claims that may be made against a new employee for services furnished on behalf of his or her old employer during the time that he or she is employed by the new employer. Several commenters suggested that we incorporate the cost of tail coverage in the determination of PLI annual premium data.

Response: Although we agree with the commenters that it might be desirable to use tail coverage premium data in addition to the annual premium data that are currently used in the revisions to resource-based malpractice RVUs, we have been unable to identify a nationally representative source of tail coverage premium data. We are continuing to work with the RUC PLI Workgroup, the AMA, and the various specialty organizations to identify a nationally representative source of tail coverage premium data for future rulemaking.

Comment: One commenter recommended that professional liability insurance data for all specialties should be used rather than the data from the top 20 Medicare specialties.

Response: Although it might be desirable to obtain premium data from every conceivable specialty in the practice of medicine, it is not possible to obtain this scope of data under the time constraints associated with collecting the most current premium data. In order to conduct surveys that collect the maximum amount of premium data from all geographic areas without being too intrusive to the State Departments of Insurance and private insurance companies, we chose to limit the scope of the data collection to the top 20 Medicare specialties. Further, utilizing PLI data from the top 20 Medicare specialties encompasses 80 percent of fee schedule services.

Comment: Several commenters requested that we use data from the Physician Insurers Association of America (PIAA) in the development of resource-based malpractice RVUs. This commenter further requested that we provide concise requirements for those data collection efforts.

Response: We did explore the use of data from PIAA in the development of resource-based malpractice RVUs. Unfortunately, the PIAA does not include actual physician claims-made premium data by insurer and specialty classification. The information that was available from PIAA ranged from insured demographics information to medical malpractice claims trends.

Regarding our criteria for premium data collection efforts, we have shared the criteria for those premium data collection efforts with the RUC PLI Workgroup.

Comment: Several commenters recommended that the malpractice RVUs should remain stable. Commenters suggested that any budget neutrality adjustments, positive or negative, that might occur due to the 5-year review of malpractice RVUs should be made to the conversion factor and not to the malpractice RVUs.

Response: We acknowledge the comments that suggest that any adjustments for budget neutrality not be performed on the RVUs, but we note that any budget neutrality adjustments to the RVUs do not change the relative relationship among the values for the services but instead uniformly change all relative values. Regarding malpractice RVUs specifically, malpractice RVUs are by nature not ''stable.'' When the malpractice RVUs are reviewed and updated, the malpractice RVUs associated with all services could potentially change. Additionally, for 2005, we are mandated by statute to apply at least a 1.5 percent increase to the conversion factor. Thus, if the budget neutrality associated with updated malpractice RVUs were negative, it would not be possible to ensure budget neutrality and comply with the statutory 1.5 percent update.

Comment: One commenter recommended that the exceptions to the surgical risk factor be modified to include coding changes since the initiation of the resource-based malpractice RVUs in 2000. The previous update to the malpractice RVUs made service-specific exceptions, whereby certain codes were assigned the higher surgical risk factor in the calculation of their final malpractice RVU. The commenter specifically requested that due to CPT coding modifications, the following codes should also receive this same coding modification and receive the greater of their actual average risk factor or the risk factor for cardiac catheterization: 92973–92974, 93501–93533, 93580–93581, 93600–93613, and 93650–93652.

Response: In order to retain the exceptions that were identified in the previous malpractice RVU update for this new series of services, we will assign the greater of the actual average risk factors or the risk factor for cardiac catheterization services.

Comment: Several commenters agreed with our use of the work RVUs as the best available data source for adjusting the malpractice RVUs for risk of service. These commenters noted, as we did, that the work RVUs are not a perfect proxy for risk of service, but are the best available source at this time. Commenters requested that we continue our use of work RVUs as the adjuster to malpractice RVUs for risk of service, but also requested that we be responsive to potential anomalies that may be identified.

Response: We agree with these comments and look forward to continuing our work with the various organizations to identify all potential anomalies in the malpractice RVUs.

Comment: One commenter expressed concern that, although malpractice premiums have increased for all specialty practices, some specialty practices will experience a decline in payments as a result of the 5-Year Review of malpractice RVUs. This commenter suggested that additional dollars need to be added to the system to account for rising PLI costs.

Response: The impact of the malpractice RVU revisions on an individual specialty organization is not a direct reflection of the increases or decreases in their malpractice premiums but instead reflects increases or decreases in a specific state's premiums as compared to the national average. In some instances, specialty organizations might have experienced slight increases in their respective malpractice premiums since the last malpractice RVU update, but these increases have occurred at a slower rate than the national average increase for all specialty organizations. The result is a negative impact on these specialties. Specialty organizations that have increased at a rate higher than the national average will experience positive impacts.

Comment: One commenter believes that additional dollars should be added to the Medicare physician fee schedule to account for escalating professional liability insurance premiums.

Response: The Medicare Economic Index (MEI) is the device by which additional dollars are added to the physician fee schedule. For 2005, the cost category associated with professional liability insurance has increased by 23.9 percent. However, for 2004 and 2005, section 601 of the MMA established an update of 1.5 percent.

Comment: The American College of Radiology (ACR) commented that there is an imbalance between the distribution of malpractice RVUs to the professional component and technical component of a service. The ACR requested that we work with ACR staff to identify alternative methodologies for the more appropriate valuation of technical component services.

Response: Physician work RVUs are used to adjust for risk of service. Because technical component services do not have physician work RVUs, they are still valued using charge-based RVUs instead of the resource-based malpractice RVU methodology. We look forward to working with the ACR and other interested specialty organizations to examine alternative methodologies that would allow technical component services to also reflect resource-based malpractice RVUs.

Final Decision

We are implementing the revised 2005 malpractice RVUs as proposed with the modifications noted in the discussions above. Additionally, we are continuing to work with the AMA's RUC to—

- Consider the appropriateness of a dominant specialty approach;
- Identify the most current nationally representative professional liability insurance premium data;
- Review the current ISO crosswalks; and
- Review aberrant data patterns in low-utilization services for possible inclusion in a future rulemaking cycle.

D. Coding Issues

1. Change in Global Period for CPT Code 77427, *Radiation Treatment Management, Five Treatments*

This code was included in the November 2, 1999 physician fee schedule final rule (64 FR 59380) and was effective for services beginning January 1, 2000. In that rule, and subsequent rules, we have applied a global indicator of ''xxx'' to this code, meaning that the global concept does not apply. It was brought to our attention that this global indicator is incorrect and that the code should be assigned a 90-day global period because the RUC valuation of this service reflected a global period of 90 days which we had accepted. Therefore, we proposed to correct the global indicator for this service to reflect a global period of 90 days (090).

Comment: Specialty organizations representing radiation oncology and radiology as well as individual physicians and providers, and the AMA, all expressed concern about this proposal to change the global period for CPT code 77427. The commenters stated that this code is universally recognized as a recurring service that can be provided multiple times during a course of radiation. This code is usually submitted once for each group of five treatments (or fractions) and represents substantial services furnished during that group (typically 1 week) of five treatments. Commenters believe this proposed change would—

- Contradict the current CPT definitions;
- Not reflect the process of care for radiation;
- Countervene the essence of the RUC valuations; and
- Negate the guidelines that we previously issued.

Because a change in the global period could have a significant impact on the process of care for radiation oncology, commenters urged us to withdraw this proposal or to delay implementation until there is further discussion with the specialty organizations and the RUC, and clarification of billing matters related to this proposed change are provided.

Response: Based on the concerns raised by the commenters, we are not changing the global period for this service as proposed.

Result of Evaluation of Comments

We are retaining the global period of ''xxx'' for CPT code 77427.

2. Requests for Adding Services to the List of Medicare Telehealth Services

As discussed in the proposed rule (69 FR 47510), section 1834(m) of the Act defines telehealth services as professional consultations, office and other outpatient visits, and office psychiatry services defined as of July 1, 2000 by CPT codes 99241 through 99275, 99201 through 99215, 90804 through 90809, and 90862. In addition, the statute requires us to establish a process for adding services to, or deleting services from, the list of telehealth services on an annual basis. In the CY 2003 final rule, we established a process for adding to or deleting services from the list of Medicare telehealth services (67 FR 79988). This process provides the public an opportunity on an ongoing basis to submit requests for adding a service. We assign any request to add a service to the list of Medicare telehealth services to one of the following categories:

• *Category 1:* Services that are similar to office and other outpatient visits, consultation, and office psychiatry services. In reviewing these requests, we look for similarities between the proposed and existing telehealth services in terms of the roles of, and interactions among, the beneficiary, the physician (or other practitioner) at the distant site and, if necessary, the telepresenter. We also look for similarities in the telecommunications system used to deliver the proposed service, for example, the use of interactive audio and video equipment.

• *Category 2:* Services that are not similar to the current list of telehealth services. Our review of these requests includes an assessment of whether the use of a telecommunications system to deliver the service produces similar diagnostic findings or therapeutic interventions as compared with the face-to-face ''hands on'' delivery of the same service. Requestors should submit evidence showing that the use of a telecommunications system does not affect the diagnosis or treatment plan as compared to a face-to-face delivery of the requested service.

Requests for adding services to the list of Medicare telehealth services must be submitted and received no later than December 31st of each calendar year to be considered for the next proposed rule. For example, requests submitted in CY 2003 are considered for the CY 2005 proposed rule. For more information on submitting a request for addition to the list of Medicare telehealth services, visit our Web site at *http://www.cms.hhs.gov/physicians/telehealth*.

We received the following public requests for addition in CY 2003:

• Inpatient hospital care (as represented by CPT codes 99221 through 99223 and 99231 through 99233).

• Emergency department visits (as defined by CPT codes 99281 through 99285).

• Hospital observation services (as represented by CPT codes 99217, 99218 through 99220).

• Inpatient psychotherapy (as defined by CPT codes 90816 through 90822).

• Monthly management of patients with end-stage renal disease (ESRD), (as represented by HCPCS codes G0308 through G0319).

• Speech and audiologist services (as defined by CPT code range 92541 through 92596).

• Case management (as identified by CPT codes 99361 and 99362)

• Care plan oversight services (as represented by CPT codes 99374 and 99375).

After reviewing the public requests for addition, we proposed to add ESRD–related services as described by G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318 to the list of Medicare telehealth services. However, we specified that the required clinical examination of the vascular access site must be furnished face-to-face ''hands on'' (without the use of an interactive telecommunications system) by a physician, certified nurse specialist (CNS), nurse practitioner (NP), or physician's assistant (PA). An interactive telecommunications system may be used for providing additional visits required under the 2 to 3 visit Monthly Capitation Payment (MCP) code and the 4 or more visit MCP code.

Moreover, we proposed to add the term ''ESRD–related visits'' to the definition of Medicare telehealth services at § 410.78 and § 414.65 as appropriate.

We did not propose to add any additional services to the list of Medicare telehealth services for CY 2005.

For further information on the addition to the list of telehealth services, see the **Federal Register** dated August 5, 2004 (69 FR 47510).

Inpatient Hospital Care, Hospital Observation Services, Inpatient Psychotherapy, and Emergency Department Services

Comment: We received conflicting comments on our proposal not to add inpatient hospital care, hospital observation services, inpatient psychotherapy, and emergency department services to the list of approved telehealth services. For example, one professional society supported our proposal not to add inpatient hospital care, hospital observation services, inpatient psychotherapy, and emergency department services to the list. That commenter believes conclusive efficacy data is necessary before adding the aforementioned services. Likewise, an association representing emergency department management agreed that emergency department visits should not be added to the list of Medicare telehealth services. That commenter believes that hospitals in rural areas have physicians with sufficient experience to handle the complexities of emergent care.

An association representing family physicians agreed with our proposal not to add inpatient hospital care and hospital observation services. However, they disagreed with our proposal not to add emergency department visits to the list of Medicare telehealth services. The commenter stated that emergency department visits should not be assigned to category 2 based on the acuity of the patient. The commenter believes that the range of potential acuity is the same in the emergency room as it is in the office setting and noted that office and other outpatient visits are currently on the list of Medicare telehealth services. A professional society encouraged us to reexamine the request to add inpatient hospital care, observation services, and inpatient psychotherapy to the list of Medicare telehealth services in the future.

Response: We agree that the acuity for some patients may be the same in the emergency department as in a physician's office. However, we also believe that more acutely ill patients are more likely to be seen in the emergency department. Although telehealth is an acceptable alternative to face-to-face ''hands on'' patient care in certain settings, the potential for misdiagnosis and/or mismanagement, with more serious consequences, exists in high acuity environments like the emergency department when telehealth is used as a replacement for an onsite physician or practitioner. The practice of emergency medicine often requires frequent patient reassessments, rapid physician interventions, and sometimes the continuous physician interaction with ancillary staff and consultants. We do not have evidence suggesting the use of telehealth could be a reasonable surrogate service for this type of care. In the absence of sufficient evidence that illustrates that the use of a telecommunications system produces

similar diagnoses or therapeutic interventions as would the face-to-face delivery of inpatient hospital care, emergency department visits, hospital observation services, and inpatient psychotherapy, we do not plan to add these services to the list of approved telehealth services. As discussed in the proposed rule, we believe that the current list of Medicare telehealth services is appropriate for hospital inpatients, emergency room cases, and patients designated as observation status. If guidance or advice is needed in these settings, a consultation may be requested from an appropriate source.

Comment: A telehealth association and a telehealth network requested that we clarify what consultation codes could be used for hospital inpatients, emergency room cases, and patients designated as observation status.

Response: The appropriate consultation code depends on the admission status of the beneficiary. When the beneficiary is an inpatient of a hospital, the physician or practitioner at the distant site bills an initial or follow-up inpatient consultation as described by CPT codes 99251 through 99263. For the hospital observation setting and emergency department, the appropriate office or other outpatient consultation code is CPT codes 99241 through 99245.

Comment: Some commenters believe that hospital inpatient care, inpatient psychotherapy, observation services, and emergency department visits should all be assigned to category 1 because they are clinically the same as a consultation. Moreover, the commenters expressed their opinion that a telecommunications system would not substitute for an in-person practitioner for the requested hospital services.

Response: We agree that the key components of a consultation are similar to inpatient hospital care, observation services, and emergency department visits. However, a consultation service is distinguished from the requested hospital services because it is provided by a physician or practitioner whose opinion or advice regarding evaluation and management of a specific problem is requested by another physician or appropriate source. The ongoing management of the patient's condition remains the responsibility of the practitioner who requested the consultation. As discussed in our response to another comment, a consultation may be provided as a Medicare telehealth service for hospital inpatients, emergency room cases, and patients designated in observation status.

In furnishing a consultation as a telehealth service, the physician at the distant site provides additional expertise, to ensure optimal patient outcomes. For consultation services, a practitioner is available to manage the patient at the originating site. However, adding the requested hospital services would permit a telecommunications system to be used as a substitute for an onsite practitioner because the physician or practitioner at the distant site assumes responsibility for the ongoing management of the patient's condition.

End Stage Renal Disease—Monthly Management of Patients on Dialysis

Comment: Many commenters, including a telehealth association, a nephrology nurses association, a renal physicians association, a health system, a community hospital, a telemedicine law group, and others applauded our proposal to add the ESRD-related services with 2 or 3 visits per month and ESRD-related services with 4 or more visits per month to the list of Medicare telehealth services. For example, two commenters believe that adding these services will help provide dialysis patients living in rural areas sufficient access to nephrology specialists and will save both patients and practitioners a significant amount of travel time. Additionally, many commenters expressed strong support for not permitting the visit that includes a clinical examination of the vascular access site to be added to the list of Medicare telehealth services and agreed that this exam should be furnished in person.

Response: We agree with the comments.

Comment: With regard to furnishing ESRD-related visits under the MCP, a nephrology association suggested that we permit the use of e-mail and telephone conferencing for one year. The commenter believes this grace period would enable physicians and originating sites to acquire the necessary technology and execute their implementation plans. Additionally, an association of kidney patients questioned whether telehealth services would be available to ESRD patients in non-rural areas.

Response: Services added to the list of Medicare telehealth services are subject to the requirements and conditions of payment in the law and regulations. Under the Medicare telehealth provision, the use of an interactive audio and video telecommunications system that permits real-time interaction between the patient, physician or practitioner at the distant site, and telepresenter (if necessary) is a substitution for the face-to-face requirements under Medicare. Electronic mail systems and telephone calls are specifically excluded from the definition of an interactive telecommunications system. Moreover, we do not have the legislative authority to expand the geographic areas where telehealth services may be furnished. Telehealth services may only be furnished in non-Metropolitan Statistical Area counties or rural health professional shortage areas.

Comment: An association representing kidney patients questioned whether we plan to evaluate the provision of telehealth services to ESRD patients to determine best practices.

Response: We believe that most physicians and practitioners will use telehealth services for providing additional visits required under the MCP as appropriate to manage their patients on dialysis. However, we would welcome specific data on best practice methods for furnishing ESRD-related services as telehealth services.

Comment: Some commenters indicated a belief that the ESRD-related services were assigned to category 2 for review. For example, one telehealth group believed that a discrepancy exists between the rationale we used to add ESRD-related services to the list of telehealth services and our decision not to add inpatient hospital care, observation services, inpatient psychotherapy, and emergency department visits. The commenter stated that ESRD-related services were added in the absence of randomized clinical trials or comparison studies and mentioned that the same level of evidence was submitted for ESRD-related services as for other requests (for example, inpatient hospital services). The commenter requested clarification on the method used to assign services to category 1 or category 2.

Response: As discussed in the proposed rule, the MCP represents a range of services provided during the month, including various physician and practitioner services, such as the establishment of a dialyzing cycle, outpatient evaluation and management of the dialysis visit(s), telephone calls, and patient management as well as clinically appropriate physician or practitioner visit(s) during the month. At least one of the visits must include a clinical examination of the vascular access site furnished face-to-face, ''hands-on'' by a physician, CNS, NP, or PA.

We considered the outpatient evaluation and management of the dialysis visits to be similar to an office

visit and other outpatient visits currently on the list of Medicare telehealth services. However, we believe that the clinical examination of the vascular access site is not similar to the existing telehealth services, and, therefore, it meets the criteria for a category 2 request. We did not propose to add a comprehensive visit including a clinical examination of the vascular access site, to the list of Medicare telehealth services because the requestor did not provide comparative analyses illustrating that the use of a telecommunications system is an adequate substitute for a face-to-face clinical examination of the vascular access site. However, as discussed in the proposed rule, we do believe that the subsequent visits to monitor the patient's condition met our criteria for approving a category 1 request. For category 1 services, we look for similarities between the proposed and existing telehealth services in terms of the roles of, and interactions among, the beneficiary, the physician or practitioner at the distant site, and, if necessary, the telepresenter.

Therefore, we proposed that the MCP physician, that is, the physician or practitioner responsible for the evaluation and management of the patient's ESRD, and other practitioners within the same group practice or employed by the same employer or entity, may furnish additional ESRD-related visits as telehealth services using an interactive audio and video telecommunications system. However, for purposes of billing the MCP, at least one visit must include a clinical examination of the vascular access site, and must be furnished face-to-face, ''hands on'' by a physician, CNS, NP, or PA each month.

Comment: One commenter requested that we allow a physician or surgeon located at the originating site (who is not the MCP physician) to furnish ESRD-related visits involving the clinical examination of the vascular access site. The commenter stated that having a physician or surgeon skilled in vascular access management available to work in coordination with the MCP physician is necessary for geographically remote areas such as Alaska and in severe weather conditions. The commenter believes that this type of arrangement is well suited for telehealth.

Response: The MCP physician may use another physician to provide some of the visits during the month however, the non-MCP physician must have a relationship with the billing physician such as a partner, employees of the same group practice or an employee of the MCP physician, for example, the physician at the originating site is either a W–2 employee or 1099 independent contractor.

Case Management and Care Plan Oversight (Team Conferences and Physician Supervision)

A telehealth association and a network of clinics requested clarification on—

- The scope of authority relating to the addition of services that do not require a face-to-face encounter with the patient; and
- Whether our policy for care plan oversight is similar to the interpretation of an x-ray and other services that do not require a face-to-face encounter.

Additionally, a neurological society urged us to reconsider our decision not to add medical team conferences to the list of telehealth services. The commenter argued that adding medical team conferences as a telehealth service would improve the quality of the care plan and save time for all physicians involved in the patient's care.

Response: We add services to the list of Medicare telehealth services that traditionally require a face-to-face physician or practitioner encounter. The use of an interactive audio and video telecommunications system, permitting real time interaction between the beneficiary, physician or practitioner at the distant site, and telepresenter (if necessary) is a substitute for face-to-face requirements under Medicare. Services not requiring a face-to-face encounter with the patient that may be furnished through the use of a telecommunications system are already covered under Medicare. As discussed in chapter 15, section 30 of the Medicare Benefit Policy Manual, payment may be made for physicians' services delivered via a telecommunications system for services that do not require a face-to-face patient encounter. The interpretation of an x-ray, electrocardiogram, electroencephalogram and tissue samples are listed as examples of these services. The Medicare Benefit Policy Manual may be found on our Web site at *http://www.cms.hhs.gov/manuals/* by selecting the internet-only manuals link.

Medical team conferences and monthly physician supervision do not require a face-to-face encounter with the patient, and, thus, a telecommunications system may be used to accomplish them. However, Medicare payment for CPT codes 99361, 99362, and 99374 are bundled; no separate payment is made under the Medicare program for these services, and CPT code 99375 (physician supervision; 30 minutes or more) is invalid for Medicare payment purposes. We pay for monthly physician supervision as described by HCPCS codes G0181 and G0182.

Process for Adding Services to the List of Medicare Telehealth Services

Comment: We received conflicting comments on our process for adding services to the list of Medicare telehealth services. For example, a surgeons' association supported the evidence-based approach for adding category 2 services. However, a school of medicine and a telemedicine and electronic health group believe that we should consider changing our categorical system for adding a service to the list of Medicare telehealth services, specifically, in relation to the requested hospital services for hospital inpatients, emergency room cases, and patients designated as observation status.

One of the commenters believes that the decision to use a telehealth system should be up to the physician or practitioner at the distant site. The commenter argues that, if the physician or practitioner at the distant site is not comfortable in making a clinical judgment, the patient may be asked to travel to the physician's office for further examination.

Moreover, the commenter contends that the nature of telehealth services is not well suited for clinical trials and that the evidence that we require under category 2 may never be obtained because of the lack of reimbursement. As an alternative, the commenters recommended a method of review that considers—

- Clinical utilization of the requested telehealth service;
- The opinions of physicians and practitioners furnishing the telehealth service; and
- The opportunity for the physicians and practitioners to prove the service is being delivered appropriately via telecommunications system.

Response: We believe that the current method for reviewing requests for addition already considers the criteria mentioned by the commenter. The process for adding services to the list of Medicare telehealth services provides the public an ongoing opportunity to propose services that they believe are appropriate for Medicare payment. Requestors may submit data showing that patients who receive the requested service via telecommunications system are satisfied with the service delivered and that the use of a telecommunications system does not change the diagnosis or therapeutic

interventions for the requested service. Additionally, we believe that having different categories of review allows us to add requested services that are most like the current telehealth services (for example, office visits, consultation, and office psychiatry) without subjecting these requests to a comparative analysis.

Since establishing the process to add services to the list of Medicare telehealth services, we have added the psychiatric diagnostic interview examination and have proposed specific ESRD-related services for the CY 2005 rule.

Comment: One commenter recommended that we replace the term face-to-face with ''in-person''. The commenter believes that the term ''in-person'' is a better description of an encounter where the practitioner is in the same physical location as the beneficiary.

Response: The commenter's suggestion to use the term ''in-person'' to describe an encounter where the physician or practitioner and the beneficiary are physically in the same room has been noted. We will consider the commenter's suggestion as we discuss Medicare telehealth payment policy in the future.

Report to Congress

Comment: An audiology society and a language and hearing association strongly believe that most audiology services and speech therapy can be furnished remotely as telehealth services. To that end, many commenting groups and associations requested that we complete the report to Congress (as required by section 223(d) of the BIPA) and urged us to recommend adding speech language pathologists and audiologists as medical professionals that may provide and receive payment for Medicare telehealth services.

Moreover, in light of the proposed addition of ESRD-related services to the list of telehealth services, many of these same commenters along with a nephrology society requested that we recommend adding dialysis facilities to the list of originating sites. One commenter requested that we add the patient's home to the definition of an originating site.

Response: The report to Congress on additional sites and settings, practitioners, and geographic areas that may be appropriate for Medicare telehealth payment is under development. We are considering the suggestions raised by the commenters as we formulate our recommendations to the Congress.

Result of Evaluation of Comments

We are adding ESRD-related services as described by G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318 to the list of Medicare telehealth services. However, we will require that the complete assessment must include a face-to-face clinical examination of the vascular access site furnished ''hands on'' (without the use of an interactive telecommunications system) by a physician, clinical nurse specialist, nurse practitioner, or physician's assistant. An interactive telecommunications system may be used for providing additional visits required under the 2 to 3 visit MCP code and the 4 or more visit MCP code. Additionally, we are adding the term ''ESRD–related visits'' to the definition of Medicare telehealth services at § 410.78 and § 414.65, as appropriate.

3. National Pricing of G0238 and G0239 Respiratory Therapy Service Codes.

In the 2001 final rule, we created the following three G codes for respiratory therapy services:

- G0237 Therapeutic procedures to increase strength or endurance of respiratory muscles, face-to-face, one-on-one, each 15 minutes (includes monitoring).
- G0238 Therapeutic procedures to improve respiratory function, other than ones described by G0237, one-on-one, face-to-face, per 15 minutes (includes monitoring).
- G0239 Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals (includes monitoring).

We assigned RVUs to one of the codes (G0237), and indicated that the other two codes (G0238 and G0239) would be carrier-priced. Since the services represented by these codes are frequently being performed in comprehensive outpatient rehabilitation facilities (CORFs), paid under the physician fee schedule through fiscal intermediaries, there has been some uncertainty surrounding the payment for the carrier-priced services. We believe assigning RVUs to G0238 and G0239 will provide needed clarity. Since these services are typically performed by respiratory therapists, we did not assign physician work to G0237, and we did not propose work RVUs for either G0238 or G0239.

Therefore, we proposed to value nationally the practice expense for these services using the nonphysician work pool. We proposed to crosswalk practice expense RVUs for G0238 to those for G0237 based on our belief that the practice expense for the activities involved is substantially the same for both services.

For G0239, we believe a typical group session to be 30 minutes in length and to consist of 3 patients. Therefore, for the practice expense RVUs for G0239, we proposed using the practice expense RVUs of G0237 reduced by one-third to account for the fact that the service is being provided to more than one patient simultaneously and each patient in a group can be billed for the services of G0329.

We also proposed a malpractice RVU of 0.02, the malpractice RVU assigned to G0237, for these two G–codes.

Comment: Commenters supported the national pricing for these 2 G–codes, G0238 and G0239. However, these organizations disagree with our RVU assignment. Specifically, most commenters disagreed with the lack of physician work RVUs and also believed that the malpractice RVU is inadequate to reflect the costs associated with the delivery of the services. These organizations contend that pulmonary rehabilitation services ''include a physician-directed individualized plan of care using multidisciplinary qualified health professionals to enhance the effective management of pulmonary diseases and resultant functional deficits.'' They believe that beneficiaries may receive pulmonary rehabilitation services at physician offices, outpatient departments of acute care hospitals, CORFs and rehabilitation clinics. The commenters noted that physicians and qualified nurse practitioners (NPs) and PAs order, supervise, and approve the plans of care for patients receiving respiratory therapy services, irrespective of the delivery setting.

Because respiratory rehabilitation is often furnished in a physician office, these organizations believe the malpractice RVU assigned is inadequate to account for the physician involvement and requested that a more appropriate risk factor be used.

Response: Because we believe that respiratory therapists (RTs) typically deliver these services, it would be inappropriate to assign a physician work RVU to these services. The malpractice RVU of 0.02 is similar to RVUs of therapeutic procedures delivered by physical and occupational therapists for similar services, including procedures performed one-on-one and in groups. We believe that the 0.02 malpractice RVU fairly represents the risk value inherent in the provision of these procedures. However, because the commenters expressed concerns about work and malpractice RVUs, we are assigning these RVUs on an interim

basis, and we are requesting that the RUC or HCPAC consider this series of three G–codes at an upcoming meeting.

Because RTs cannot directly bill Medicare for their services, these G-codes can only be billed as incident to services in physician offices and outpatient hospital departments or as CORF services. When performed in the CORF setting, these services must be delivered by qualified personnel, that is, RTs and respiratory therapy technicians, as defined at § 485.70. The CORF benefit requires the physician to establish the respiratory therapy plan of care and mandates a 60-day recertification for therapy plans of care, including physical therapy (PT), occupational therapy (OT), speech language pathology (SLP), and respiratory therapy. As we stated in the December 31, 2002 final rule, we believe that specially trained professionals (that is, registered nurses, physical therapists and occupational therapists) can also provide these services.

These respiratory therapy G-codes were designed to provide more specific information about the medically necessary services being provided to improve respiratory function and to substitute for the physical medicine series of CPT codes 97000 through 97799, except when services are furnished and meet all the requirements for physical and occupational therapy services.

Comment: While three commenters voiced concerns about the significant undervaluing of these codes, one commenter noted that the practice expense RVUs fail to recognize the intensity of services and the cost of monitoring and other equipment associated with providing these services.

Response: We agree that the practice expenses, particularly the equipment, for G0237 and G0238 are not equivalent and that there are more resources required to provide the medically necessary services of G0238. The necessary monitoring equipment referenced by commenters were considered at the time G0327 was originally valued. The appropriate direct inputs will be added to the practice expense database. However, we identified the omission of therapeutic exercise equipment for G0238 and G0239 and we will also add this to the practice expense database.

Result of Evaluation of Comments

We are assigning practice expense and malpractice RVUs to G0238 and G0239 and will add the additional items to the practice expense database. These codes are being valued in the nonphysician work pool as proposed. We will also ask the RUC or HCPAC to consider these codes.

4. Bone Marrow Aspiration and Biopsy through the Same Incision on the Same Date of Service.

In the August 5, 2004 rule, we proposed a new add-on G-code, G0364 (proposed as G0XX1): Bone marrow aspiration performed with bone marrow biopsy through same incision on same date of service. The physician would use the CPT code for bone marrow biopsy (38221) and G0364 for the second procedure (bone marrow aspiration).

We believe that there is minimal incremental work associated with performing the second procedure through the same incision during a single encounter. We estimated that the time associated with this G-code is approximately 5 minutes based on a comparison to CPT code 38220 bone marrow aspiration which has 34 minutes of intraservice time and a work RVU of 1.08 work when performed on its own. We proposed 0.16 work RVUs for this new add-on G-code and malpractice RVUs of 0.04 (current malpractice RVUs assigned to CPT code 38220). For practice expense, we proposed the following practice expense inputs:

— Clinical staff time: Registered nurse—5 minutes Lab technician—2 minutes
— Equipment: Exam table

We also proposed a ZZZ global period (code related to another service and is always in the global period of the other service) for this add-on code since this code is related to another service and is included in the global period of the other service.

In the August 5, 2004 proposed rule, we also stated that if the two procedures, aspiration and biopsy, are performed at different sites (for example, contralateral iliac crests, sternum/iliac crest or two separate incisions on the same iliac crest), the −59 modifier, which denotes a distinct procedural service, is appropriate to use and Medicare's multiple procedure rule will apply. In this instance, the CPT codes for aspiration and biopsy are each being used.

Comment: Many commenters supported creation of this G-code; however, all commenters stated that the time for this procedure (5 minutes) was substantially underestimated. Commenters recommended increasing the added incremental time associated with the aspiration to 15 minutes. One commenter noted that this time is needed for the actual aspiration procedure, approving the quality of the aspiration, collecting flow cytometry and chromosome studies, preparing additional slides, ordering appropriate lab tests on the slides, and performing the added recordkeeping and documentation. Another commenter provided a detailed description of the activities involved in this procedure. Commenters also recommended that the practice expense input for the nurse assisting with the procedure should be increased to 15 minutes.

Response: We continue to believe that the proposed 5 minutes of physician time, 5 minutes of registered nurse time, and 2 minutes of lab technician time reflect the additional effort involved when a bone marrow aspiration is performed in conjunction with a bone marrow biopsy through the same incision during a single encounter. It is our understanding that some of the activities attributed to the additional 15 minutes of physician work generally are performed by ancillary staff, for example, preparing slides. While we appreciate the information provided, we believe that the majority of the effort and specific tasks discussed are accounted for in the CPT code for bone marrow biopsy (38221) which is the primary code being billed.

Comment: Two physician specialty societies, representing radiologists and interventional radiologists, questioned the need for the proposed code, because the multiple surgical discount rule that reduces payment for a subsequent lower valued service applies, thereby taking into account any savings in physician work. If we choose to proceed with the proposal, the commenter recommended the RVUs be consistent with those determined using the current values for CPT codes 38220 and 38221 and the multiple surgical discount rule.

Response: One of the primary reasons for our proposal for this G-code was that we believe that, even with the application of the multiple procedure reduction, we would be overpaying for these services when they are performed on the same day, at the same encounter and using the same incision.

Result Of Evaluation of Comments

We are finalizing our proposal and using new G-code G0364, Bone marrow aspiration performed with bone marrow biopsy through the same incision on the same date of service. Payment is based on the work and malpractice RVUs and practice expense inputs proposed and the global period for this service is ''ZZZ''.

5. Q-Code for the Set-Up of Portable X-Ray Equipment

The Q-code for the set-up of portable x-ray equipment, Q0092, is currently paid under the physician fee schedule and is assigned an RVU of 0.33. In 2004, this produces a national payment of $12.32. This set-up code encompasses only a portion of the resources required to provide a portable x-ray service to patients. In 2003, portable x-ray suppliers received total Medicare payments of approximately $208 million. More than half of these payments (approximately $116 million) were for portable x-ray transportation (codes R0070 and R0075). The portable x-ray set-up code (Q0092) generated approximately $19 million in payments. The remainder of the Medicare payments for portable x-ray services (approximately $73 million) were for the actual x-ray services themselves.

As discussed in the August 5, 2004 proposed rule, the Conference Report accompanying the Consolidated Appropriations Bill, H.R. 2673, (Pub. L. 108–199, enacted January 23, 2004) urged the Secretary to review payment for this code, and the portable x-ray industry has also requested that we reexamine payments for this code.

Q0092 is currently priced in the nonphysician work pool. At the time we modeled this change for the proposed rule, removing this code from the nonphysician work pool had an overall negative impact on payments to portable x-ray suppliers (as a result of decreases to radiology codes that remain in the nonphysician work pool) and a negative impact on many of the codes remaining in the nonphysician work pool. An alternative to national pricing of portable x-ray set-up would be to require Medicare carriers to develop local pricing as they do currently for portable x-ray transportation. We requested comments on whether we should pursue national pricing for portable x-ray set-up outside of the nonphysician work pool or local carrier pricing for 2005, or whether we should continue to price the service in the nonphysician work pool.

Comment: Most commenters recommended removing portable x-ray from the nonphysician work pool, using the ''existing data'' from the American College of Radiology (ACR) supplemental practice expense survey as the practice expense per hour proxy. However, the National Association of Portable X-Ray Suppliers (NAPXP) requested additional time to review information they received from us just 3 days before the close of the comment period. This association requested that they be allowed to submit supplemental comments.

Response: ACR requested that we delay incorporating their survey data for 1 year. Using the data for one code, as proposed by commenters, would be inconsistent with that request. We believe it is inappropriate to use the new survey data for this code but no other code. Even if we removed the set-up code from the nonphysician work pool and calculated its practice expense RVU using the ACR data, the increase in payment for the portable x-ray set-up code would be largely offset by lower payment for x-ray services. Payments for other services in the nonphysician work pool would also decline affecting other specialties, such as radiology, radiation oncology, cardiology, allergy, audiology and others. Further, the portable x-ray set-up code is yet to be refined, and we believe that the 45 minutes of staff time that is used to determine its value is likely overstated. We believe it is preferable to address refinement of the code and pricing the service outside of the nonphysician work pool together. Therefore, in 2005, we are continuing to price this service within the nonphysician work pool.

The NAPXP requested more time to review the data we supplied them. NAPXP's comment implying that we withheld ''data'' from them is simply wrong. In an effort to explain the theoretical reasons for our statements that removing this service from the nonphysician work pool could lower overall payments to portable x-ray suppliers, we prepared an illustration for another association as a follow-up request after a meeting, where we were asked to explain our proposed rule analysis. The explanation contained no new data. Moreover, we provided the explanatory information to NAPXP as soon as they requested it. Since the information NAPXP complains about was illustrative only, we do not believe NAPXP has been prejudiced in any way. Moreover, we are willing to explain the information to NAPXP and to consider any comments they may have as we consider changes to the practice expense methodology for 2006.

6. Venous Mapping for Hemodialysis

In the August 5, 2004 rule, we proposed a new G-code (G0XX3: Venous mapping for hemodialysis access placement (Service to be performed by operating surgeon for preoperative venous mapping prior to creation of a hemodialysis access conduit using an autogenous graft). Autogenous grafts have longer patency rates, a lower incidence of infection and greater durability than prosthetic grafts. Use of autogenous grafts can also result in a decrease in hospitalizations and morbidity related to vascular access complications. We stated that creation of this G-code will enable us to distinguish between CPT code 93971 (Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study) and G0XX3 in order to allow us to track use of venous mapping for quality improvement purposes.

We also proposed that this G-code be billed only by the operating surgeon in conjunction with CPT codes 36819, 36821, 36825, and 36832 and that we would not permit payment for CPT code 93971 when this G-code is billed, unless code CPT 93971 was being performed for a separately identifiable clinical indication in a different anatomic region.

We proposed to crosswalk the RVUs for the new G-code from those of CPT code 93971 and also assigned this new G-code a global period of ''XXX,'' which means that the global concept does not apply.

Comment: Commenters representing specialty societies and individual providers were generally supportive of the proposal for this new code, but expressed the following three primary concerns:

- Commenters did not agree with restricting this code to the operating surgeon, stating that such a restriction could limit access and serve as a barrier in providing this service. They also stated that this proposed restriction is not reflective of current practice, since nonsurgeons often perform this procedure.
- Commenters did not agree with the proposed descriptor. They indicated that the proposed descriptor did not reflect the procedure as it is now performed and suggested (a) alternate wording, such as ''vascular mapping,'' ''autogenous AV fistula,'' and ''prosthetic graft,'' ''vessel mapping;'' (b) that two G-codes should be created to distinguish between a complete bilateral and unilateral or limited studies. Other commenters noted that the proposal did not distinguish between mapping by venography or ultrasound (duplex), and some commenters suggested creating an additional G-code to distinguish between these procedures.
- Commenters stated that the comparison to CPT code 93971 in the proposed rule undervalues the service. While there are differences, the closer analogue in terms of time and resources required is CPT code 93990, Duplex scans of hemodialysis access.

Response: We proposed the G-code to create the opportunity for us to analyze

the relationship between venous mapping utilization and fistula formation.

Based on the comments we received, we are revising the code descriptor to enable clinicians, other than the operating surgeon, who provide care to ESRD patients the opportunity to bill for this service.

We believe that vessel mapping requires the assessment of the arterial and venous vessels in order to provide the information necessary for the creation of an autogenous conduit. Therefore, we are also revising payment for this code and will crosswalk it to CPT code 93990 for work, malpractice, and practice expense RVUs because these RVUs more appropriately reflect the work and resources of this new G-code. The G-code and descriptor for this service will be G0365, Vessel mapping of vessels for hemodialysis access (Services for preoperative vessel mapping prior to creation of hemodialysis access using an autogenous hemodialysis conduit, including arterial inflow and venous outflow). This code can only be used in patients who have not had a prior hemodialysis access prosthetic graft or autogenous fistula and is limited to two times per year.

We will not permit separate payment for CPT code 93971 when this G-code is billed, unless CPT code 93971 is being performed for a separately identifiable indication in a different anatomic region. We also note that other imaging studies may not be billed for the same site on the same date of service unless an appropriate ''KO'' modifier indicating the reason or need for the second imaging study is provided on the claim form.

We will follow the utilization closely this year to better understand whether this code is used as intended.

III. Provisions Related to the Medicare Modernization Act of 2003

A. Section 611—Preventive Physical Examination

Section 611 of the MMA provides for coverage under Part B of an initial preventive physical examination (IPPE) for new beneficiaries, effective for services furnished on or after January 1, 2005, subject to certain eligibility and other limitations.

In the August 5, 2004 proposed rule, we described a new § 410.16 (Initial preventive physical examination: conditions for and limitations on coverage) that would provide for coverage of the various IPPE services specified in the statute. As provided in the statute, this new coverage allows payment for one IPPE within the first 6 months after the effective date of the beneficiary's first Part B coverage period, but only if that coverage period begins on or after January 1, 2005. To implement the statutory provisions, we proposed definitions of the following terms:

- Eligible beneficiary;
- An initial preventive physical examination;
- Medical history;
- Physician;
- Qualified NPP;
- Social History, and
- Review of the individual's functional ability and level of safety.

In keeping with the language of section 611 of the MMA, we defined the term ''eligible beneficiary'' to mean individuals who receive their IPPEs within 6 months after the date of their first Medicare Part B coverage period, but only if their first Part B coverage period begins on or after January 1, 2005. This section also defines the term ''Initial Preventive Physical Examination'' to mean services provided by a physician or a qualified NPP consisting of: (1) A physical examination (including measurement of height, weight, blood pressure, and an electrocardiogram, but excluding clinical laboratory tests) with the goal of health promotion and disease detection; and (2) education, counseling, and referral for screening and other covered preventive benefits separately authorized under Medicare Part B.

Specifically, section 611(b) of the MMA provides that the education, counseling, and referral of the individual by the physician or other qualified NPP are for the following statutory screening and other preventive services authorized under Medicare Part B:

- Pneumococcal, influenza, and hepatitis B vaccine and their administration;
- Screening mammography;
- Screening pap smear and screening pelvic exam services;
- Prostate cancer screening services;
- Colorectal cancer screening tests;
- Diabetes outpatient self-management training services;
- Bone mass measurements;
- Screening for glaucoma;
- Medical nutrition therapy services for individuals with diabetes or renal disease;
- Cardiovascular screening blood tests; and
- Diabetes screening tests.

Based on the language of the statute, our review of the medical literature, current clinical practice guidelines, and United States Preventive Services Task Force (USPSTF) recommendations, we interpreted the term ''initial preventive physical examination'' for purposes of this benefit to include all of the following service elements:

1. Review of the individual's comprehensive medical and social history, as those terms are defined in proposed § 410.16(a);

2. Review of the individual's potential (risk factors) for depression (including past experiences with depression or other mood disorders) based on the use of an appropriate screening instrument, which the physician or other qualified NPP may select from various available standardized screening tests for this purpose, unless the appropriate screening instrument is defined through the national coverage determination (NCD) process;

3. Review of the individual's functional ability and level of safety, as described in proposed § 410.16(a), (that is, at a minimum, a review of the following areas: Hearing impairment, activities of daily living, falls risk, and home safety), based on the use of an appropriate screening instrument, which the physician or other qualified NPP may select from various available standardized screening tests for this purpose, unless the appropriate screening instrument is further defined through the NCD process;

4. An examination to include measurement of the individual's height, weight, blood pressure, a visual acuity screen, and other factors as deemed appropriate by the physician or qualified NPP, based on the individual's comprehensive medical and social history and current clinical standards;

5. Performance and interpretation of an electrocardiogram;

6. Education, counseling, and referral, as appropriate, based on the results of the first five elements of the initial preventive physical examination; and

7. Education, counseling, and referral, including a written plan provided to the individual for obtaining the appropriate screening and other preventive services, which are separately covered under Medicare Part B benefits; that is, pneumococcal, influenza, and hepatitis B vaccines and their administration, screening mammography, screening pap smear and screening pelvic examinations, prostate cancer screening tests, colorectal cancer screening tests, diabetes outpatient self-management training services, bone mass measurements, screening for glaucoma, medical nutrition therapy services, cardiovascular (CV) screening blood tests, and diabetes screening tests.

The proposed ''medical history'' definition includes the following elements:

- Past medical history and surgical history, including experience with illnesses, hospital stays, operations, allergies, injuries, and treatment.
- Current medications and supplements, including calcium and vitamins.
- Family history, including a review of medical events in the patient's family, including diseases that may be hereditary or place the individual at risk.

The proposed ''physician'' definition means for purposes of this provision a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Act).

The proposed ''qualified nonphysician practitioner'' for purposes of this provision means a PA, NP, or clinical nurse specialist (CNS) (as authorized under sections 1861(s)(2)(K)(i) and 1861(s)(2)(K)(ii) of the Act and defined in section 1861(aa)(5) of the Act, or in regulations at § 410.74, § 410.75, and § 410.76).

The proposed ''social history'' definition includes, at a minimum, the following elements:

- History of alcohol, tobacco, and illicit drug use.
- Work and travel history.
- Diet.
- Social activities.
- Physical activities.

The proposed definition of ''Review of the individual's functional ability and level of safety'' includes, at a minimum, a review of the following areas:

- Hearing impairment.
- Activities of daily living.
- Falls risk.
- Home safety.

We also proposed conforming changes to specify an exception to the list of examples of routine physical examinations excluded from coverage in § 411.15(a)(1) and § 411.15(k)(11) for IPPEs that meet the eligibility limitation and the conditions for coverage that we are specifying under § 410.16, Initial preventive physical examinations.

With regards to the issue of payment for the IPPE, in the August 5, 2004 proposed rule we stated that there is no current CPT code that contains the specific elements included in the IPPE and proposed to establish a new HCPCS code to be used for billing for the initial preventive examination. As required by the statute, we indicated that this code includes an electrocardiogram, but does not include the other previously mentioned preventive services that are currently separately covered and paid under the Medicare Part B screening benefits. When these other preventive services are performed, they must be identified using the existing appropriate codes.

Proposed payment for this code was based on the following:

- *Work RVUs:* We proposed a work value of 1.51 RVUs for G0344 (G0XX2 in proposed rule) based on our determination that this new service has equivalent resources and work intensity to those contained in CPT E/M code 99203, *new patient, office or other outpatient visit* (1.34 RVUs), and CPT code 93000 *electrocardiogram, complete* (0.17 RVUs), which is for a routine ECG with the interpretation and report.

- *Malpractice RVUs:* For the malpractice component of G0344, we proposed malpractice RVUs of 0.13 in the nonfacility setting based on the malpractice RVUs currently assigned to CPT code 99203 (0.10) and CPT code 93000 (0.03). In the facility setting, we proposed malpractice RVUs of 0.11 based on the current malpractice RVUs assigned to CPT code 99203 (0.10) and 93010 (an EKG interpretation with a value of 0.01).

- *Practice Expense RVUs:* For the practice expense component of G0344, we proposed practice expense RVUs of 1.65 in the nonfacility setting based on the practice RVUs assigned to CPT code 99203 (1.14) and CPT code 93000 (0.51). In the facility setting, we proposed practice expense RVUs of 0.54 based on the practice expense RVUs assigned to CPT code 99203 (0.48) and 93010 (0.06).

Because some of the components for a medically necessary Evaluation and Management (E/M) visit are reflected in this new G code, we also proposed, when it is appropriate, to allow a medically necessary E/M service no greater than a level 2 to be reported at the same visit as the IPPE. That portion of the visit must be medically necessary to treat the patient's illness or injury or to improve the function of a malformed body member and should be reported with modifier—25. We also stated the physician or qualified NPP could also bill for the screening and other preventive services currently covered and paid by Medicare Part B under separate provisions of section 1861 of the Act, if provided during this IPPE.

The MMA did not make any provision for the waiver of the Medicare coinsurance and Part B deductible for the IPPE. Payment for this service would be applied to the required deductible, which is $110 for CY 2005, if the deductible is not met, and the usual coinsurance provisions would apply.

Analysis of and Response to Comments

We specifically solicited public comments on the definition of the term ''initial preventive physical examination,'' with supporting documentation. For example, we indicated that we chose not to define the term, ''appropriate screening instrument,'' for screening individuals for depression, functional ability, and level of safety, as specified in the rule, because we anticipated that the examining physician or qualified NPP may want to use the test of his or her choice, based on current clinical practice guidelines. We believe that any standardized screening test for depression, functional ability, and level of safety recognized by the American Academy of Family Physicians, the American College of Physicians-American Society of Internal Medicine, the American College of Preventive Medicine, the American Geriatrics Society, the American Psychiatric Association, or the USPSTF, or other recognized medical professional group, would be acceptable for purposes of meeting the ''appropriate screening instrument'' provision. We asked that commenters making specific recommendations on this or any related issue provide documentation from the medical literature, current clinical practice guidelines, or the USPSTF recommendations.

We received 71 public comments on the proposed rule regarding IPPE. Commenters included national and State professional associations, medical societies and medical advocacy groups, hospital associations, hospitals, managed care plans, physicians, senior advocacy groups, health care manufacturers, and others. Although a number of commenters expressed concern that the proposed rule was too prescriptive and not sufficiently targeted to prevention, a large majority of the commenters enthusiastically supported most of the coverage provisions of the proposed rule. Many of the commenters, however, suggested clarification and revision of the rule in a number of different areas, including the proposed definitions of ''initial preventive physical examination,'' ''physician,'' and ''qualified nonphysician practitioner.'' Commenters also raised questions regarding other issues, such as those relating to the need for us to educate Medicare beneficiaries and providers with respect to the new benefit, and to monitor the implementation of the new benefit. Finally, commenters offered suggestions and questions with regards to payment issues, evaluation and

management services (E/M) and coinsurance and Part B deductible issues.

A summary of the comments and our responses are presented below.

Comment: A number of commenters expressed concern that in the proposed rule, we had gone beyond the coverage criteria that were specified in the statute for the new benefit. They noted that the additional criteria was too prescriptive and would only add confusion and an additional burden for physicians in determining what medical services are necessary for each beneficiary they evaluate. Several commenters indicated that while the proposed definition for the scope of the benefit was well-intentioned, the beneficiary's physician or other provider was the best person to determine what medical services are necessary in providing a thorough physical and to be responsive to the individual's age, gender, and particular health risks. In general, they suggested that we not interfere in a physician's judgment by attempting to standardize by Federal regulations the specific medical services to be included under the new benefit.

Response: Section 611 of the MMA defines the scope of the IPPE benefit as physicians' services consisting of a physical examination (including measurement of height, weight, and blood pressure and an electrocardiogram) with the goal of health promotion and disease detection, as well as certain education, counseling, and referral services with respect to other statutory screening and preventive services also covered under the Medicare statute. We believe that the statutory parenthetical language, (including measurement of height, weight, and blood pressure and an electrocardiogram) recognizes that other services could be contained within the IPPE benefit. We are using the authority under section 1871(a) of the Act through the rulemaking process to provide clarity as to the specific services that are to be included under the new benefit.

We believe that adding these additional services will help to ensure that a full and complete IPPE is provided to each beneficiary who chooses to take advantage of the service and that all beneficiaries who decide to do this are treated in a relatively uniform manner throughout the country. With an estimated 200,000 individuals expected to enroll in Medicare Part B each month starting in January 2005, who will be eligible to receive the IPPE benefit, we believe that it is paramount that we promulgate a minimum list of required services important to the goals of health promotion and disease detection that must be included in the new benefit, and we are specifying those service elements in the final rule.

The ''Initial Preventive Physical Examination'' Definition (IPPE) (§ 410.16(a))

Comment: Three commenters indicated that this new benefit presents a unique opportunity to offer Medicare beneficiaries with a visit focused on prevention at the start of their Part B enrollment. They suggested, that we shift our focus in service element 1 of the definition of the new IPPE from a comprehensive to a more targeted priority list of modifiable risk factors, screening tests, and immunizations that are supported by the strongest evidence of effectiveness, and have been proven to improve the health of beneficiaries.

Response: We agree that the intent of the new benefit is to deliver clinical preventive services that are accepted and effective in helping to keep people healthy and reduce the burden of disease whenever possible. Therefore, we agree to revise the language in service element 1 to read as follows: ''Review of the individual's medical and social history with particular attention to modifiable risk factors for disease.''

Comment: Three commenters indicated that the collection of information on a beneficiary's social history such as social activities, work and travel history, is a distraction and is not needed by the physician or other qualified NPP who is performing the preventive physical examination. The commenters suggest that we eliminate the proposed definition and not require the collection of this information.

Response: We agree that information on work and travel history, and social activities may not be necessary for purposes of the new preventive physical examination and thus we are removing those elements from the minimum requirements for the ''social history'' definition. However, we believe it is important to retain three elements of the Social history definition in the final rule and they will be reflected in that document as follows:

- History of alcohol, tobacco, and illicit drug use.
- Diet.
- Physical activities.

Comment: Several commenters requested that we add language to service element 1 to allow practitioners to ascertain information from individuals about additional disease or other diagnoses such as including questions regarding past diagnoses or treatment of cancer, diabetes, elevated blood sugar, height loss, previous fractures, and medical conditions that may increase a person's risk of coagulopathic disorders such as deep venous thrombosis (DVT).

Response: In applying our definition of ''past medical history'' we expect that physicians and qualified NPPs performing the IPPE will be able to ask about an array of medical illnesses, including prior diagnoses and treatment of conditions such as cancer, diabetes, risk factors for osteoporosis such as height loss or previous fractures, and history of coagulopathic disorders such as DVT. Therefore, we do not see a need to expand the proposed definition as the commenters have suggested, and we have decided to leave it unchanged in the final rule.

Comment: Three commenters asked us to add language to either service element 1 or 3 to allow practitioners to screen individuals for memory impairment.

Response: Currently, the USPSTF has found insufficient evidence to recommend for or against routine screening for dementia with standardized instruments in asymptomatic persons. However, the USPSTF notes that patients with problems in performing daily activities should have their mental status evaluated and clinicians should remain alert for possible signs of declining cognitive function. We included as part of the definition for service element 3, ''Review of the individual's functional ability and level of safety,'' a review of the patient's activities of daily living. While not exhaustive, this review will primarily aid physicians in identifying a patient's problems with regard to performing these activities and the role cognitive impairment may play in these deficits.

Comment: One commenter proposed that we not use the NCD process to revise the content of the IPPE in the future. The NCD process would be too slow or cumbersome to allow us to keep the content of the examination consistent with current clinical practice.

Response: For service elements 2 and 3, which discuss the future use of the NCD process in determining appropriate screening instruments we will delete the following: ''unless the appropriate instrument is defined through the NCD process.'' We will add language that states available standardized screening tests must be recognized by national medical professional organizations.

Comment: Several commenters requested that we clarify our intent as to whether the depression screening assessment in service element 2 will include consideration of the potential for depression as well as an assessment

of an individual's current depression status. Another commenter asked us to clarify our intent with respect to the use of a screening instrument for persons with a current diagnosis of depression.

Response: We agree with the commenters that the regulation language on depression screening needs to be clarified. We are revising service element 2 to read ''review of the individual's potential (risk factors) for depression, including current or past experience with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the physician or other qualified NPP may select from various available standardized screening tests designed for this purpose and recognized by national medical professional organizations.''

Comment: Three commenters expressed the view that the proposed screening tests for falls risk and home safety in service element 3 were not supported by direct scientific evidence, and should be dropped from the IPPE benefit in the final rule.

Response: Falls are among the most common and serious problems facing elderly persons. They are associated with considerable morbidity such as hip fractures and overall reduced level of functioning. The USPSTF also notes that falls are the second leading cause of unintentional injury deaths in the United States. The death rate due to falls increases as a person ages. According to the National Center for Injury Prevention and Control, approximately one-half to two-thirds of all falls occur in and around a person's home. Therefore, discussing with patients home safety tips may reduce some home hazards. In addition, the USPSTF recommends counseling patients on specific measures to reduce the risk of falling, although direct evidence of effectiveness has not yet been established. Therefore, we believe that questioning and counseling patients to determine their risk of falling and home safety is warranted as part of the IPPE benefit.

Comment: Several commenters from the audiology community have asked us to clarify the meaning of the proposed requirement in service element 3, which includes (among other things) a review of any hearing impairment. In addition, several commenters have requested that we clarify whether a hearing assessment is required as part of service element 3, or whether questions (or a questionnaire) advanced to an individual about any possible hearing problems would suffice for purposes of this part of the new benefit. The commenters ask for provider flexibility in meeting this requirement.

Response: The regulatory intent of service element 3 is that we expect that the physician or qualified NPP will engage in a dialogue with patients concerning these issues by asking the individual appropriate questions or using a written questionnaire to address hearing impairment, activities of daily living, falls risk, and home safety. We do not intend for actual screening instruments such as audiometric screening tests to be used. After questioning the individual, if abnormalities are identified, additional follow-up services may be warranted and may include education, counseling, and referral (if appropriate.)

Therefore, we are revising the language of service element 3 to read ''review of the individual's functional ability and level of safety, based on the use of appropriate screening questions or a screening questionnaire which the physician or qualified NPP may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national medical professional organizations.''

Medically necessary diagnostic hearing tests, including hearing and balance assessment services, performed by a qualified audiologist are covered as other diagnostic tests under section 1861(s)(3) of the Act and would be separate from the new IPPE benefit. These services may be appropriate when a physician or other qualified NPP orders a diagnostic hearing test for the purpose of obtaining information necessary for the physician's diagnostic evaluation or to determine the appropriate medical or surgical treatment of a hearing deficit or related medical problem. However, coverage of this testing is excluded by virtue of section 1862 (a)(7) of the Act when the diagnostic information required to determine the appropriate medical or surgical arrangement is already known to the physician, or the diagnostic services are performed only to determine the need for the appropriate type of hearing aid. For further information about the application of the hearing test exclusion to diagnostic hearing tests and payment for these services, we suggest review of section 80.3 to 80.3.1 of the Medicare Benefit Policy Manual.

Comment: Several commenters suggested that we expand the services to be included as part of service element 4 that was proposed for coverage under the IPPE benefit to include: (1) Palpitation/auscultation of carotid arteries; (2) palpitation/auscultation of abdominal aorta; and (3) the ankle-brachial index (ABI) test for peripheral arterial disease (PAD).

Response: Currently, routine screening of asymptomatic persons for carotid artery stenosis via palpation/auscultation of the carotid arteries or carotid ultrasound is not recommended by organizations such as the USPSTF, which provides guidelines on this issue. Therefore, we are not adding routine screening of asymptomatic individuals for carotid artery stenosis to service element 4 in the absence of evidence of the effectiveness of the screening. In addition, the USPSTF has determined that there is insufficient evidence to recommend for or against routine screening of asymptomatic adults for abdominal aortic aneurysm (AAA) by palpation/auscultation or ultrasound of the abdominal aorta so we are not adding that type of screening to service element 4.

Finally, the USPSTF does not recommend routine screening for PAD in asymptomatic persons. However, they also state that clinicians, should be aware of symptoms and risk factors for PAD and evaluate patients accordingly. Therefore, routine screening for PAD with the use of the ABI will not be required as part of the initial preventive physical examination.

Comment: One commenter asked for clarification on whether the proposed regulatory language ''and other factors deemed appropriate by the physician or qualified nonphysician practitioner,'' as specified in service element 4, would permit inclusion of coverage of a screening for chronic obstructive pulmonary disease (COPD) through spirometric testing under the IPPE benefit.

Response: The intent of this language for the actual physical examination portion of the IPPE benefit is to leave to the discretion of the physician or other qualified NPP whether to perform commonly utilized physical examination measures such as auscultation of the heart or lungs on a particular patient, if needed. Spirometry as a screening test for COPD, however, would not be considered to fall within the scope of the physical examination element of the IPPE benefit.

Comment: A number of commenters suggested that we add an assessment of abdominal obesity or alternatively the calculation of the body mass index (BMI) to the vital signs part of service element 4 to help in determining if an individual is at risk for a heart attack, diabetes, or other medical problems.

Response: By requiring measurement of height and weight as part of the IPPE in element 4 (an examination to include

measurement of an individual's height, weight, blood pressure), we believe that the physician or other qualified NPP performing the IPPE will use that information to determine an individual's BMI if necessary.

Comment: Three commenters expressed concern about the wide latitude given to physicians and other qualified NPPs providing the IPPE benefit to select whichever screening test they prefer to use in connection with the assessment of visual acuity. The commenters believe that setting vague boundaries around what constitutes an appropriate screening instrument could open the door for inappropriate use of preventive services. To avoid this, the commenters recommend narrowly defining the appropriate screening instrument for visual acuity in service element 4 by specifying the use of the Snellen test for that purpose.

Response: We agree that the Snellen test is a widely available test used to assess a person's visual acuity. Other similarly available tests for visual acuity also exist, however, and may convey similar results for individual physicians and other clinicians. While we expect that many physicians will utilize the Snellen test in assessing a beneficiary's visual acuity for the purpose of this new benefit, we are not mandating the use of the Snellen test or any other specific visual acuity test in order to meet the requirements of element 4 in the final rule.

Comment: One commenter noted that the proposed rule allows for coverage of the assessment in service element 4 of ''other factors as deemed appropriate based on the individual's comprehensive medical and social history.'' The commenter expressed the view that the quoted language might result in the possibility that virtually any patient's abnormality identified during the preventive physical examination might lead to further evaluation of the patient and a cascade of diagnostic workup of questionable health benefit to the patient and potentially of great cost to the Medicare program. In view of these concerns, the commenter recommended using more restrictive language that would allow for additional assessment of other factors only when they are supported by evidence-based clinical practice guidelines.

Response: Our purpose in proposing the specific quoted language referenced in service element 4 was to allow for the physician or other qualified NPP to perform a limited physical examination of those key elements such as height, weight, blood pressure, and a visual acuity screen that may be important in detecting disease. However, we have specified that additional physical examination measures may be performed if deemed appropriate based on the issues identified by the physician or other clinician in the review of service elements 1 to 3. While we will not specify in the final rule that these additional measures must be supported by evidence-based practice guidelines, we will state that the practitioner performing the preventive examination follow current clinical standards and those guidelines, of course, may include the evidence-based guidelines referenced by the commenter.

Comment: One commenter recommends that we include in our guidelines for the IPPE benefit information that informs the physician or other qualified NPP of: (1) The need to refer patients to occupational therapists when a more extensive evaluation of activities of daily living, falls risk, and home safety is warranted; and, (2) when, such referrals would be medically appropriate.

Response: As part of the final rule, service element 6 of the IPPE benefit will require, education, counseling, and referral, as appropriate, based on the individual's results of the previous 5 elements of the IPPE benefit. However, appropriate referral of a patient to an occupational therapist is left to the discretion of the physician or other qualified NPP who is treating the patient for the medical problem that is identified, subject to contractors' medical necessity review. We do not believe there is a need for us to issue guidelines to our contractors on this point.

Comment: Several commenters indicated that they were concerned about use of the term ''counseling'' in service elements 6 and 7 of the definition of the IPPE because it lacked sufficient clarity. The commenters indicated that counseling may include varying amounts of time depending upon the intensity of the type of service provided, the ability of the individual receiving the counseling to understand the information that is being communicated, etc. The commenters suggested that either we not use the term counseling or clarify its meaning in the final rule.

Response: Use of the term counseling in connection with service element 7 is mandated by section 611 of the MMA, and thus, it is appropriate to use the term in the final rule. However, we would like to clarify this issue in connection with both service elements 6 and 7 of the new benefit. In most cases, we do not expect that the physician or other qualified NPP performing the service should need to spend more than a few minutes of brief education and counseling with a new beneficiary on appropriate topics as required by element 7. Nonetheless, it is possible that it may be necessary to spend more than a few minutes on the education and counseling required by element 6. As the commenters have indicated, the education and counseling required may involve varying amounts of time depending upon the medical problem or problems that are being considered, based on the results of elements 1 to 5, and the intensity of the service that is believed to be medically necessary at that time.

Comment: Three commenters indicated that they support proposed service element 6 on ''education, referral, and counseling deemed appropriate based on the results of the review and evaluation of services,'' in service elements 1 to 5 because it offers an unprecedented opportunity to counsel beneficiaries about health behaviors (for example, stopping smoking, losing weight). Nonetheless, they were concerned about possible over-utilization of services that might result from that provision, and suggest that we clarify that these education, counseling and referral efforts be concordant with evidence-based practice guidelines.

Response: We will not specify in the final rule that education, counseling, and referral efforts must be consistent with evidence-based practice guidelines. We expect that physicians and other qualified NPPs will provide appropriate education, counseling, and referral that utilizes evidence-based practice guidelines and current clinical standards. In addition, follow-up care obtained outside of the IPPE Benefit must be reasonable and necessary based on Section 1862(a)(1)(A) of the Act.

Comment: A number of commenters requested that we clarify the written plan provision of service element 7 that was included in the proposed rule. Several commenters indicated that two problems they see with this requirement are: (1) It is not clearly defined and thus could impose a significant burden on physicians and other clinicians, if it is not more carefully written; and, (2) it does not acknowledge that alternative mechanisms may already be in place that could better facilitate coordination of care for these beneficiaries than the proposed written plan requirement. For example, one commenter suggests that some physicians and other clinicians may currently be using electronic technology to track the delivery of preventive services and should not be

required to file written plans. Instead, the commenter recommends that we craft language to require physicians to demonstrate a system for ensuring that beneficiaries receive recommended screening and preventive services and allow physicians flexibility to determine the design and medium that such a system would employ.

Response: We agree that the term written plan may not offer a sufficiently clear description of our intentions in requiring the physician or other qualified NPP who also performs the IPPE to carry out the statutory mandate that eligible beneficiaries be provided with education, counseling, and referral for screening and other preventive services described in section 1861(ww)(2) of the Act. Our intent in the proposed rule was that each physician or other qualified NPP provide their eligible beneficiaries at the time of the examination with appropriate education, counseling, and referral(s), including a brief written plan such as a checklist, which is provided to the beneficiary for obtaining the appropriate screening and/or other preventive services that are covered as separate Medicare Part B benefits to which he or she is entitled. We acknowledge that physicians or qualified NPPs may have an alternative mechanism in place to ensure that beneficiaries receive recommended screening and other preventive services that does not provide for a written plan to be provided to the beneficiary. However, the intent of the written plan requirement is to promote and encourage beneficiary participation in the health care process by making them aware, briefly in writing of the screening and prevention services for which they are entitled under the Medicare Part B program.

In conclusion, we will revise service element 7 to read ''education, counseling, and referral, including a brief written plan such as a checklist, be provided to the individual for obtaining appropriate screening and other preventive services, which are separately covered under Medicare Part B benefits.''

The ''Physician'' Definition (§ 410.16(a))

Comment: One commenter expressed concerns regarding the definition of a physician. The commenter expressed concern that the proposed rule limits the type of practitioner who is considered qualified to perform the new preventive physical examination. The commenter states that this restriction was not specified by the Congress in section 611 of the MMA or its accompanying conference committee report, and suggests that it should be revised to allow all practitioners, including doctors of podiatric medicine, who are defined as a physician under section 1861(r) of the Act, to be considered qualified to perform the preventive physical examination.

Response: Section 611 of the MMA amended the statute to provide that payment for the IPPE must be made under the Medicare physician fee schedule, as provided in section 1848(j)(3) of the Act, but it did not specifically define what type of physician is eligible for performing this examination. In developing the proposed rule on which physicians are considered qualified to perform the IPPE, we considered the various types of physicians that are identified in section 1861(r)(2), (r)(3), (r)(4), and (r)(5) of the Act. These include doctors of dental surgery, doctors of podiatric medicine, doctors of optometry, and chiropractors, whose scope of medical practice is generally limited by State law to a particular part (or parts) of the human anatomy.

These state licensing restrictions would likely make it difficult for those practitioners to perform all of the services required. Based on this information, we are leaving the definition of a physician unchanged in the final rule.

The ''Qualified Nonphysician Practitioner'' Definition (§ 410.16(a))

Comment: One commenter indicated concern that in the proposed rule certified nurse-midwives (CNMs) are not eligible to furnish the new preventive physical examinations, but physicians and certain other NPPs are eligible to provide those services to Medicare beneficiaries. The commenter indicates that CNMs are fully qualified to provide physical examination and checkups covered by the statute and that they do so on a daily basis as a basic component of the care they provide their clients. The commenter states that we may be constrained by the statute as enacted by Congress on this subject, but suggests that we should review the issue and if possible revise the proposed rule to include CNMs among those who are considered to be eligible to provide the new service in the final rule.

Response: Section 611 of the MMA amended the statute to provide that in addition to physicians certain NPPs, that is, PAs, NPs, and CNS (as authorized under section 1861(s)(2)(K)(i) and (ii) of the Act, and defined in section 1861(aa)(5) of the Act, or in regulations at § 410.74, § 410.75, and § 410.76) will be able to furnish the new preventive physical examination to eligible beneficiaries effective January 1, 2005. Thus, Congress did not specifically authorize CNMs to perform the IPPE. Unless CNMs are able to qualify as one of these other types of NPPs designated by the statute for purposes of the new IPPE benefit, they will not be eligible to provide this service to beneficiaries for Medicare Part B coverage purposes.

Other Issues

Comment: One commenter requested that we clarify application of the proposed IPPE definition to managed care plans where preventive physical examinations are available to Medicare enrollees on an annual basis and they are not limited to a one-time benefit. Generally in the case of managed care plans, it is indicated that the extent of their typical annual preventive examination is determined by the enrollee's physician or other treating physician, depending upon the patient's history and clinical indications. The commenter asks that we allow managed care plans greater flexibility in providing their Medicare enrollees with the various service elements described in the proposed rule. Alternatively, the commenter requests that we clarify in the final rule that managed care plans will need to provide their Medicare enrollees with all elements of the new benefit only if requested to do so by a particular Medicare enrollee.

Response: Section 611 of the MMA requires that IPPEs be made available to all Medicare beneficiaries who first enroll in Medicare Part B on or after January 1, 2005, and who receive that benefit within 6 months of the effective date of their initial Part B coverage period. The new statute does not allow for any exceptions to be made to the coverage of IPPEs for beneficiaries who are members of managed care plans. In fact, section 1852(a) of the Act provides that generally each managed care plan must, at a minimum, provide to its Medicare members all of those items and services (other than hospice care) for which benefits are available under Parts A and B for individuals residing in the area served by the plan. Nonetheless, if a particular Part B member of the plan chooses not to take advantage of the IPPE benefit, for example, because it would duplicate an annual preventive physical exam that has already been provided to that member, the plan would not be obligated to provide the IPPE to that member.

Comment: One commenter noted that while the screening benefits listed in paragraph (A)(1) on **Federal Register**

page 47514 (vol. 69, No. 150) includes ''(5) colorectal cancer screening test,'' the list of screening benefits described in the same section, paragraph (7) on page 47515 does not include that type of cancer screening test. The commenter requests that we include colorectal cancer screening in the list of screening services described on page 47515 of the Physician Fee Schedule Proposed Rule and any other sections of any proposed rule in which covered screening benefits are listed to ensure there is no confusion regarding what services should discussed with patients during the IPPE.

Response: We agree with the commenter that there was an error of omission relative to colorectal cancer screening in the language in the preamble to the proposed rule in the list of screening benefits described on page 47515 of the Physicians Fee Schedule, and we have corrected that oversight in this final rule.

Comment: One commenter requests that we clarify the part of the definition of the IPPE (service element 7) that refers to the provision of education, counseling, and referral of the individual for coverage of bone mass measurements by adding the term ''Dual Energy X–Ray Absorptiometry'' (DEXA) to that provision. The commenter states that DEXA testing is the most accurate method available for diagnosis of osteoporosis and that early detection of this condition paramount for preventing further bone loss and eventual fractures. The commenter is concerned that unless this is clarified in the final rule, local Medicare contractors may exclude coverage for the DEXA test as part of the IPPE benefit.

Response: Our existing regulations governing bone mass measurements are published in § 410.31. While we agree that the DEXA scan is a very commonly used method for the initial diagnosis of osteoporosis, we do not believe that it would be appropriate to add any specific reference to the DEXA test in the IPPE definition because it may be perceived as endorsing one test over another. We do not believe this would be appropriate. Physicians and other qualified NPPs who perform IPPE services may provide appropriate education, counseling, and referral of their Medicare patients for the bone density tests. The counseling and referral may include choosing the appropriateness of the diagnostic modalities for the particular patient.

Comment: A number of commenters have asked us to provide information to Medicare physicians and qualified NPPs performing the IPPE for appropriate referral of their patients when treatment or a more extensive evaluation of patients is needed as part of service element 6.

Response: As part of the final rule, under service element 6, providers are required to furnish their patients with education, counseling, and referral, as appropriate, based on the individual's results of service elements 1–5 of the IPPE service. However, appropriate referral of a patient, of course, is left to the discretion of the physician or other qualified NPP who is treating the patient for the medical problem that is identified.

Comment: One commenter asked us how we plan to monitor the effectiveness of the IPPE benefit over the next several years.

Response: As indicated in the final rule, we have established unique billing codes for the IPPE service which physicians and other qualified NPPs must use in billing Medicare Part B for the new service. Establishing those codes will allow us to monitor over time the extent to which the eligible Medicare Part B population is utilizing the new service, which will be of interest to our program administrators, members of the Congress, and the general public.

Comment: One commenter asked how providers of IPPE services will know if a particular beneficiary is eligible to receive the new benefit due to the statutory time and coverage frequency (one-time benefit) limitations.

Response: The statute provides for coverage of a one-time IPPE benefit that must be performed for new beneficiaries by qualified physicians or certain specified NPPs within the first 6 months period following the effective date of the beneficiary's first Part B coverage. Since physicians or other qualified NPPs may not have the complete medical history for a particular new beneficiary, including information on possible use of the one-time benefit, these clinicians are largely relying on their own medical records and the information the beneficiary provides to them in establishing whether or not the IPPE benefit is still available to a particular individual and was not performed by another qualified practitioner. Since a second IPPE will always fall outside the definition of the new Medicare benefit, an advance beneficiary notice (ABN) need not be issued in those instances where there is doubt regarding whether the beneficiary has previously received an IPPE. The beneficiary will always be liable for a second IPPE no matter when it is conducted. However, for those instances where there is sufficient doubt as to whether the statutory 6-month period has lapsed, the physician or other qualified NPP should issue an ABN indicating that Medicare may not cover and pay for the service. If the physician or other qualified NPP does not issue an ABN and Medicare denies payment because the statutory time limitation for conducting the initial IPPE has expired, then the physician or other qualified NPP may be held financially liable.

Comment: Several commenters asked that we provide explicit instructions and guidelines, respectively, to providers and beneficiaries regarding the details of what will be included in the new benefit, the eligibility requirements, and how providers must bill Medicare for the new service.

Response: Medicare will release appropriate manual and transmittal instructions and information from our educational components for the medical community, including a MedLearn Matters article and fact sheets like the ''2005 Payment Changes for Physicians and Other Providers: Key News From Medicare for 2005''. The medical community can join this effort in educating physicians, qualified NPPs, and beneficiaries by distributing their own communications, bulletins or other publications.

In addition, we have specifically included information on the new IPPE benefit in the 2005 version of the *Medicare and You Handbook* and the revised booklet, *Medicare's Preventive Services.* A new 2-page fact sheet on all of the new preventive services, including the IPPE benefit, is currently under development, and a bilingual brochure for Hispanic beneficiaries will also be available in the new future. This information will be disseminated by our regional offices, State Health Insurance Assistance Programs (SHIPs), and various partners at the national, State, and local levels. Information on the new benefit will also be made available to the public through medicare.gov, the cms.gov partner Web site, 1–800–MEDICARE, numerous forums hosted by CMS, and conference exhibits and presentations.

Comment: Many of the major physician specialty societies believe the payment, as proposed, is undervalued for what is believed to be a labor-intensive IPPE. They request that we use the existing CPT preventive medicine services code series rather than creating a new G-code. These codes have higher RVUs than the office or other outpatient visit code 99203. For example, preventive medicine services visit code 99387 has total nonfacility RVUs of 4.00 while the corresponding value for 99203 is 2.58.

Response: The existing CPT preventive medicine services codes

(99381–99397) are not covered by Medicare. In accordance with section 1862(a)(1)(A) of the Act that requires us to pay only for services that are reasonable and necessary for the treatment of an illness or injury or to improve the function of a malformed body member, we have not covered E/M visits for screening purposes.

The IPPE is intended to target selected modifiable risk factors and secondary prevention opportunities shown by evidence to improve the health and welfare of the beneficiary, and is less focused on a comprehensive physical examination compared to the typical service provided in accordance with CPT code 99397. We equated the resources anticipated with this service to the existing new office or other outpatient visit. For CPT code 99203 the RUC survey data shows 53 physician minutes (including pre-service time, intra-service time and post-service time) with 51 minutes of staff time. We believe the IPPE will reflect these time approximations. We will be looking at the data and consulting with the medical community after initial experience with this new benefit to determine if this payment has been valued appropriately.

Comment: Two commenters suggested that we allow the IPPE either on a yearly basis or every decade after the initial evaluation.

Response: The IPPE was specifically legislated as a one time only benefit for the beneficiary newly enrolled in the Medicare program. This visit familiarizes the beneficiary with a physician or qualified NPP who will highlight the assessments available to help prevent and detect disease and also make available the educational, counseling and referral opportunities to the new Medicare recipient. Our policy anticipates physicians will make appropriate and individualized referrals for the beneficiary. Expanding the number of routine physicals would require additional legislation (See section 1862(a)(7) of the Act).

Comment: Many commenters asked if the IPPE may be provided without performing the EKG at the same visit. They asked to have the EKG component unbundled from the evaluation and management component that had been specified in the proposed rule for the IPPE service since a physician may not have the equipment and capability of providing EKG services to their patients in the office suite or clinic. Additionally, others asked if a physician would be denied payment for the IPPE if the screening EKG was not performed because a diagnostic EKG was performed in a recent visit or if a diagnostic EKG was warranted at the IPPE visit.

Response: Section 611 of the MMA does require a screening EKG to be performed as part of the IPPE visit. We recognize that there are a number of primary care physicians or other clinicians furnishing the service who may want to refer their beneficiaries to outside practitioners or entities for performance and interpretation of the EKG service rather than performing it themselves. Therefore, if an individual physician or other qualified NPP does not have the capacity to perform the EKG in the office suite, then alternative arrangements will need to be made with an outside physician or other entity in order to make certain that the EKG is performed. In circumstances where the primary care physician or qualified NPP refers the beneficiary to an outside physician or entity for the EKG service, we expect that the primary care physician or qualified NPP will incorporate the results of the EKG into the beneficiary's medical record to complete the IPPE. Both components of the IPPE, the examination portion and the EKG, must be performed for either of the components to be paid. Billing instructions for physicians, qualified NPPs and providers will be issued. In order to address these potentially occurring scenarios to complete the IPPE and EKG we have created the following HCPCS codes:

- G0344: *Initial preventive physical examination; face-to-face visit services limited to new beneficiary during the first six months of Medicare enrollment*
- G0366: *Electrocardiogram, routine ECG with at least 12 leads with interpretation and report, performed as a component of the initial preventive physical examination*

A physician or qualified NPP performing the complete service would report both G0344 and G0366.

- G0367: *tracing only, without interpretation and report, performed as a component of the initial preventive physical examination*
- G0368: *interpretation and report only, performed as a component of the IPPE*

RVUs for payment for these new HCPCS codes will be crosswalked from the following CPT codes:

- G0344 will crosswalk from CPT code 99203 *(Office or other outpatient visit)*
- G0366 will crosswalk from CPT code 93000 *(Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report)*
- G0367 will crosswalk from CPT code 93005 *(Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report)*
- G0368 will crosswalk from CPT code 93010 *(Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only)*

Note that HCPCS codes G0366 and G0367 are not payable under the physician fee schedule in the facility setting.

To comply with MMA the IPPE must include the EKG regardless of whether a diagnostic EKG was recently performed. An EKG performed by the physician or qualified NPP during the IPPE visit must be reported with HCPCS code G0366. Medicare does not cover a screening EKG alone.

Comment: One commenter asked if physicians and qualified NPP who see patients in Federally Qualified Healthcare Centers (FQHCs) will be able to provide and bill under the FQHC all-inclusive rate.

Response: Physicians and other qualified NPPs in RHCs and FQHCs may provide this new benefit and follow normal procedures for billing for RHCs and FQHC services. Payment for the professional services will be made under the all-inclusive rate.

Comment: Many physician specialty societies did not agree with our proposal to limit the level of a medically necessary E/M visit when performed and billed with the IPPE. They contend that most Medicare patients, even if known to their physician, come to the IPPE visit with multiple chronic problems often necessitating immediate evaluation and treatment at a level of care equal to a level 4/5 E/M visit code. They also state that current Medicare policy does permit a medically necessary E/M visit at whatever level is appropriate when the noncovered preventive medicine services (CPT codes 99381–99397) are performed. They ask that we eliminate the restriction for the level of service for a medically necessary E/M visit performed at the same visit as the IPPE visit.

Response: The physician will need to schedule time with the beneficiary identifying the available preventive and educational opportunities. A level 2 new or established patient office or other outpatient visit code was proposed because we believe there is a substantial overlap of practice expense, malpractice expense and physician work in both history taking and examination of the patient with the IPPE and another E/M service. We do not want to prohibit the use of an appropriate level of service when it is necessary to evaluate and treat the beneficiary for acute and chronic

conditions. At the same time, we believe the physician is better able to discuss health promotion, disease prevention and the educational opportunities available with the beneficiary when the health status is stabilized and the beneficiary is physically receptive.

We will remove the restriction limiting the medically necessary E/M service to a level 2 visit code. CPT codes 99201 through 99215 may be used depending on the circumstances and appended with CPT modifier ''25 identifying the E/M visit as a separately identifiable service from the IPPE code G0344 reported.

We do not believe this scenario will be the typical occurrence and, therefore, we will monitor utilization patterns for the level 4/5 new or established office or other outpatient visit codes being reported with the IPPE. If there are consistent data that demonstrate high usage of level 4/5 E/M codes we may need to revise the policy.

Comment: Two commenters asked if we would permit separate payment for a digital rectal exam (DRE) when performed on the same day as the initial preventive physical examination.

Response: Currently Medicare does not make separate payment for DRE (code G0102) when performed on the same day as an E/M service. We will maintain the current policy and not pay separately for a DRE performed during the IPPE visit. A DRE is usually furnished as part of an E/M service and is bundled into the payment for an E/M service when a covered E/M service is furnished on the same day as a DRE. It is a relatively quick and simple procedure and if it is the only service furnished or is provided as part of an otherwise noncovered service it would be payable if coverage requirements are met.

Comment: Several commenters requested guidance on documentation.

Response: It is expected that the physician will use the appropriate screening tools. As for all E/M services, the 1995 and 1997 E/M documentation guidelines must be followed for recording information in the patient's medical record. The screening tools used, EKG documentation, referrals and a written plan for the patient also must be included in the patient's medical record. These forms and methods of documentation mirror those that would be used in typical physician practice with patient visits and do not add an additional burden to the physician.

Comment: Several commenters expressed concern that the non-waived deductible and coinsurance will be a disincentive to the beneficiary having the IPPE. They are concerned that some beneficiaries will not avail themselves of the opportunity of the IPPE visit because of the beneficiary's cost share.

Response: The MMA did not waive the deductible and coinsurance, therefore, we must implement the provision as written.

Result of Evaluation of Comments

In view of the comments, we have decided to make several revisions in § 410.16(a) relative to service elements 1, 2, and 3. We are revising § 410.16(a)(1)(i) language in service element 1 to read as follows: ''Review of the individual's medical and social history with particular attention to modifiable risk factors for disease.''

We are clarifying the regulation language on depression screening (service element 2) by revising § 410.16(a)(1)(ii) to specify that review of the individual's potential (risk factors) for depression, including current or past experience with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the physician or other qualified NPP may select from various available standardized screening tests designed for this purpose and recognized by national medical professional organizations. To allow for a certain amount of provider flexibility in meeting the requirements of the regulatory intent of service component 3 we are revising § 410.16(a)(1)(iii) to specify that review of the individual's functional ability and level of safety, based on the use of appropriate screening questions or a screening questionnaire, which the physician or qualified NPP may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national medical professional organizations.

To clarify the requirements of the regulatory intent of service component 7 we are revising § 410.16(a)(1)(vii) to specify that education, counseling, and referral, including a brief written plan such as a checklist be provided to the individual for obtaining the screening and other preventive services for the individual that are covered as separate Medicare Part B benefits.

The ''social history'' definition in the final rule will be revised to include 3 elements:

- History of alcohol, tobacco, and illicit drug use.
- Diet.
- Physical activities.

With regard to payment of the IPPE, we will use the new HCPCS codes and payment will be based on the RVUs of the CPT codes crosswalked as stated above. We will not finalize our proposal to allow a medically necessary E/M service no greater than a level 2 to be reported at the same visit as the IPPE.

B. Section 613—Diabetes Screening

Section 613 of the MMA adds section 1861(yy) to the Act and mandates coverage of diabetes screening tests.

The term ''diabetes screening tests'' is defined in section 613 of the MMA as testing furnished to an individual at risk for diabetes and includes a fasting blood glucose test and other tests. The Secretary may modify these tests, when appropriate, as the result of consultations with the appropriate organizations. In compliance with this directive, we consulted with the American Diabetes Association, the American Association of Clinical Endocrinologists, and the National Institute for Diabetes and Digestive and Kidney Diseases.

1. Coverage

We proposed in § 410.18 that Medicare cover—

- A fasting blood glucose test; and
- Post-glucose challenge tests; either an oral glucose tolerance test with a glucose challenge of 75 grams of glucose for non-pregnant adults, or a 2-hour post-glucose challenge test alone.

We would not include a random serum or plasma glucose for persons with symptoms of uncontrolled diabetes such as excessive thirst or frequent urination in this benefit because it is already covered as a diagnostic service. This language is not intended to exclude other post-glucose challenge tests that may be developed in the future, including panels that may be created to include new diabetes and lipid screening tests. We also would include language that would allow Medicare to cover other diabetes screening tests, subject to a NCD process.

The statutory provision describes an ''individual at risk for diabetes'' as having any of the following risk factors:

- Hypertension.
- Dyslipidemia.
- Obesity, defined as a body mass index greater than or equal to 30 kg/m2.
- Previous identification of an elevated impaired fasting glucose.
- Previous identification of impaired glucose tolerance.
- A risk factor consisting of at least two of the following characteristics:

+ Overweight, defined as a body mass index greater than 25 kg/m2, but less than 30.

+ A family history of diabetes.

+ A history of gestational diabetes mellitus or delivery of a baby weighing greater than 9 pounds.

+ 65 years of age or older.

For individuals previously diagnosed as diabetic, there is no coverage under this statute.

The statutory language directs the Secretary to establish standards regarding the frequency of diabetes screening tests that will be covered and limits the frequency to no more than twice within the 12-month period following the date of the most recent diabetes screening test of that individual.

We proposed that Medicare beneficiaries diagnosed with pre-diabetes be eligible for the maximum frequency allowed by the statute, that is, 2 screening tests per 12 month period. We defined ''pre-diabetes'' as a previous fasting glucose level of 100–125 mg/dL, or a 2-hour post-glucose challenge of 140–199 mg/dL. This definition of pre-diabetes was developed with the assistance of the American Association of Clinical Endocrinologists, concurs with the Centers for Disease Control and Prevention (CDC) definition, and complements the definition of diabetes that we published November 7, 2003 (68 FR 63195).

2. Payment

We proposed to pay for diabetes screening tests at the same amounts paid for these tests when performed to diagnose an individual with signs and symptoms of diabetes. We would pay for these tests under the clinical laboratory fee schedule. We proposed to pay for these tests under CPT code 82947 Glucose; quantitative, blood (except reagent strip), CPT code 82950, post glucose dose (includes glucose), and CPT code 82951 Glucose; tolerance test (GTT), three specimens (includes glucose). To indicate that the purpose of the test is for diabetes screening, we would require that the laboratory include a screening diagnosis code in the diagnosis section of the claim. We proposed V77.1 special screening for diabetes mellitus as the applicable ICD–9–CM code for this purpose. Because laboratories are required and accustomed to submitting diagnosis codes when requesting payment for testing, we believe including a screening diagnosis code is appropriate for this benefit.

Comment: One commenter questioned whether there is statutory authority to expand eligibility for individuals. Adding that, section 613 of the MMA gives authority for additional test and frequency, not additional individuals.

Response: There is no statutory authority to expand eligibility for individuals. Section 613 of the MMA establishes coverage for beneficiaries who are at risk for developing diabetes. Beneficiaries who are pre-diabetic fall within 1861(yy)(2)(D) or (E) and are at an increased risk for developing diabetes. This increased risk separates them from the general at-risk population and requires the course of their care to be managed closer and more frequently.

For individuals not meeting the ''pre-diabetes'' criteria, we proposed that one diabetes screening test be covered per individual per year.

Comment: Several comments were received that recommended we provide physicians with clear guidance about Medicare's covered services to help patients control their diabetes. The commenters also asked that we inform providers about other covered services, such as Hgb1AC tests, that will help patients avoid painful diabetes-related complications.

Response: We will be releasing two publications. The *Dear Doctor Package* publication, which includes the ''2005 FACT SHEET'', will be sent to the contractors on a CD on or about October 15, 2005 and distributed to the providers by November 15, 2005. The *Medicare Coverage of Diabetes Services and Supplies* publication was originally written in 2002. It was revised in 2003 to update the Part B premium amount and is being revised again this year to update the premium amount and to include any information relevant to the MMA. This document will be available on the CMS Web site and at 1–800–MEDICARE.

Comment: We received several comments suggesting that screening should not require a physician's prescription or referral in order to be covered under Medicare Part B. This approach would follow the successful precedent established by us with other screening tests such as mammograms.

Response: The legislative history on mammography did result in us allowing self-referral for mammograms. However, Medicare rules have required that laboratory tests for screening or other diagnoses must be ordered by licensed health care practitioners, specifically physicians, PAs, NPs, or CNSs.

Comment: Comments were received recommending that the final rule include coverage of one annual diabetes screening for all Medicare beneficiaries.

Response: The benefit of screening all Medicare beneficiaries is not supported by current evidence. We plan risk-based frequency limitations of coverage for diabetes screening based upon the statute requirements. Furthermore, we believe beneficiaries with pre-diabetes may warrant a more frequent follow-up and this is permitted at the professional judgment of the health care practitioner.

Comment: We received a few comments suggesting the addition of the C-peptide test, as it is sometimes useful in Type 1 or Type 2 diabetes.

Response: We believe that C-peptide testing is appropriate for diagnostic evaluation, but not for screening. It is currently covered under the general lab benefit as a diagnostic test when it is medically necessary.

Comment: The American Society for Clinical Pathology (ASCP) has urged us to add CPT 82950 glucose; post glucose dose (includes glucose). This test is more frequently used to screen for diabetes. GTT is a more definitive test usually requested when questionable results from random, fasting or postprandial glucose levels are obtained. As written, the proposed rule appears to exclude 82950 as a screening test.

Response: We appreciate attention being drawn to the apparent exclusion of CPT code 82950, which was not our intention and we have corrected that omission.

Comment: A commenter suggested that due to increased incidence of obesity in recent years that family history of diabetes be defined as persons with Type 2 Diabetes in one or more first or second-degree relatives.

Response: The comments received did not provide a clear consensus on the definition of family history of diabetes. Thus the definition of family history of diabetes will be left to the professional judgment of the treating physician or qualified non-physician practitioner based on the beneficiary's medical history and best practice standards.

Comment: The American Clinical Laboratory Association (ACLA) believes that the other codes on the NCD routine screening list that currently result in a diabetes denial on the basis of routine screening should be covered under the new diabetes screening benefit.

Response: We believe the majority of individuals who will seek care under this benefit will conform to the V77.1 code. We are willing to review a sample of claims and determine if other specific codes are appropriate code for this benefit. Codes that need to be considered for this new benefit can be brought to our attention through the national coverage determination process for laboratories.

Comment: A comment was received recommending that the proposed rule be clarified to refer to a ''fasting blood glucose test'' rather than a ''fasting plasma glucose test'' since the CPT code

does not differentiate between blood and plasma.

Response: We agree with the recommendation to change the term ''fasting plasma glucose test'' to ''fasting blood glucose test''.

Comment: A comment was received recommending additional diabetes screening tests be added through a less formal process of consultation with manufacturers, health care providers, patients, and other stakeholders, as contemplated by Congress. The commenter further stated that the NCD process is complex and time consuming, delaying the coverage of new tests.

Response: We believe the evidence-based NCD process is an effective process to review and analyze items and services as potential benefits for Medicare beneficiaries. Because the NCD process allows for public comment before we make any changes, we believe this is the appropriate process for any future changes. Further, we may not be able to accept every stakeholder's recommendation because of instructional, coding, or claims issues which must be resolved before any benefit can be implemented.

Result of Evaluation of Comments

Our review of the comments has led to the elimination of the word ''plasma'' from the term ''fasting plasma glucose test.'' The word ''plasma'' will be replaced with the term ''blood''. We have corrected the unintentional omission of CPT code 82950, post glucose dose (includes glucose) as a diabetes screening test. The providers and beneficiaries are reassured that there will be clear guidance on covered services by way of two publications: The *Dear Doctor Package*, which includes the ''2005 Fact Sheet'' and *Medicare Coverage of Diabetes Services and Supplies*. We continue to promote healthcare practitioner autonomy with our policy of risk-based frequency limitations on items and services provided to our beneficiaries. We recognize the differing opinions with regard to the usage of the NCD process to review potential new items and services such as new diabetes screening tests for our beneficiaries. To provide transparency, timeliness and fairness, a formal process is necessary. Historically, the NCD process has been open to all interested parties and has proven to be an effective process.

Based on reasoning from the responses to the comments we received, at this time we will not be accepting the following suggestions.

- Reversing policy requiring a physician's or a qualified non-physician's prescription or referral for diabetes screening tests.
- Providing coverage of one annual diabetes screening test for all Medicare beneficiaries.
- Adding coverage of C-peptide test as a screening test.
- Bypassing the current NCD process for a less formal process to add additional diabetes screening tests.

C. Section 612—Cardiovascular Screening

Section 612 of the MMA adds section 1861(xx) to the Act and provides for Medicare coverage of cardiovascular (CV) screening blood tests for the early detection of CV disease or abnormalities associated with an elevated risk for that disease effective on or after January 1, 2005.

Upon reviewing the USPSTF reports, the scientific literature and comments of professional societies, trade associations, the industry, and the public, we proposed in the August 5, 2004 **Federal Register**, that the benefit for CV screening would include the use of three clinical laboratory tests to detect early risk for CV disease. Since the three tests, a total cholesterol, a HDL-cholesterol, and a triglycerides test, could be ordered as a lipid panel or individually, the frequency was limited to one of each individual test or combination as a panel every 5 years.

When we researched the benefit, some scientific experts proposed that the use of only the total cholesterol test as a single test every 2 years was adequate. After reviewing the literature and comments, we concluded that each test in the lipid panel is important since each test predicts the risk for CV disease independently. It would be prudent, therefore, to promote the benefit as three separate tests every 5 years. The decision to limit the frequency to 5 years, rather than more frequent testing every 2 years was due to information found in the Clinical Considerations of the USPSTF which indicate that the cholesterol values of elderly persons, who are the majority of the Medicare population, change slowly as they age. We also proposed that any changes to the list of tests could be made after a review of recommendations by the USPSTF and the use of the NCD process.

We proposed that for the claims processing and payment system, the coding of the tests would be made using the CPT codes available for the lipid panel or the three tests individually coded with the use of V codes to identify the tests were ordered for screening purposes. We also stated that we would pay for these CV screening tests at the same amounts paid for these tests to diagnose an individual with signs of CV disease and that these would be paid under the clinical laboratory fee schedule. The proposed coverage requirements were set forth in new § 410.17.

In response to the proposed rule, we received letters and e-mails from 28 commenters representing professional societies, trade groups, the industry, and individuals, who wrote on 26 different issues. One commenter represented 14 medical societies. Each commenter had many concerns and the comments were grouped into 26 areas of concern.

Comment: Three commenters expressed concern that many laboratories perform direct measurement LDL reflexively when triglycerides exceed certain parameters. The commenters are concerned that if screening direct measurement LDL is statutorily excluded then the Medicare beneficiaries would be liable for these tests without prior notice.

Response: Section 410.32 requires that tests be ordered by a treating physician and used in the management of the patient. We have interpreted this provision to restrict the furnishing of reflex testing to situations where it is clear that the physician is ordering reflex testing at specific parameters and where the physician has an option to order the test without the reflex portion. Thus, laboratories must offer physicians the ability to order a lipid panel without the option to perform the direct measurement LDL. We strongly encourage physicians to order lipid panels without the direct measurement LDL reflex option to protect Medicare beneficiaries from incurring a charge for this service without advanced notice.

If the screening lipid panel results indicate a triglyceride level that indicates the need for a direct measurement LDL, the physician may order this test once the results of screening lipid panel are reported. The NCD for lipid testing includes coverage of direct measurement LDL for patients with hyperglyceridemia. *[http://www.cms.hhs.gov/ mcd/viewncd.asp ?ncd_id=190.23&ncd_ version=1&show=all]*

We do not require the patient to physically return to the treating physician for an office visit and ordering of subsequent testing. Physicians may order such tests based on the results of the CV screening. The Medicare law and regulations do not prohibit the use of the same sample of blood to be used for direct measurement LDL following a lipid panel with very high triglycerides. Laboratories may archive the initial specimen and use it

for subsequently ordered medically necessary direct measurement LDL.

Comment: One commenter suggested that if the direct LDL cholesterol is included in the CV risk screening benefit, we must provide guidance to laboratories regarding whether or not the direct LDL must be billed with the −59 modifier for the charge to be reimbursed.

Response: Since the direct LDL cholesterol is not being added to the CV screening benefit, there is no change to the billing.

Comment: One commenter requested that the V codes (V81.0, V81.1, and V81.2) be added to the Lipid NCD and that the NCD Edit Software be modified to accept these V codes (V81.0, 81.1, and 81.2) on a frequency basis.

Response: The Laboratory NCD Edit Module will be modified to accept the V codes for matching the CPT codes with the ICD–9–CM code for those tests within the lipid NCD that are part of this statutory benefit. The entire lipid NCD is not open for modification. The frequency is determined by the NCD process and implemented through changes to the claims processing system to edit the patient history and coding.

Comment: One commenter asked that Medicare contractors provide explicit instructions to physicians to provide the necessary V codes (or their corresponding narratives) since screening is normally non-covered.

Response: We will release the appropriate manual, transmittal instructions and information from our educational components for the medical community including a MedLearn Matters article and fact sheets such as the ''2005 Payment Changes for Physicians and Other Providers: Key News From Medicare for 2005.'' Laboratories can join this effort to educate physicians and beneficiaries by distributing their own communication, bulletins or other publications. Some of this information will also be part of the ''Welcome to Medicare Preventive Services Package.''

Comment: Three commenters recommended that high sensitivity C-reactive protein (hsCRP) be considered as a test for this benefit since the AHA and CDC issued a Class IIa recommendation stating that hsCRP measurements for risk stratification add important information to the ''classic'' cholesterol and HDL measurement. They cited that given Congressional intent, we should include this measure in its list of ''approved'' screening tests and, if not, that we immediately request that USPSTF conduct a formal review of hsCRP as a screening test. Four commenters recommended the addition of the ABI test. Another requested the inclusion of the 12-lead ECG, the echocardiogram, and tests for carotid artery disease. Another requested the coverage of blood pressure screening. Finally, another commenter suggested that we allow the broadest access and maximize the potential for tests.

Response: We appreciate the commenters' suggestions to include hsCRP and the other tests. In our efforts to develop the proposed rule, many tests were considered for inclusion in the list of screening tests for this benefit. There was insufficient evidence to include any additional tests beyond the lipid panel tests. The information we received in the development of the proposed rule did not support the inclusion of these additional tests but we invite the public to submit scientific literature for our consideration. Other new types of CV screening blood tests may be added under this new screening benefit if we determine them appropriate through a subsequent NCD. 68 FR 55634 (Sept 26, 2003) or *http://www.cms.hhs.gov/coverage/8a.asp].*

Comment: Two commenters recommended that we add HCPCS codes for the Lipid Panel and components as waived tests since they are performed in physician offices and other sites with Clinical Laboratory Improvement Amendments (CLIA) Certificates of Waiver.

Responses: Under CLIA, a facility with a CLIA certificate of waiver can only perform those tests that are approved by the FDA as waived tests. We update the list of waived tests and their appropriate CPT codes on a quarterly basis through our program transmittal process. When we program the claims system to look for the AMA CPT codes for Lipid Panel or any of the three tests which make up the panel, the system will recognize those waived tests performed using the same code plus the QW modifier that are medically necessary.

Comment: Two commenters requested clarification of the frequency limits for the three tests considered for this benefit. They asked if we would cover: (1) A lipid panel; (2) one or more component tests making up the lipid panel once every 5 years; or (3) each of the 4 HCPCS codes listed every 5 years.

Response: The intent of the benefit is to screen for CV disease. Since we believe most physicians would order the Lipid Panel as a single test, our intention was to cover the panel. We recognize that physicians may have different approaches to reaching their decision to treat, and therefore, we have to make available the possibility that physicians could order the individual tests which make up the panel. No matter how the physician(s) order the tests, our intention is to cover each of the 3 component tests (that is, a total cholesterol, a triglycerides test, and an HDL cholesterol) once every 5 years.

Comment: Two commenters asked that we clarify the reasons for having V codes for screening tests added from the MMA rather than the past practice of developing G codes (unique HCPCS codes; temporary codes). This commenter believed that the change to V codes would cause confusion to the databases like the Physician/Supplier Procedure Summary Master File. This confusion would result in improperly filed provider claims and this would lead to a different and confusing method of processing claims.

Response: The decision to use ICD–9–CM codes rather than continue to add G codes was made because we try to utilize existing coding structures where possible and create G codes if there is a specific programmatic need. The laboratory community has lobbied against the use of G codes for a few years. Also the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Standardization Requirements are working toward phasing out G codes, which are CMS only codes. The claims processing and editing systems are expected to be adjusted to manage this change.

Comment: Five commenters questioned the reasons for establishing limits on the frequency of this benefit since this places great legal, administrative, and financial burden for providers to manage this type of information. One commenter suggested the use of a chit that beneficiaries would receive and redeem for testing so laboratories would not need to keep records.

Response: The statute requires a frequency limit. Since laboratories may not have the complete medical history for individuals, including their history of CV screening tests, they are largely relying on the physician's order in establishing whether the test is medically necessary and covered by Medicare. However, relying on the physician's order does not provide the laboratory with proof that the CV screening test is medically necessary since the beneficiary may be treated by multiple physicians who may have ordered these tests independently within the 5 year coverage window. If the laboratory has sufficient doubt, the laboratory may issue an Advanced Beneficiary Notice (ABN) to the beneficiary indicating that Medicare may not cover the CV screening test. If the laboratory does not issue an ABN to

the beneficiary who has received more that one CV screening test during the previous five years, the laboratory may be financially liable for the cost of the test. Laboratories are not required to issue an ABN if the physician has already issued one.

In addition, section 40.3.6.4(C) titled ''Frequency Limited Items and Services'' of Chapter 30 of Pub 100–4 of the ''Internet Only Manual'' provides additional guidance for those instances where Medicare has imposed frequency limitations on items or services. This section instructs providers that the provider may routinely give ABNs to beneficiaries and that whenever such a routine ABN is provided to a beneficiary, the ABN must include the frequency limitation as the reason for which Medicare will deny coverage.

Comment: Several commenters, including the ACR and the SIR, offered their assistance to us when we determine whether noninvasive testing for CV disease is necessary.

Response: Since the organizations that suggested noninvasive tests for inclusion in this benefit provided the materials for our review, it is not necessary for us to seek outside assistance. We appreciate the commenters' offer of assistance.

Comment: Four commenters suggested that the CV screening benefit stipulate an age for the population to be tested. We reviewed the USPSTF recommendation that promoted testing for men 35 years and older and women 45 years and older. The commenters believe this age range should be lowered to include those aged 20 years and older and asked us to consider including younger people in this benefit.

Response: The statutory change for this benefit did not include an age for the person to be tested. While some of the USPSTF recommendations included an age or an age range, none was selected for the proposed rule. Since the majority of the individuals in Medicare are generally 65 and older, the belief was that we are looking at an older population rather than concentrating our resources on the younger beneficiaries who may also be disabled and Medicaid eligible or could be eligible for other services due to other complications of CV disease. While there may be individuals younger than 65 years of age that could benefit from this testing, this benefit is intended for those entitled to Medicare. Therefore, any patient entitled to Medicare would be covered for this benefit as specified in this rule.

Comment: One commenter noted that if the patient did not fast for the screening test (fasting may be difficult for some patients), the calculation of LDL cholesterol may be inaccurate. This commenter recommended that for screening purposes, an alternative to repeating the full lipoprotein profile in the fasting state would be a follow-up direct measurement of LDL cholesterol.

Response: If a patient cannot fast and the physician believes the patient's medical history and circumstances suggest the beneficiary is at risk of CV disease, then any additional testing beyond an initial screening would need to be done under the diagnostic clinical laboratory benefit. Under the screening benefit, a repeated full lipoprotein profile (fasting) or a second LDL cholesterol (fasting) would not be covered for anyone who failed to fast when they had their first set of tests.

Comment: Several commenters suggested that the tests that the USPSTF approves for CV screening blood tests be automatically adopted and covered by Medicare for the purposes of this benefit. We would not need to use the NCD process to add tests to this benefit. Immediate adoption of USPSTF recommendations will remove us from our own lengthy review.

Response: While the USPSTF process is well established, we believe it is prudent to review any recommendations from the USPSTF before implementing them. In the proposed rule, we asked the public how we should make changes for this benefit. Because the national coverage determination process allows for public comment before we make any changes, we believe this is the most appropriate basis for any future changes. Further, we may not be able to accept every USPSTF recommendation because of instructional, coding or claims issues that must be resolved before any benefit can be implemented.

Comment: Several commenters questioned whether the screening benefit for CV disease included noninvasive tests or whether it was limited only to blood tests. Further, they recommended that the adoption of noninvasive tests be tied to recommendations of the USPSTF or to an NCD.

Response: We interpreted this portion of the screening benefit to permit noninvasive tests for which there was a blood test recommended by the USPSTF (for example, there is a blood test for cholesterol and if a noninvasive test was developed that detected characteristics of cholesterol, could provide a meaningful (comparison) result and accurate reading) then the noninvasive test could be considered for inclusion in the screening benefit. Noninvasive tests would not be immediately included but would be subject to a review before adoption. When it is time to consider the addition of tests or changes to the list of tests, we will consider any changes through an NCD. This benefit is not limited only to blood tests.

Comment: One commenter recommended that we include a fasting blood glucose test as part of the CV screening blood benefit and that we cover this test every 2 years for beneficiaries over 45 and for younger beneficiaries who are obese or have a family history of diabetes. Fasting blood glucose is inherently a CV screening test because diabetes carries increased risk of CV disease.

Response: While some people who have diabetes exhibit other factors associated with CV disease, we do not see the necessity to adjust the CV screening benefit to include a fasting blood glucose test. The diabetes screening benefit should be able to identify these individuals. Medicare does not plan to duplicate tests when they are available through other screening programs.

Comment: One commenter requested the inclusion of V70.0 for routine examination to be added as one of the ICD–9-CM codes to be covered for screening for CV screening blood tests. They asked that the NCD on lipid panel be reviewed for any codes that were previously denied as routine screening in the past, and that these codes be considered for inclusion under this new benefit.

Response: We believe the majority of individuals who will seek care under this benefit will fit the V81.0, V81.1, or V 81.2 codes. We are willing to review a sample of claims and determine if V70.0 is an appropriate code for this benefit. At this time, we are unable to add V70.0 to the instructions being cleared. Codes that are to be considered for this new benefit must be brought to our attention through the national coverage determination process for laboratories.

Comment: One commenter suggested that the proposed § 410.17 include reference to whether beneficiaries will incur out-of-pocket costs for CV screening blood tests.

Response: Section § 410.17 is specific to coverage instructions for screening tests for the early detection of CV disease. We do not believe it is necessary to revise § 410.17 to include payment instructions. We have indicated that Medicare would pay for the tests under the clinical laboratory fee schedule. Currently under this payment system, beneficiaries do not incur copayments and deductibles in accordance with section 1833(a)(1)(D)(i) of the Act, and is included in

instructions at Medicare Claims Processing Manual, Pub. 100–04, chapter 16, § 30.2.

Comment: Two commenters asked us to clarify why we chose 5 years as the timeframe for the benefit, rather than the 2 years allowed by the statute.

Response: Our primary goal was to allow testing for the population that needed to be screened. In the preamble to the proposed rule, we stipulated that the Clinical Considerations of the USPSTF indicate, while screening may be appropriate in older people, repeated screening is less important because lipid levels are less likely to increase after age 65. Screening individuals more often than necessary might lead to unnecessary expenses and treatment. The scientific literature indicates that lipid levels in the elderly are fairly stable. Therefore, we proposed screening once every 5 years and have not received sufficient evidence to change this position.

Comment: Two commenters suggested that a two-tiered benefit be developed that would allow lipid profile screening tests at least every 5 years for beneficiaries when risk factors are not evident and a second group be screened at least every 2 years. The second group would include individuals who have modifiable risk factors (for example, tobacco smoking, high blood pressure, physical inactivity, obesity, and diabetes mellitus) and non-modifiable risk factors (such as age, gender, race, and family history).

Response: While the CV screening benefit could be expanded to include individuals other than those mentioned in the proposed rule, preventive benefits were added to the Medicare Program on a limited basis as science and technology permit them. Since some of the individuals in the second group already would be screened through the IPPE and the Diabetes Screening Benefit, we are not developing a second tier at this time. We believe expanding this to a second tier would waste precious resources of time and money and not contribute to lowering the risk factors for individuals with CV disease.

Comment: One commenter questioned why we proposed to use the NCD process as the method of making changes to the list of tests covered by the CV screening blood test benefit. The commenter wrote that the MMA does not require that the NCD process be utilized. They indicated that there is no need for us to conduct our own assessment since a thorough evaluation of the test was to be done by the USPSTF in determining that the test is one that it recommends. The commenter objected to the use of the NCD process for consideration of new tests because of the significant delays that mark this process. The commenter also stated that all that would be needed for us to approve the coverage of additional CV screening tests is the recommendation of the USPSTF.

Response: In establishing the benefit for CV screening blood tests, the Congress gave the Secretary the authority to determine which tests would be covered by this benefit. We do not believe it would be proper to delegate this function to USPSTF or any other entity. In the proposed rule, we proposed the tests to be covered for the new benefit when it becomes effective January 1, 2005 and at the same time, we offered the NCD process for changes to this benefit. We proposed that future tests would be added after reviewing the recommendations of the USPSTF and the use of the NCD process. The NCD process actually has several methods for evaluating which tests we may eventually cover. The NCD process includes an application for a new coverage issue, a reconsideration of an existing policy, or a coding change for laboratory tests. We believe the use of the NCD process is a worthwhile endeavor since it is a public process and less time consuming than rulemaking. The use of an NCD is authorized by Section 1871 of the Act.

Comment: One commenter suggested that we include triglycerides as a test for the CV screening blood test benefit since the 2001 USPSTF recommendations for screening for lipid disorders associated with CV disease only includes measurement of total cholesterol and high-density lipoprotein cholesterol (HDL–C).

Response: We have included the triglycerides test as one of the tests for screening for CV disease. For some individuals, triglycerides may detect a risk factor for CV disease. That is why it was more prudent to select a lipid profile that includes the three tests (total cholesterol, HDL-C, and the triglycerides) rather than to indicate the use of individual tests with different test intervals and different ordering patterns.

Comment: One commenter requested that the frequency limit for lipid testing of 5 years be waived if the patient develops a risk factor, such as diabetes, a marked weight gain, etc. in the interval.

Response: A patient screened for lipid testing could also meet the requirements for screening under the diabetes screening benefit. If a patient developed further risk factors which negate the need for continued screening under the CV screening blood test benefit, their additional signs or symptoms would probably cause the person to need to seek treatment which would be covered under other benefits including diagnostic clinical laboratory testing.

Comment: One commenter questioned whether § 410.16 that permits qualified nurse practitioners and others to order CV screening tests under the physical examination (section 611 of the MMA) is inconsistent with § 410.17 that requires that the laboratory tests be ordered by the treating physician (§ 410.32(a)).

Response: Section 410.16 addresses services by NPs because of conforming changes made in section 611(d) of the MMA. Section 410.32(a)(3) permits certain NPPs to furnish services that would be physicians' services if furnished by a physician and who are operating within the scope of their authority under State law and within the scope of their Medicare statutory benefit. We believe that the statute permits the use of NPPs to order tests described under § 410.17 without a change in the statute. The general rule for laboratory tests is that the tests must be ordered by the treating physician and in the instance of screening tests, the treating NPP may be regarded as a physician for this purpose.

Comment: One commenter believed that screening every 5 years was too long a period between tests and that the data we collect be used to allow more frequent testing.

Response: We have heard from commenters that the frequency limitation of keeping records for the 5 years is difficult because of storage, access and retrieval, and orders from multiple physicians. Change in the frequency (that is, the number of times a patient can be tested during a given timeframe) will be considered if the scientific literature supports it. We do not believe we are permitted to change the frequency based solely upon the logistical difficulties in collecting, consolidating, and maintaining administrative data. Modifying the benefit to permit more frequent testing will not resolve these administrative difficulties. However, we will take this recommendation under advisement as we continue to consider the associated clinical data, but will not make any changes for the final rule.

Comment: One commenter requested that blood be removed from the title of this benefit for the final rule. The commenter believed the narrow focus on blood would restrict the types of tests that would be administered for detecting CV disease.

Response: In developing the proposed rule, we included blood in the title of this benefit to be consistent with the

history of this benefit and to distinguish the tests in the benefit. We believe that noninvasive tests could be covered and this benefit is not limited only to blood tests.

Comment: One commenter suggested that the CV screening benefit include an appropriate screening instrument. As with depression, the examining physician has a test based on clinical practice guidelines to use as a tool for assessing the patient. Since the American Heart Association (AHA) and the ACC Guidelines for PAD are expected to be published in 2005, the commenter is requesting that we adapt the patient assessment and include these guidelines under the CV screening benefit.

Response: Since the publication of the AHA and ACC Guidelines has not taken place, it would be difficult to evaluate this document and how physicians would use this in the course of examining a patient. Physicians may use their best judgment for how they assess an individual patient and whether additional specific tests from the AHA and ACC guidelines would be more helpful than what is already included in the screening benefit for CV disease is not something we can conclude at this time. The NCD process is available when additional tests should be considered.

Result of Evaluation of Comments

After reviewing all the comments, we have plans to include the V codes (V81.0, V81.1 and V81.2) in the Laboratory Edit Module, and to release manual and transmittal instructions and information to smooth the transition for the new benefit. Providers who routinely give ABNs to beneficiaries must include in the ABN that the frequency limitation is the reason for which Medicare will deny coverage. A patient who has an ABN and exceeds the frequency limitation may incur out-of-pocket charges. We will finalize the changes to § 410.17 as proposed.

D. Section 413—Physician Scarcity Areas and Health Professional Shortage Areas Incentive Payments

[If you choose to comment on issues in this section, please include the caption ''HPSA Zip Code Areas'' at the beginning of your comments.]

Section 413(a) of the MMA provides a new 5 percent incentive payment to physicians furnishing services in physician scarcity areas (PSAs). The MMA added a new section 1833(u) of the Act that provides for paying primary care physicians furnishing services in a primary care scarcity county and specialty physicians furnishing services in a specialist care scarcity county an additional amount equal to 5 percent of the amount paid for these services.

Section 1833(u) of the Act defines the two measures of physician scarcity as follows:

1. Primary care scarcity areas—determined by the ratio of primary care physicians to Medicare beneficiaries. A primary care physician is a general practitioner, family practice practitioner, general internist, obstetrician, or gynecologist.

2. Specialist care scarcity areas—determined by the ratio of specialty care physicians to Medicare beneficiaries. The specialist care PSA ratio includes all physicians other than primary care physicians as defined in the definition of primary care scarcity areas.

To identify eligible primary care and specialist care scarcity areas, we ranked each county by its ratio of physicians to Medicare beneficiaries. In accordance with the statute, in the list of primary care and specialist care scarcity counties, only those counties with the lowest ratios that represent 20 percent of the total number of Medicare beneficiaries residing in the counties were considered eligible for the 5 percent incentive payment. In accordance with the section 1833(u) of the Act, we also treated a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification) as an equivalent area (that is, equal to a full county).

Consistent with section 1833(u)(4)(C) of the Act, all PSAs were assigned their 5-digit zip code area so that we may automatically provide the 5 percent incentive payment to eligible physicians. For zip codes that cross county boundaries, we used the dominant county of the postal zip code (as determined by the U.S. Postal Service) to identify areas eligible to receive the 5 percent payment. Section 1833(u)(4)(C) of the Act also requires us to publish a list of eligible areas as part of the proposed and final physician fee schedule rules for the years for which PSAs are identified or revised and to post a list of PSAs on our Web site. *See* Addenda J and H for the zip codes of primary care and specialist care PSAs. The PSA lists by zip code and county are also available on our Web site at *http://www.cms.hhs.gov/providers/bonuspayment.* Since we are publishing these lists for the first time in this final rule with comment period, we are accepting comments for 60 days after the date of publication of this regulation on the zip codes and counties qualifying as physician scarcity areas and will address the comments in next year's fee schedule.

In addition to creating of the 5 percent PSA incentive payment, section 413 of the MMA amended section 1833(m) of the Act to mandate that we pay the 10 percent health professional shortage areas (HPSA) incentive payment to eligible physicians in full county HPSAs without any requirement that the physician identify the HPSA area. We can only achieve this result by assigning zip codes to eligible areas. *See* Addenda I and K for the lists of eligible primary care and mental health HPSAs by zip code. Consistent with the Act, we have also posted a list of links on our Web site at *http://www.cms.hhs.gov/providers/bonuspayment* to assist those physicians located in eligible areas where automation is not feasible, that is, the eligible area could not be assigned a zip code.

In the August 5, 2004 proposed rule, we proposed conforming changes to our regulations to add § 414.66 to provide a 5 percent incentive payment to eligible physicians furnishing covered services in eligible PSAs. We also proposed conforming changes to our regulations to add § 414.67 to codify the 10 percent incentive payment to eligible physicians furnishing covered services in eligible HPSAs, established under the Omnibus Budget Reconciliation Act of 1987 (OBRA) (Pub. L. 100–203), previously implemented through manual issuance.

We received 23 letter comments on the bonus payment provisions of section 413 of the MMA. A summary of those comments and our responses follows:

Comment: One commenter questioned the rationale behind using zip codes for the purpose of identifying eligible areas for physician bonuses. The commenter believes that zip codes are less accurate than political boundaries (counties, census civil divisions, and census tracts).

Response: The statute requires the identification of PSAs on a county basis, except for rural areas (using the Goldsmith Modification). At this time, we can only determine physician scarcity for Goldsmith areas at the zip code level since the Medicare beneficiary data is currently unavailable at the census tract level.

Automation of physician bonus payments can only be achieved by assigning zip codes to eligible areas. That is, the zip code place of service is the only data element reported on the Medicare claim form that would allow automation.

Comment: A commenter believes that our proposal to identify qualified PSAs and HPSAs by zip code for automatic payment purposes is problematic

because zip codes cross county lines. The commenter suggested that a more user-friendly option would be to add a county identifier to the claim form.

Response: The addition of a county code would not resolve the issue of identifying the claims that would have a bonus because not all designated HPSAs and PSAs are full counties. We cannot identify, for an automated payment, services furnished in counties that are only partially designated and Goldsmith areas that are not full counties. In addition, there currently is no place on the standard electronic claims form to accommodate the entry of a county code.

Comment: A commenter requested clarification regarding circumstances when automation of bonus payments is not feasible.

Response: When the boundaries of zip code areas precisely overlay with the boundaries of eligible HPSAs and PSAs, automation of bonus payments is feasible. In other words, eligible physicians furnishing services to Medicare patients within these zip code areas will automatically receive their bonus payments. We can also automate bonus payments within zip code areas that cross outside of qualified county boundaries as long as the zip code, as determined by the U.S. Postal Service, is dominant to the qualified scarcity county. We cannot automate bonus payments when boundaries of zip code areas only partially coincide with the boundaries of HPSAs and PSAs.

Comment: One commenter requested clarification regarding the application of the billing modifier in determining physician eligibility. The commenter inferred from the proposed rule that, if the zip code is not posted as a qualified area, an eligible physician could still receive a bonus payment if a modifier is used.

Response: Eligible physicians furnishing covered services in a portion of an eligible PSA, which cannot be properly assigned a zip code to permit automation of the bonus payment, would need to include the new physician scarcity modifier on the Medicare claim in order to receive the bonus payment. Lists of the zip codes that are eligible for the automated payment, as well as a list of the counties that are eligible to receive the PSA bonus are available on our Web site at *http://www.cms.hhs.gov/providers/bonuspayment.* If a service is provided in a zip code area that is not listed on the automated payment files, but is within a designated physician scarcity county, the physician must submit the ''AR'' billing modifier with the service in order to receive the bonus payment. Separate lists for the primary care PSAs and the specialty care PSAs are provided on our Web site for both the automated zip codes and the counties.

Comment: A commenter requested clarification on what ratios would be used to identify PSAs. The Health Resources and Services Administration (HRSA) uses a national ratio of 3,500:1, or 3,000:1 if high needs are shown. The commenter requested information on which ratios would be used to determine PSAs for specialty providers, and whether the ratios would be different for different specialty care providers.

Response: Only those counties with the lowest primary care ratios that represent 20 percent of the total number of Medicare beneficiaries residing in the counties will be considered eligible for the 5 percent incentive payment. In other words, we ranked each county by its ratio of physicians to beneficiaries and then designated counties as scarcity areas with the lowest ratios until 20 percent of the Medicare population was reached. A separate specialist physician ratio was calculated to identify specialist care PSAs using the same methods stated. The statutory mandate precludes us from adopting a national physician-to-patient ratio similar to the HPSA designations. By statute, the 20 percent population threshold must serve as the qualifying condition for all counties/rural areas.

For calculating the ratios, section 1833(u)(6) of the Act, as added by the MMA, defines a primary care physician as a general practitioner, family practice practitioner, general internist, obstetrician, or gynecologist. In accordance with the statute, all other physicians were grouped together as specialists for purposes of determining the specialist care PSA list.

Comment: A commenter requested clarification regarding the frequency of updating the eligible zip code list for automatic HPSA bonus payments and its impact on otherwise eligible physicians.

Response: Determination of zip codes eligible for automatic HPSA bonus payment will be made on an annual basis, and there will not be any mid-year updates. We will effectuate revisions made to designations by HRSA the following year for purposes of automatic bonus payments. Consequently, if HRSA changes to the HPSA designations remove physicians in those areas from receiving automatic payment, the zip code areas will remain eligible until the next year when we remove the zip code from our approved list.

Eligible physicians furnishing covered services in newly-designated HPSAs are permitted to add a modifier to their Medicare claims to collect the HPSA incentive payment until our next annual posting of eligible zip codes for automation of bonus payments. In cases where a zip code cannot be properly assigned to the newly-qualified HPSA, physicians furnishing services in the area must continue to bill for the incentive payments using the appropriate modifier.

Comment: A commenter requested that we provide FQHCs with the 5 percent PSA incentive payment. Since the statute does not explicitly exclude other physicians' services (that are billed on an all-inclusive basis), such as those provided in FQHCs or RHCs, the commenter stated that we should extend the new 5 percent bonus payment to FQHC physicians.

Response: As defined in section 1861(aa) of the Act, FQHC and RHC services are not physicians' services, even though physicians' services are frequently a component of the services furnished in these facilities. The services are rather identified as FQHC services. Therefore, services furnished by these providers are not eligible for the incentive payment.

Comment: A commenter has questioned our proposal not to apply the new 5 percent physician incentive payment to the technical component of physicians' services. The commenter stated that extending the new bonus payment to both the professional and technical component of the physicians' services is consistent with Congressional intent and would simplify claims processing.

Response: Section 1833(u) of the Act provides for incentive payments for physicians' services furnished in PSAs. We note that the statute contains two definitions of physicians' services. The first, which appears at section 1861(q) of the Act, defines physicians' services as ''professional services performed by physicians including surgery, consultation, and home, office, and institutional calls.'' The second, which refers to services paid under the physician fee schedule, is found at section 1848(j)(3) of the Act and contains a broader definition of physician services. However, that definition applies only for purposes of section 1848 of the Act.

Since the incentive payment is not included in section 1848 of the Act, the definition of physicians' services specified in section 1861(q) of the Act is the definition that applies. Thus, we believe the best reading of the statute is that only *professional* services furnished

by physicians are eligible for incentive payments.

Comment: A commenter recommended that we extend the HPSA bonus payment to all physicians, regardless of their specialty, when their services are furnished within a mental health HPSA. The commenter believes there is no statutory basis to limit incentive payments just to psychiatrists within mental health HPSAs.

Response: We provide HPSA bonus payments in primary medical care HPSAs to all physicians regardless of specialty (including psychiatrists) in light of the fact that there is significant overlap between primary medical care HPSAs and mental health HPSAs. Furthermore, most primary medical HPSAs, especially in rural areas, also have shortages of specialists. Consequently, there is no apparent need to distinguish between physician specialties within primary medical care HPSAs for determining physician eligibility for bonus payment purposes. However, in the situation where the mental health HPSA does not overlap with a primary medical care HPSA, we allow only psychiatrists to collect the incentive payment. Within these stand-alone mental health HPSAs, there is an adequate supply of physicians for the provision of medical services and a shortage only of those providing mental health services. Therefore, it would be inconsistent with the HPSA incentive payment provisions, as well as an inappropriate use of the Medicare Trust Fund, to pay bonuses to physicians who furnish medical services in service areas without shortages of primary medical services.

Comment: A commenter requested that we count only those practicing physicians who treat Medicare patients when determining the ratio of beneficiaries to practicing physicians. To count all practicing physicians, including those who do not treat Medicare patients would undermine the intent of the provision.

Response: The statute does not permit us to count only Medicare participating physicians to determine PSAs. The statute explicitly requires that we calculate the primary and specialist care ratio by the number of physicians in the active practice of medicine or osteopathy within the county or rural area. Therefore, we must include in the physician tally all actively practicing physicians when determining PSAs.

Comment: A commenter asked that we clarify our methods for determining the number of primary care and specialty care physicians to calculate the physician-to-beneficiary ratio for identifying PSAs. The commenter suggested that we use only the number of practicing physicians when determining the beneficiary to physician ratio, that is, distinguish between licensed physicians and practicing physicians when determining ratios of primary care and specialty care since some physicians continue to be licensed after they retire.

Response: As required by section 413 of the MMA, the determination of eligible PSAs is based on the ratio of ''active practice'' physicians to Medicare beneficiaries within a county or rural area (using the Goldsmith Modification). The physician data source used in calculating scarcity areas is contained in the following:

- The 2001 Physician Characteristics file; and
- The 2001 Physician Address file.

These data are a compilation of:

- The December 2001 AMA Master file;
- The December 2001 American Osteopathic Association (AOA) Physician file; and
- The National Health Service Corps 2001 participant listing.

These physician data files allow for the identification of the physician's active status. Some of the key status indicators to identify practicing physicians include ''clinically active'' and ''Federal employment'' status. Clinically active status was determined using the type of practice, professional employment, and major professional activity fields from AMA and AOA. For example, determining non-active status is based on physicians who—

(1) Are involved in administration, medical teaching, research, and other non-patient care activities; or

(2) Have self-identified as fully retired or otherwise inactive.

We believe that the indicator field of ''fully retired or otherwise inactive'' addresses the specific issue of a physician maintaining his or her license after he or she retires.

Comment: A commenter expressed concern about our use of the AMA database to determine the number of licensed physicians engaged in direct patient care in each State. The commenter claims that the AMA database overstates the number of practicing physicians in the State of California by at least 10,000 physicians. In light of this concern, the commenter stated that we should use State medical board licensing information rather than the AMA database in determining the physician counts.

Response: The physician data source used in calculating scarcity areas is contained in the 2001 Physician Characteristics file and the 2001 Physician Address file. These data are a compilation of the December 2001 AMA Master file, the December 2001 AOA Physician file, and the National Health Service Corps 2001 participant listing. We made the decision to use the AMA Master file as well as the other files as the sources of physician data in scarcity calculations because there is no other adequate source of national physician data. It may be possible to obtain physician data from each individual State agency, but doing so would entail considerable administrative and technical difficulties. Furthermore, methods of gathering and compiling data may be inconsistent in different States. State agencies may vary greatly in terms of the methods used to update physician databases, the frequency of updates, how the data are stored, the type of information collected, and so forth. In addition, States may use their own classification systems for physician specialties, types of practice, and other key information, and these systems may change over time.

Comment: A commenter encouraged us to implement similar incentive payment programs for non-physician practitioners, for example, Certified Registered Nurse Anesthetists and physician assistants.

Response: We do not have the authority to provide bonus payments to non-physicians. Sections 1833(m) and 1833(u) of the Act authorize bonus payments only to physicians.

Comment: A commenter requested that we immediately publish the already identified PSAs by zip code and specify the specialties in short demand within each eligible PSA.

Response: Lists of the zip codes that are eligible for the automated payment, as well as a list of the counties that are eligible to receive the PSA bonus, are now available on our Web site at *http://www.cms.hhs.gov/providers/bonuspayment.* See Addenda J and H for the zip code list of PSAs for primary care and specialist care.

We have forwarded to the Health Resources and Services Administration the request for identification of specialties in short supply within PSAs. That Agency has responsibility for physician manpower issues.

Comment: A commenter requested that the list of scarcity areas should be made interim in the final fee schedule rule in order to give physicians sufficient time to review and comment on the proposal.

Response: Although we made these lists public on our Web site on October 1, 2004, we will accept comments for 60 days after the date of publication of this regulation on the zip codes and counties

qualifying as physician scarcity areas and will address the comments in next year's fee schedule.

Comment: A commenter expressed appreciation for our effort to fairly implement the incentive payments to physicians in scarcity areas. As this new incentive payment program is implemented, physicians must be informed that this bonus is available, and it must be simple for them to receive the bonus.

Response: We have already made available on our Web site at *http://www.cms.hhs.gov/providers/bonuspayment* the lists of the zip codes that are eligible for the automated payment, as well as a list of the counties that are eligible to receive the PSA bonus. We have also issued a *Medlearn* article to educate the physician community regarding Medicare physician incentive payment programs. For a copy of this provider education article go to: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0449.pd.* Lastly, Medicare's contractors have established their own Web site links for the HPSA incentive payment program to facilitate the payment of these bonuses to eligible physicians.

Comment: A commenter expressed support of our proposed changes relating to incentive payments for services provided in areas designated as HPSAs and PSAs. The commenter also commended us for our prompt implementation of section 413 of the MMA. Another commenter expressed appreciation that the new 5 percent incentive is available to specialists in counties with short supply of these physicians.

Response: We appreciate this positive feedback from the provider community.

Comment: A commenter has questioned the rationale for our policy of imposing, as a condition of eligibility, the requirement that the specific location at which the service is furnished must be considered a HPSA or PSA. Since physicians do not always reside in the county where they provide services, identifying PSAs on one basis and paying for them on another basis may be problematic.

Response: According to section 1833 of the Act, we make bonus payments for physicians' services furnished in an eligible HPSA or PSA. Thus, the place of service controls the availability of the bonus. A physician providing a service in his or her office, a patient's home, or in a hospital may receive the incentive payment only if the service occurs within an eligible shortage or scarcity area.

Comment: One commenter believes that podiatric physicians, who are considered specialists, should be among those eligible to receive the additional 5 percent incentive payment.

Response: Section 1833(u) of the Act, as added by the MMA, specifically defines ''physician'' as one described in section 1861(r)(1) of the Act. Therefore, we do not have authority to make bonus payments to podiatrists.

Commenter: A commenter expressed concern that our systems had trouble implementing the HPSA bonuses under Method II for Critical Access Hospital (CAH) participation, and some providers have waited more than two years for increased Medicare payments.

Response: Although some fiscal intermediaries may not have been accustomed to processing physician claims, these systems were updated and the problems resolved as of July 1, 2004.

Comment: A commenter from California requested that physicians who provide Medicare services only through managed care not be included in our calculations. The commenter believes that including physicians who only treat managed care patients in the count to determine physician scarcity areas will lead to a gross overstatement of the number of physicians available to provide care to fee-for-service Medicare patients.

Response: We do not believe that we have the legal authority to exclude managed care physicians from the ratio calculations. Moreover, excluding managed care physicians in the county-wide physician tally would not change PSAs in California based on our calculations. In fact, excluding the managed care physicians would make five eligible areas ineligible.

Result of Evaluation of Comments

We are finalizing § 414.66 and § 414.67 as proposed. We are accepting public comments on the zip code areas.

E. Section 303—Payment for Covered Outpatient Drugs and Biologicals

1. Average Sales Price (ASP) Payment Methodology

a. Background

Medicare Part B covers a limited number of prescription drugs and biologicals. For the purposes of this proposed rule, the term ''drugs'' will hereafter refer to both drugs and biologicals. Medicare Part B covered drugs generally fall into the following three categories:

- Drugs furnished incident to a physician's service.
- Durable medical equipment (DME) drugs.
- Drugs specifically covered by statute (for example, immunosuppressive drugs).

Section 303(c) of the MMA revises the payment methodology for Part B covered drugs that are not paid on a cost or prospective payment basis. In particular, section 303(c) of the MMA amends Title XVIII of the Act by adding section 1847A, which establishes a new ASP drug payment system. In 2005, almost all Medicare Part B drugs not paid on a cost or prospective payment basis will be paid under this system.

The new ASP drug payment system is based on data submitted to us quarterly by manufacturers. Payment amounts will be updated quarterly based on the manufacturer's ASP calculated for the most recent calendar quarter for which data are available. We intend to implement the quarterly pricing changes through program instructions or otherwise, as permitted under Section 1847A(c)(5)(C). For calendar quarters beginning on or after January 1, 2004, the statute requires manufacturers to report their ASP data to us for almost all Medicare Part B drugs not paid on a cost or prospective payment basis. Manufacturers' submissions are due to us not later than 30 days after the last day of each calendar quarter.

The methodology for developing Medicare drug payment allowances based on the manufacturer's submitted ASP data is described in this final rule and reflected in final revisions to the regulations at § 405.517 and new Subpart K in part 414. Several comments discussed aspects of the manufacturers' calculation of ASP that are beyond the scope of this final rule. We did not propose any changes to the regulations concerning the manufacturer's calculation of ASP. We also received other comments regarding the use of the least costly alternative (LCA) methodology when pricing drugs, and requests for new HCPCS codes for drugs and coverage of compounded drugs. These comments are also outside the scope of this final rule. We did not propose any changes to the LCA policy, the HCPCS process, or coverage of compounded drugs.

b. Provisions of the Final Rule

i. The ASP Methodology

Effective 2005, payment for certain drugs and biologicals not paid on a cost or prospective payment basis furnished on or after January 1, 2005 will be based on an ASP methodology.

As described in section 1847A(b)(3)(A) of the Act for multiple source drugs and section 1847A(b)(4)(A) for single source drugs, the ASP for all

drug products included within the same billing and payment code [or HCPCS code] is the volume-weighted average of the manufacturers' average sales prices reported to us across all the NDCs assigned to the HCPCS code. Specifically, section 1847A(b)(3)(A) of the Act and section 1847A(b)(4)(A) of the Act require that this amount be determined by—

- Computing the sum of the products (for each National Drug Code assigned to those drug products) of the manufacturer's average sales price and the total number of units sold; and
- Dividing that sum by the sum of the total number of units sold for all NDCs assigned to those drug products.

Section 1847A(b)(1)(A) of the Act requires that the Medicare payment allowance for a multiple source drug included within the same HCPCS code be equal to 106 percent of the ASP for the HCPCS code. This payment allowance is subject to applicable deductible and coinsurance. The payment limit is also subject to the two limitations described below in section III.E.1.b.v of this preamble concerning widely available market prices and average manufacturer prices in the Medicaid drug rebate program. As described in section 1847A(e) of the Act, the payment limit may also be adjusted in response to a public health emergency under section 319 of the Public Health Service Act in which there is a documented inability to access drugs and a concomitant increase in the price of the drug which is not reflected in the manufacturer's average sales price.

Section 1847A(b)(1)(B) of the Act requires that the Medicare payment allowance for a single source drug HCPCS code be equal to the lesser of 106 percent of the average sales price for the HCPCS code or 106 percent of the wholesale acquisition cost of the HCPCS code. This payment allowance is subject to applicable deductible and coinsurance. The payment limit is also subject to the two limitations described below in section III.E.1.b.v concerning widely available market prices and average manufacturer prices in the Medicaid drug rebate program. As described in section 1847A(e) of the Act, the payment limit may also be adjusted in response to a public health emergency under section 319 of the Public Health Service Act.

Comment: One commenter suggested that we implement the ASP methodology on a pilot basis prior to a national rollout. A physician interest group recommended that we delay the implementation of the ASP payment system for at least one year. The interest group stated that we should inform physicians of the ASP for all covered drugs before the final rule is issued and allow physicians to comment on the proposed rates after an informed and complete review process.

Response: The law requires that the new ASP-based drug pricing system be implemented January 1, 2005. The January 1, 2005 prices will be based on the data submitted to us no later than 30 days after the end of the third calendar year quarter of 2004. Given the requirements surrounding the timing of the promulgation of the physician fee schedule final rule, we will not have the January 1, 2005 prices available before the publication of the final rule. However, our goal is to provide as much information on Medicare Part B drug payment rates as possible as early as possible prior to the January 1, 2005 effective date of those rates.

Comment: A provider asked that we earmark funds to enable physicians to transition from the AWP–15 percent payment system to the ASP + 6 percent payment system.

Response: We do not have statutory authority to create such a transition fund.

Comment: One commenter stated that the ASP plan does not account for price increases in a timely manner. Another commenter expressed concern that because ASP modifications lag by at least two calendar quarters, market prices would not be reflected in a drug's payment limit for at least six months after a pricing adjustment.

Response: The ASP methodology is based on average sales prices reported by manufacturers quarterly. Manufacturers must report to us no later than 30 days after the close of the quarter. We implement these new prices through program instructions or otherwise at the first opportunity after we receive the data, which is the calendar quarter after receipt.

Comment: Some commenters expressed concern that the ASP + 6 percent payment methodology would discourage providers from using generic drugs and would increase the tendency to use newer or more expensive agents.

Response: It is true that the higher the average sales price of a drug, the greater amount of money represented by 6 percent of that price. However, Section 1847A specifies that payment is at 106 percent of ASP. The law requires the use of the new ASP + 6 percent payment system except in the limited instances described below in Sections V and VI.

Comment: Several commenters suggested that we should establish a mechanism to provide the public with an opportunity to identify errors in the ASP-based payment rates before the start of the calendar quarter in which the rates are effective. They believe that this mechanism would minimize errors by permitting posting of the rates several weeks prior to the effective date.

Response: Our goal is to provide as much information on Medicare Part B drug payment rates as possible as early as possible prior to the effective date of those rates.

Comment: A physician specialty group recommended that we use our inherent reasonableness authority to increase drug payments up to 15 percent where necessary to make the Medicare payment level sufficient to cover the price of drugs charged by specialty distributors that service the physician office market.

Response: We do not have sufficient data to determine whether our inherent reasonableness authority would apply in this instance. Even if our inherent reasonableness authority were triggered, our data are insufficient to determine whether the adjustment the commenters request would be appropriate.

Comment: Several commenters urged us to weigh the full range of potential consequences to patient care, especially in the oncology setting, with the implementation of the ASP payment methodology. They recommended that we take into consideration concerns such as the potential inability of providers to purchase drugs below the new reimbursement rate, the inability of oncologists to provide access to important under-reimbursed support services, and the disproportionate impact of these changes on rural providers necessitating a shift in care of sick cancer patient from community settings to the hospital. Some commenters suggested that we place a form on its Web site enabling beneficiaries to identify access problems. One commenter suggested that we perform a 1-year monitoring study to evaluate the quality of care issues and delay implementation until the results of the study are known.

Response: Although we do not expect access problems under the new ASP + 6 percent payment system, we will be monitoring patient access through our 1–800–MEDICARE line, regional office staff, claims analysis, and other environmental scanning activities. We will work with Congress if access issues arise. The law requires that the new ASP-based drug pricing system be implemented January 1, 2005.

Comment: Several commenters expressed concern regarding the statements on joining group purchasing organizations (GPOs) to improve their purchasing power. They indicate that

the size of the discount is based on the individual GPO member's purchases, not the combined purchases of the GPO members. Thus, membership in a GPO would not necessarily result in a greater discount. They also point out that retail pharmacies do not have access to GPO purchasing arrangements. One commenter requested that we offer more tangible suggestions for obtaining drugs at the ASP +6 percent price other than encouraging physicians to participate in purchasing groups.

Response: The law requires that the new ASP-based drug pricing system be implemented January 1, 2006. A recent survey of oncology practices performed by the American Society of Clinical Oncology indicated that the purchase price of drugs is not necessarily driven by practice size. It would appear that smaller purchasers are on average sometimes able to achieve similar drug pricing to larger purchasers. The OIG is conducting a study due not later than October 1, 2005, on the ability of different size physician practices in the specialties of hematology, hematology/oncology, and medical oncology to obtain drugs at 106 percent of the average sales price. We are currently conducting another MMA-mandated study of sales of drugs to large volume purchasers that is due not later than January 1, 2006. We will seek to work with physicians, providers, and suppliers on ways to encourage prudent purchasing, including to the extent practicable the dissemination of information on lower cost suppliers of Medicare Part B drugs. We would welcome suggestions on ways to accomplish this goal.

Comment: One commenter suggested that classes of trade should be taken into account when establishing ASP payment rates.

Response: The law does not permit the exclusion of or differentiation by classes of trade in the calculation of the ASP payment rates, except for the specific statutory exceptions described in the Medicaid best price calculation under sections 1927(c)(1)(C)(i) and 1927(c)(1)(C)(ii)(III) of the Act. The statute specifies a payment rate of 106 percent of ASP.

Comment: A drug manufacturer urges us to reject any requests to publish the NDC-specific ASPs as the publishing of the rates would facilitate inappropriate conduct.

Response: The law does not permit the disclosure of NDC level ASPs in a form that discloses the identity of a specific manufacturer or prices charged by the manufacturer except in accordance with Section 1927(b)(3)(D) of the Act. That provision permits the disclosure of such data as the Secretary determines to be necessary to effectuate the provisions of section 1847A of the Act.

v. Limitations on ASP

Section 1847A(d)(1) of the Act states that ''The Inspector General of the Department of Health and Human Services shall conduct studies, which may include surveys, to determine the widely available market prices of drugs and biologicals to which this section applies, as the Inspector General, in consultation with the Secretary, determines to be appropriate.'' Section 1847A(d)(2) of the Act states that ''Based upon such studies and other data for drugs and biologicals, the Inspector General shall compare the average sales price under this section for drugs and biologicals with—

- The widely available market price for such drugs and biologicals (if any); and
- The average manufacturer price (as determined under section 1927(k)(1)) for such drugs and biologicals.''

Section 1847A(d)(3) of the Act states that ''The Secretary may disregard the average sales price for a drug or biological that exceeds the widely available market price or the average manufacturer price for such drug or biological by the applicable threshold percentage (as defined in subparagraph (B)).'' Section 1847A(d)(3)(B) states that ''the term 'applicable threshold percentage' means—

- In 2005, in the case of an average sales price for a drug or biological that exceeds widely available market price or the average manufacturer price, 5 percent; and
- In 2006 and subsequent years, the percentage applied under this subparagraph subject to such adjustment as the Secretary may specify for the widely available market price or the average manufacturer price, or both.''

Section 1847A(d)(3)(C) of the Act states that ''If the Inspector General finds that the average sales price for a drug or biological exceeds such widely available market price or average manufacturer price for such drug or biological by the applicable threshold percentage, the Inspector General shall inform the Secretary (at such times as the Secretary may specify to carry out this subparagraph) and the Secretary shall, effective as of the next quarter, substitute for the amount of payment otherwise determined under this section for such drug or biological the lesser of—

- The widely available market price for the drug or biological (if any); or
- 103 percent of the average manufacturer price (as determined under section 1927(k)(1)) for the drug or biological.''

Comment: One commenter urged us to provide further guidance on the widely available market price (WAMP) methodology, specifically how the OIG will compare ASP to WAMP. The commenter also requested guidance on how WAMP will be determined in the case of multiple drugs represented by a single J-code. Other commenters stated that we should provide greater guidance for how it will substitute WAMP for ASP. These commenters also suggested that we provide guidance on how it will treat quarterly oscillations between ASP and WAMP.

Response: The OIG is developing its methodology regarding the widely available market price. Because the determination of WAMP is within OIG's purview, we believe it is premature to address the implementation issues prior to the OIG establishing its methodology and conducting its first review.

Comment: Several commenters recommend that we make adjustments where there is a disparity between the ASP-based payment limit and the physician acquisition cost. These commenters recommended that we raise the payment rate if the WAMP is higher than ASP.

Response: Section 1847A of the Act does not provide authority to increase the ASP-based payment system based on the review of the OIG.

vi. Payment Methodology in Cases Where the Average Sales Price During the First Quarter of Sales Is Unavailable

Section 1847A(c)(4) of the Act states that ''In the case of a drug or biological during an initial period (not to exceed a full calendar quarter) in which data on the prices for sales for the drug or biological is not sufficiently available from the manufacturer to compute an average sales price for the drug or biological, the Secretary may determine the amount payable under this section for the drug or biological based on—

- The wholesale acquisition cost; or
- The methodologies in effect under this part on November 1, 2003, to determine payment amounts for drugs or biologicals.''

Comment: Several commenters requested that we provide guidance on how the payment rate for a new drug in its second calendar quarter will be determined. They recommend that we utilize the same methodology for the 2nd quarter payment as for the 1st quarter; that is, use the WAC or methodologies in effect on November 1, 2003.

Response: Pursuant to section 1847A(c)(4) of the Act, during an initial period (not to exceed a full calendar quarter) where data on prices for sales for a drug are not sufficiently available from the manufacturer to compute an ASP, we will pay based on WAC or the methodologies in effect on November 1, 2003 for a limited period. This time period will start on the date that sales of the drug begin and end at the beginning of the quarter after we receive information from the manufacturer regarding ASP for the first full quarter of sales.

c. Payment for Influenza, Pneumococcal, and Hepatitis B Vaccines

Section 1841(o)(1)(A)(iv) of the Act requires that influenza, pneumococcal, and hepatitis B vaccines described in subparagraph (A) or (B) of section 1861(s)(10) of the Act be paid based on 95 percent of the average wholesale price (AWP) of the drug. The AWP payment rates for these vaccines will be updated quarterly. No commenters objected.

d. Payment for Drugs Furnished During 2005 in Connection With the Furnishing of Renal Dialysis Services if Separately Billed by Renal Dialysis Facilities

Section 1881(b)(13)(A)(ii) of the Act indicates that payment for a drug furnished during 2005 in connection with the furnishing of renal dialysis services, if separately billed by renal dialysis facilities, will be based on the acquisition cost of the drug as determined by the Inspector General(IG) report to the Secretary required by section 623(c) of the MMA or, insofar as the IG has not determined the acquisition cost with respect to a drug, the Secretary shall determine the payment amount for the drug. In the report, ''Medicare Reimbursement for Existing End-Stage Renal Disease Drugs,'' the IG found that, on average, in 2003 the four largest chains had drug acquisition costs that were 6 percent lower than the ASP of 10 of the top drugs, including erythropoietin. A sample of the remaining independent facilities had acquisition costs that were 4 percent above the ASP. Based on this information, the overall weighted average drug acquisition cost for renal dialysis facilities is 3 percent lower than the ASP. Therefore, we proposed that payment for a drug or biological furnished during 2005 in connection with renal dialysis services and separately billed by renal dialysis facilities will be based on the ASP of the drug minus 3 percent. We proposed to update this quarterly based on the ASP reported to us by drug manufacturers.

We received numerous comments regarding our proposed payments rate of ASP minus 3 percent. Those comments and responses are provided below.

Comment: Commenters questioned the basis for our decision to pay for separately reimbursed drugs at a rate of ASP minus three percent. These commenters stated that ASP minus 3 percent was not acquisition cost as determined by OIG and did not reflect the acquisition cost relationship between these drugs. Some commenters questioned the relationship between the ASP definition used by the OIG and the current definition. Commenters stated that we should base the payment rates on the acquisition cost of each drug as reported by the OIG updated to 2005 rather than an ASP-based formula. Some commenters indicated that the acquisition cost should be updated to 2005 and suggested an update using the same annual factor used for budget neutrality calculations. For drugs not included in the OIG report, some commenters suggested that we use the same methodology for most other Medicare Part B drugs, namely ASP plus 6 percent. Commenters indicated we should consider two tiers of payment based on provider size to minimize the discrepancy between large and small providers or in the absence of two tiers base the payment on the acquisition cost of the facilities not owned or managed by the four largest providers. Commenters also asked for clarification of the payment basis for separately billable ESRD drugs other than EPO billed by hospital based ESRD facilities since these drugs historically were not paid based on AWP but rather based on reasonable cost.

Response: We agree with the commenters who suggested we base the 2005 payment rates for separately billable ESRD drugs on the actual dollar value of the acquisition costs as determined by the IG rather than the acquisition costs relative to the ASP. We also agree that we should update the IG acquisition costs to calculate 2005 rates. After consideration of the available price data, we have determined that the Producer Price Index (PPI) for prescription preparations is the most appropriate price measure for updating EPO and other separately billable drugs from 2003 to 2005. The PPI for prescription preparations is released monthly by the Bureau of Labor Statistics, and reflects price changes at the wholesale or manufacturer stage. By comparison, the Consumer Price Index (CPI) for prescription drugs reflects price changes at the retail stage. Because EPO and many of the separately billable drugs used by dialysis facilities are purchased directly from the manufacturer, the use of a price index that measures wholesale rather than retail prices is more appropriate. The PPI for prescription drugs is the measure used in the various market baskets that update Medicare payments to hospitals, physicians, skilled nursing facilities, and home health agencies. In addition, the PPI for prescription drugs was recommended for use in the proposed composite rate market basket detailed in the 2003 Report to Congress.

Based on historical data through the second quarter of 2004, we used the Global Insight Inc. forecast of the PPI for prescription drugs to determine the update factors for 2004 and 2005. We feel the use of an independent forecast, in this case from Global Insight Inc., is superior to using the Naational Health Expenditure projections for drug prices (which is the CPI for prescription drugs) and is consistent with the methodology used in projecting market basket increases for Medicare prospective payment systems.

We also agree with those commenters who suggested that the drugs not contained in the IG study should be paid at ASP plus 6 percent. We believe it is appropriate for the payment amount for these drugs when separately billed by ESRD facilities during 2005 to be the same as the payment amount for other entities that are paid by Medicare on other than a cost or prospective payment basis. We do not agree with commenters that we should establish separate drug payment rates for large and small providers. For reasons discussed in the section of this final rule on the ESRD composite rate, we believe it is appropriate to establish a single add-on payment to the composite rate and therefore appropriate to establish the same drug payment rates for both large and small providers. We do not believe it is appropriate to base the payment amount on only the higher acquisition cost of the facilities not owned or managed by the four largest providers and not take into account the acquisition costs of the largest four providers who represent the majority of the drug expenditures. Section 1881(b)(13)(A)(ii) of the Social Security Act refers to ''the acquisition cost of the drug or biological'' and not the acquisition costs of the drug or biological. In accordance with the statute and our understanding of Congressional intent for 2005, we believe it is more appropriate to base the 2005 payment amounts on a weighted average of the acquisition costs of the four largest providers and the other

facilities rather than base the 2005 payment amounts solely on the acquisition costs of the other facilities.

In response to the commenters who requested clarification of the payment basis for separately billable ESRD drugs other than EPO billed by hospital-based ESRD facilities, we did not propose changes to the reasonable cost payment basis for these drugs. The OIG did not study separately billable ESRD drugs other than EPO billed by hospital-based ESRD facilities and accordingly, we did not propose to change the payment basis for these drugs.

e. Payment for Infusion Drugs Furnished Through an Item of DME

In 2005, section 1841(o)(1)(D)(i) of the Act requires that an infusion drug furnished through an item of DME covered under section 1861(n) of the Act be paid 95 percent of the average wholesale price for that drug in effect on October 1, 2003. No commenters objected.

2. Drug Administration Payment Policy and Coding Effective in 2005

Section 1848(c)(2)(J) of the Act (as added by section 303(a) of the MMA) requires the Secretary to promptly evaluate existing drug administration codes for physicians' services to ensure accurate reporting and billing for those services, taking into account levels of complexity of the administration and resource consumption. According to section 1848(c)(2)(B)(iv) of the Act (as amended by section 303(a) of the MMA), any changes in expenditures in 2005 or 2006 resulting from this review are exempt from the budget neutrality requirement of section 1848(c)(2)(B)(ii) of the Act. The statute further indicates that the Secretary shall use existing processes for the consideration of coding changes and, to the extent changes are made, shall use those processes to establish relative values for those services. The Secretary is also required to consult with physician specialties affected by the provisions that change Medicare payments for drugs and drug administration.

The AMA's CPT Editorial Panel established a workgroup, with representatives from affected specialties that met earlier this year to develop recommendations to the CPT Editorial Panel in August. Based on these recommendations, that panel adopted several new drug administration codes and revised several existing codes. Subsequently, the AMA's Relative Value Update Committee (RUC) met at the end of September to make recommendations to us on the practice expense resource inputs and work relative values for the new and revised drug administration codes.

We indicated in the proposed rule that we would consider whether it is necessary for us to make coding changes effective January 1, 2005 through the use of G-codes (because the 2005 CPT book will have already been published), and we requested public comment. As described in detail below, we are establishing new G-codes for 2005 that correspond with the new CPT codes that will become active in 2006. These new G-codes are interim until 2006.

The new CPT codes can be categorized into the following three categories of drug administration services: infusion for hydration; nonchemotherapy therapeutic/diagnostic injections and infusions other than hydration; and chemotherapy administration (other than hydration) which includes infusions/injections. There are some important changes in the new codes relative to current drug administration coding. The infusion of substances such as monoclonal antibody agents or other biologic response modifiers is reported under the chemotherapy codes, instead of the nonchemotherapy infusion codes, as is currently the case. There are also new codes in both the chemotherapy and nonchemotherapy sections for reporting the additional sequential infusion of different substances or drugs.

As we stated in the proposed rule, we plan to analyze any shift or change in utilization patterns once the payment changes for drugs and drug administration required by MMA go into effect. While we do not believe the changes will result in access problems, we plan to continue studying this issue. We also note that the MMA requires the Medicare Payment Advisory Commission (MedPAC) to study how the changes in payments for drugs and drug administration affect other specialties.

We received many comments on various aspects of coding and payment for drug administration services in response to the proposed rule. We are also responding below to comments we received on the January 7, 2004 interim final rule with comment period that announced the provisions of section 303 of the MMA affecting drug administration services that took effect in 2004 (69 FR 1094). Specifically, section 303 of the MMA required the following changes in 2004: a transitional adjustment that increases payments for specific drug administration services by 32 percent in 2004 (and 3 percent in 2005); establishing work RVUs for certain drug administration services equal to the work RVUs for a level 1 office medical visit for an established patient; the incorporation of supplemental survey data in the calculation of the practice expense RVUs for drug administration codes; and allowing oncologists to bill for multiple drug administrations by the ''push'' technique on a single day.

Comment: Many commenters supported the efforts to promptly evaluate existing drug administration codes to ensure accurate reporting and billing for services. They support our proposal to use G-codes until the new CPT codes are active. They asked us to adopt the recommendations of the CPT Editorial Panel for new drug administration codes.

Response: We appreciate the support of the commenters of all of the efforts to expeditiously review and update these codes. We also would like to specifically recognize the efforts of the CPT Editorial Panel's Drug Administration Workgroup to develop the new CPT codes, the Editorial Panel for its consideration and approval of the new codes, and the RUC for its similar efforts to develop recommendations for the inputs for the new codes.

We have reviewed the recommendations of the CPT Editorial Panel and, with one exception noted below, agree with their new and revised codes for drug administration for 2005. Because the new CPT codes will not be included in the 2005 CPT, we have decided to establish G-codes, where applicable. At this time, we anticipate these new G-codes will be temporary until the new CPT codes become active January 1, 2006.

A listing of the old CPT codes and their corresponding G-codes are in the table below. Some of the old CPT codes will correspond to more than one G-code, and there are codes that will allow physicians to bill for services that previously did not have a code or were bundled into other services.

The drug administration codes are divided into three categories: infusion codes for hydration; codes for therapeutic/diagnostic injections; and chemotherapy administration codes. The descriptions of the codes below are taken primarily from the AMA CPT Editorial Panel. We are including these specific descriptions here in order to provide as much information as possible about the new G-codes prior to their implementation on January 1, 2005. However, we anticipate that we will issue further instructions regarding the appropriate use of these G-codes, including clarifications, interpretations, and other modifications to the following guidance (apart from the G-codes

themselves) as part of any instructions issued through a subregulatory process.

The codes for hydration (G0345 and G0346 in the table below) are for reporting hydration intravenous (IV) infusions consisting of a prepackaged fluid and electrolytes. These codes are not used to report infusion of drugs or other substances. The codes for chemotherapy administration are to be used for reporting the administration of non-radionuclide anti-neoplastic drugs, and anti-neoplastic agents provided for treatment of noncancer diagnoses, or substances such as monoclonal antibody agents and other biologic response modifiers. The remaining codes are for reporting injections and infusions for all drug administrations that were previously reported using CPT codes 90780–90788, 96400, and 96408–96414 (other than those described above as hydration or chemotherapy).

TABLE 8: Comparison of old CPT codes to G codes

Hydration

Old CPT	G Code	Descriptor
90780	G0345	Intravenous infusion, hydration; initial, up to one hour
90781	G0346	each additional hour, up to eight (8) hours

Injections and Infusions (Non-Chemotherapy, other than hydration)

Old CPT	G Code	Descriptor
90780	G0347	Intravenous infusion, for therapy/diagnosis, initial, up to one hour
90781	G0349	additional sequential infusion, up to one hour
90781	G0348	each additional hour, up to eight (8) hours
N/A	G0350	Concurrent infusion

Old CPT	G Code	Descriptor
90782	G0351	Therapeutic or diagnostic injection
90783	N/A	intra-arterial
90784	G0353	intravenous push, single or initial substance/drug
N/A	G0354	each additional sequential intravenous push
90788	N/A	Intramuscular injection of antibiotic
90799	N/A	Unlisted injection or infusion

Chemotherapy Administration

Old CPT	G Code	Descriptor
96400	G0355	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic
96400	G0356	hormonal anti-neoplastic
96405	N/A	Chemotherapy administration; intralesional, up to and including 7 lesions
96406	N/A	intralesional, more than 7 lesions
96408	G0357	intravenous, push technique, single or initial substance/drug
96408	G0358	intravenous, push technique, each additional substance/drug
96410	G0359	Chemotherapy administration, intravenous infusion technique; Up to one hour, single or initial substance/drug
96412	G0360	each additional hour, one to eight (8) hours
96414	G0361	initiation of prolonged chemotherapy infusion
96412	G0362	each additional sequential infusion, up to one hour
96420	N/A	Chemotherapy administration, intra-arterial; push technique
96422	N/A	infusion technique, up to one hour
96423	N/A	infusion technique, each additional hour, one to eight hours

96425	N/A	infusion technique, initiation of prolonged infusion (more than eight hours)
96440	N/A	Chemotherapy administration into pleural cavity
96445	N/A	Chemotherapy administration into peritoneal cavity
96450	N/A	Chemotherapy administration into CNS
96520	N/A	Refilling and maintenance of portable pump
N/A	G0363	Irrigation of implanted venous access device for drug delivery systems
96530	N/A	Refilling and maintenance of implantable pump
96542	N/A	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents

The following coding guidance is based on the CPT Editorial Panel's explanatory language for the new CPT codes. As noted above, we plan to issue further guidance as needed.

Infusions that were previously reported under CPT code 90780 (non-chemotherapy infusion, 1st hour) will be billed under one of three G-codes beginning January 1, 2005. The first hour of a hydration infusion will be billed under G0345. The first hour of infusion of a nonchemotherapy drug other than hydration will be billed under G0347. The first hour of infusion of anti-neoplastic agents provided for treatment of noncancer diagnoses or substances such as monoclonal antibody agents and other biologic response modifiers is billed under G0359.

Similarly, services that were previously reported under CPT code 90781 (non-chemotherapy infusion, each additional hour) will be billed under one of four G-codes beginning January 1, 2005. Each additional hour of a hydration infusion will be billed under G0346. Each additional hour of a nonchemotherapy infusion will be billed under G0348. Currently, if a second (or other subsequent) nonchemotherapy drug is administered sequentially, the physician would bill code 90781 for the additional hour of infusion. Under the new G-codes, the physician will bill G0349, the sequential administration of a second or subsequent nonchemotherapy drug. In addition, each additional hour of the infusion of anti-neoplastic agents for the treatment of noncancer diagnoses or substances such as monoclonal antibodies and other biological modifiers is billed under G0360.

Injections that were previously billed under CPT code 90782 will now be billed under HCPCS code G0351. Physicians should use HCPCS code G0352 for injections previously billed under CPT code 90783. Nonchemotherapy drugs administered by IV push (currently using CPT code 90784) should now be billed under HCPCS code G0353. The CPT book does not currently contain a code for physicians to bill a second (or other subsequent) nonchemotherapy drug administered by IV push. The CPT Editorial Panel created a new code for each additional nonchemotherapy drug administered by IV push. For 2005, the physician should bill HCPCS code G0354.

The CPT coding system will be deleting code 90788 (Intramuscular injection of antibiotic) in 2006. We are maintaining CPT code 90788 as an active code until it is changed in the CPT coding system and instructions are provided on the code to bill in its place beginning January 1, 2006.

Chemotherapy injections, previously billed under the CPT code 96400, will now be billed using one of two new G-codes. For injection of nonhormonal anti-neoplastic drugs, the physician should bill HCPCS code G0355. For injection of hormonal anti-neoplastic drugs, the physician should bill HCPCS code G0356. CPT is not recommending any changes to CPT codes 96405 (Chemotherapy administration; intralesional, up to and including 7 lesions) and 96406 (more than 7 lesions), and these codes will remain active for Medicare in 2005.

Chemotherapy drugs administered by IV push (currently billed under CPT code 96408, or, if the drug meets the expanded definition of chemotherapy including monoclonal antibodies or other biologic response modifiers, currently billed under CPT code 90784) should be billed using G0357 for the initial drug administered. In 2004, Medicare paid for the second (or other subsequent) chemotherapy drug administered by IV push under CPT code 96408. CPT will be establishing a code that recognizes the resource inputs associated with each additional chemotherapy drug administered by IV push. For 2005, the analogous code to bill the second (or other subsequent) chemotherapy drug administered by IV push is G0358.

The first hour of chemotherapy administration, previously billed under CPT code 96410, should now be billed under CPT code G0359. Each additional hour of chemotherapy (previously billed under CPT code 96412) should now be billed under CPT code G0360. CPT is also recommending a new code for the first hour of a different chemotherapy drug administered sequentially by infusion. If a second chemotherapy drug is administered sequentially, the physician should bill for HCPCS G0362 for the first hour of infusion of the second drug. All additional hours (up to eight total hours) of chemotherapy infusion should be billed using HCPCS code G0360. Prolonged chemotherapy infusions (8 hours or more, previously billed under code 96414) should be billed in 2005 using HCPCS code G0361.

For three codes (G0350, G0354, G0363), the table above has an ''N/A'' listed in the ''Old CPT'' column, meaning there were no CPT codes that existed explicitly for these services. These services will now be billable under the new coding system. For instance, CPT will be establishing a code for a ''concurrent infusion.'' A concurrent infusion refers to the simultaneous infusion of two nonchemotherapy drugs. We are using temporary code G0350 for this service. Code G0350 is an add-on code. It must be reported as an ''add-on'' or with another code and our payment reflects the incremental resources associated with infusing the second drug. For example, if two nonchemotherapy drugs are infused concurrently, the physician bills G0347 for the initial drug infused and G0350 as an add-on.

As indicated above, HCPCS code G0354 is a new code for each additional sequentialnonchemotherapy drug administered by IV push. HCPCS code G0354 is also an add-on code. In general, G0354 will be an add-on to G0353. However, it is possible that a nonchemotherapy drug administered by IV push may follow the administration of a chemotherapy drug administered by IV push, and HCPCS code G0354 would then be an add-on to HCPCS code G0357.

HCPCS code G0363 is a new code for irrigation of an implanted venous access device. There is currently no code to describe this service. Medicare will pay for G0363 if it is the only service provided that day. If there is a visit or other drug administration service provided on the same day, payment for this service is bundled into payment for the other service.

We are creating the following new add-on G-codes: G0346, G0348, G0349, G0350, G0354, G0358, G0360 and G0362. As indicated above, add-on codes must be billed with other codes, and our payment reflects the incremental resources associated with providing the additional service. The initial codes that these add-on codes could potentially be billed with include: G0345, G0347, G0353, G0357 and G0359. If a combination of chemotherapy, nonchemotherapy drugs, and/or hydration is administered by infusion sequentially, the initial code that best describes the service should always be billed irrespective of the order in which the infusions occur.

Comment: In the January 7, 2004 interim final rule with comment, we revised our payment policy for pushes of chemotherapy drugs to allow for payment of multiple pushes of different chemotherapy agents in one day. A commenter asked that we revise our policy for multiple pushes of nonchemotherapy agents, to allow multiple billings on a single day.

Response: The CPT/RUC recommendations address this comment. New codes have been created to account for the resources associated with multiple chemotherapy and nonchemotherapy drugs administered by IV push. HCPCS code G0353 is used for the initial IV push of a nonchemotherapy drug, while HCPCS code G0354 is used for each additional push of a nonchemotherapy drug. For chemotherapy drugs administered by IV push, HCPCS code G0357 is used for the first drug administered, while HCPCS code G0358 is used for each additional drug.

We also note that existing CPT codes 90782–90788 (Therapeutic, prophylactic or diagnostic injections) currently have a status indicator of ''T'', which means that payment for the service is bundled unless it is the only service billed by the physician for the patient that day. However, based on the RUC recommendations and the resulting values for the injection services, we are making the status indicator on HCPCS codes G0351—G0354 an ''A'', which will allow them to be separately paid even if another physician fee schedule service is billed for the same patient that day.

Comment: A commenter stated that, given the increased work and practice expense RVUs for drug administration codes, it follows that both the work and practice expense RVUs for the immunization administration codes (90471, 90472, 90473, and 90474) should also be increased. The commenter argued that the service involved in administering vaccines is more intense/complex than the service involved in the drug infusion codes.

Response: We agree with the commenter that the physician work and practice expenses associated with administering injections are similar to immunizations. In addition, we would point out that we currently pay for vaccine administrations (G0008–G0010) based on crosswalking the RVUs to CPT code 90471. Therefore, any changes to the physician work and practice expense RVUs for code 90471 would also affect payments for vaccine administrations.

Because we agree these services should be similar in the amount of physician work involved, we are assigning the physician work value recommended by the RUC for code 90782 (G-code G0351) to code 90471 and HCPCS G-codes G0008–G0010. We are combining the utilization data for all of these codes to determine a single practice expense RVU that will be applied to each of these codes.

We are also assigning a work RVU of 0.15 to code 90472. Codes 90473 (Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid)) and 90474 (Each additional vaccine (single or combination vaccine/toxoid)) are currently not covered. We are changing the status of these codes to ''R'', or restricted, meaning they are payable under some circumstances after carrier review. These codes will be carrier priced.

Comment: If a patient receives chemotherapy infusions, CPT code 96410 is used to report the infusion of the first drug up to one hour. Chemotherapy drugs are usually administered sequentially. Thus, if a patient receives the administration of a second chemotherapy drug at the same treatment session, CPT code 96412 is used to report the infusion of the second drug for each additional hour of infusion. In 2004, the national payment, including the transitional payment adjustment of 32 percent, for CPT code 96410 is $217. The comparable payment for CPT code 96412 is $48.

Commenters pointed out that this policy does not take into account the levels of complexity of administration and resource consumption. The administration of multiple drugs requires additional preparation time, supplies, and patient education, not currently accounted for in CPT code 96412.

Response: The CPT/RUC recommendations addressed this issue. We are implementing new code G0362, Chemotherapy administration, intravenous technique; each additional sequential infusion, up to one hour. This code will allow, effective January 1, 2005, physicians to begin to bill for the first hour of chemotherapy of the second chemotherapy drug administered.

Comment: Several commenters requested clarification that the changes to the drug administration codes resulting from the CPT changes and our G-codes would be exempted from budget neutrality by the provision at section 1848(c)(2)(B)(iv)(III), as added by MMA section 303(a)(1). This provision stipulates that the evaluation of the existing drug administration codes described above as leading to the interim G-codes and the new CPT codes for 2006, is to be exempt from budget neutrality.

Response: The commenters are correct that the additional expenditures that result from the interim G-code changes we are implementing in this rule are exempt from budget neutrality.

Comment: Several commenters asked that we continue payment for drug administration codes at the 2004 levels, which included the 32 percent transitional payment adjustment, instead of paying at the 3 percent transitional payment adjustment for 2005, or adopt other measures. For example, commenters suggested temporary codes to offset the large reductions that would otherwise go into effect in 2005.

Response: Section 303(a)(4) of the MMA is very specific on the application of the transitional payment adjustments in 2004 and 2005. We do not have the legal authority to continue payments based on the 2004 payment levels. In 2005, the transitional adjustment percentage for drug administration

decreases from 32 percent to 3 percent. No transitional percentage is applied in 2006 or subsequent years.

Comment: One commenter requested additional temporary G-codes to offset the payment reductions for oncologists that would otherwise go into effect in 2005. According to this commenter, the payment amount associated with each of these codes would be a percentage add-on amount sufficient to offset the reductions in drug margins and payments for drug administration services.

Response: We have worked extensively with the major associations representing oncologists and their patients to ensure that Medicare continues to pay appropriately for these extremely critical services. The payment changes we made for 2004, the new G-codes, and allowing additional payment for injections and additional infusions, either have already increased, or will increase, payments for drug administration services. The impacts of these changes are discussed extensively in the impact analysis section of this final rule.

In addition, as we indicated above, we plan to analyze any shift or change in utilization patterns once the payment changes for drugs and drug administration required by MMA go into effect. While we do not believe the changes will result in access problems, we plan to continue studying this issue.

Comment: One commenter expressed concern that the reductions in payments to oncologists described in the proposed rule could make it difficult, if not impossible, for many patients to continue to access cancer care in nonhospital community settings.

Response: As noted above, we have taken several steps to increase payments for drug administration services in this final rule. We recognize that oncology patients in the Medicare population undergoing chemotherapy face serious and unique issues and problems related to quality of care throughout the life cycle of their disease process; from the time of first diagnosis, through treatment, until the patient experiences an end to medical (including hospice) care. Patients, national cancer organizations, and medical providers have identified certain factors that they believe affect the comfort and ultimately the care for cancer patients in the physician office setting.

We believe that the goals and objectives of optimal treatment include reviewing and analyzing pain control management, minimization of nausea and vomiting, explaining treatment options, outlining existing chemotherapy regimens, assessing quality of life, assessing patient symptoms and complaints, supporting and educating caregivers, and avoidance of unnecessary Emergency Department visits and inpatient hospitalizations. Further, we believe that clinicians armed with appropriate assessments can proactively intervene with medical treatment and nonmedical assistance to help ameliorate some of the distressing and unpleasant, but frequent and predictable, events that may accompany certain cancers and chemotherapeutic regimens used to combat cancer.

The Secretary has been given the authority under sections 402(a)(1)(B) and 402(a)(2) of the Social Security Act Amendments of 1967 (Pub. L. 90–248), as amended, to develop and engage in experiments and demonstration projects to provide incentives for economy, while maintaining or improving quality in provision of health services. In order to identify and assess certain oncology services in an office-based oncology practice that positively affect outcomes in the Medicare population, we will initiate a one-year demonstration project for CY 2005. While we encourage optimal care in all facets of treatment, the focus of the demonstration project will be on three areas of concern often cited by patients: pain control management, the minimization of nausea and vomiting, and the reduction of fatigue.

Practitioners participating in the project must provide and document specified services related to pain control management and minimization of nausea and vomiting, and the reduction of fatigue. To facilitate the collection of this information, we have established 12 new G-codes to be reported by program participants.

G-Codes for Assessment of Nausea and/or Vomiting

G9021: Chemotherapy assessment for nausea and/or vomiting, patient reported, performed at the time of chemotherapy administration; assessment level one: not at all (for use in a Medicare-approved demonstration project).

G9022: Chemotherapy assessment for nausea and/or vomiting, patient reported, performed at the time of chemotherapy administration; assessment level two: a little (for use in a Medicare-approved demonstration project).

G9023: Chemotherapy assessment for nausea and/or vomiting, patient reported, performed at the time of chemotherapy administration; assessment level three: quite a bit (for use in a Medicare-approved demonstration project).

G9024: Chemotherapy assessment for nausea and/or vomiting, patient reported, performed at the time of chemotherapy administration; assessment level four: very much (for use in a Medicare-approved demonstration project).

G-Codes for Assessment for Pain

G9025: Chemotherapy assessment for pain, patient reported, performed at the time of chemotherapy administration, assessment level one: not at all (for use in a Medicare-approved demonstration project).

G9026: Chemotherapy assessment for pain, patient reported, performed at the time of chemotherapy administration, assessment level two: a little (for use in a Medicare-approved demonstration project).

G9027: Chemotherapy assessment for pain, patient reported, performed at the time of chemotherapy administration assessment level three: quite a bit (for use in a Medicare-approved demonstration project).

G9028: Chemotherapy assessment for pain, patient reported, performed at the time of chemotherapy administration, assessment level four: very much (for use in a Medicare-approved demonstration project).

G-Codes for Assessment for Lack of Energy (Fatigue)

G9029: Chemotherapy assessment for lack of energy (fatigue), patient reported, performed at the time of chemotherapy administration, assessment level one: not at all (for use in a Medicare approved demonstration project).

G9030: Chemotherapy assessment for lack of energy (fatigue), patient reported, performed at the time of chemotherapy administration, assessment level two: a little (for use in a Medicare approved demonstration project).

G9031: Chemotherapy assessment for lack of energy (fatigue), patient reported, performed at the time of chemotherapy administration, assessment level three: quite a bit (for use in a Medicare approved demonstration project).

G9032: Chemotherapy assessment for lack of energy (fatigue), patient reported, performed at the time of chemotherapy administration, assessment level four: very much (for use in a Medicare-approved demonstration project).

The codes correspond to four patient assessment levels (''not at all,'' ''a little,'' ''quite a bit,'' or ''very much'') for each of the following three patient status factors: nausea and/or vomiting;

pain; and lack of energy (fatigue). These levels, based on the Rotterdam scale, were chosen since they appear to be less burdensome for the practitioner and more easily understood by the patient. Participating practitioners must bill the applicable G-codes for each patient status factor (that is, one G-code each for patient comfort assessment factors: nausea and/or vomiting; pain; and fatigue) assessed during a chemotherapy encounter in order to receive payment under the demonstration. A G-code for each patient status factor must appear on the claim for payment to be made under the demonstration project. A patient chemotherapy encounter is defined as chemotherapy administered through intravenous infusion or push, limited to once per day. During the course of the demonstration, an additional payment of $130 per encounter will be paid to participating practitioners for submitting the patient assessment data as described above.

Any office-based physician or nonphysician practitioner operating within the State scope of practice laws who takes care of and administers chemotherapy to oncology patients in an office setting is eligible to participate in this demonstration project. By billing the designated G-codes, the practitioner self-enrolls in the project and agrees to all of the terms and conditions of the demonstration project.

This information will help us to work with those who care for cancer patients to determine ways to improve the quality of care and quality of life for patients as demonstrated by measuring objective parameters and the medical response to those standardized measurements. The evaluation of the project will be based on data reported to us by the practitioners and the use of our administrative claims data to examine Emergency Department visits and inpatient hospitalizations.

We anticipate that further information regarding this demonstration project will be forthcoming after publication of this final rule.

Comment: Commenters pointed out that, under the MMA, we added physician work RVUs to specified drug administration codes equivalent to a level 1 established office visit. They indicated that we should also have increased the practice expense inputs for the same drug administration codes to account for the practice expense inputs associated with a level 1 established office visit.

Response: Section 1848(c)(2)(H)(iii) of the Act (as added by 303(a)(1)(B) of the MMA) specified that we increase the work RVUs for drug administration services equal to the work RVUs for a level 1 established patient office visit (CPT code 99211). As indicated in the January 7, 2004 **Federal Register** (69 FR 1093), we established work RVUs of 0.17 for specific CPT codes that met the statutory definition of ''drug administration services.''

However, the legislation did not direct us to also increase the practice expense RVUs of the drug administration codes to include the clinical staff time associated with a level 1 office visit. The practice expense inputs of the existing CPT codes for drug administration were refined in 2002. We believe the recommendations from the PEAC included the typical clinical staff time associated with each drug administration service.

The CPT Editorial Panel approved new and revised codes for drug administration services for 2005. Depending upon the service, the RUC is recommending work RVUs for the new drug administration codes that may equal, exceed or be less than 0.17. Although section 1848(c)(2)(H)(iii) of the Act requires that the work RVUs for drug administration services shall equal those of a level 1 office medical visit, new subparagraph (J) requires the Secretary to ''promptly evaluate existing drug administration codes for physicians' services''. The statute further indicates that the ''Secretary shall use existing processes for the consideration of coding changes and * * * in establishing relative values * * *''

Because we typically use the CPT and RUC processes to establish codes and relative values, we believe the statute gives us authority to establish work RVUs at a level other than those of a level 1 established patient office visit. Therefore, for 2005, we are accepting the RUC recommendations for the interim G-codes even though they result in work RVUs that are different than 0.17.

Comment: Several organizations and physicians commented that the Medicare payments for the chemotherapy codes do not include payment for many services provided by an oncology practice. These services include support services such as nutrition counseling, social work services, case management, psychosocial counseling, and educational services provided by an oncology nurse to the patient.

Response: Under certain circumstances, Medicare does make explicit payment for clinical social worker and medical nutrition therapy services. Medicare can pay separately for the services of clinical psychologists (CPs), clinical social workers (CSWs), and nurse practitioners (NPs), clinical nurse specialists (CNS) and physician assistants (PAs).

CPs can bill directly for services and supplies they are legally authorized by the State to perform that could also be furnished by a physician or incident to a physician's service. Payment for CP services is made at 100 percent of the physician fee schedule for services they are authorized to provide that are comparable to those of a physician.

CSWs can furnish services for the diagnosis and treatment of mental illnesses that they are legally authorized by the State to provide. Payment for CSW services is made at 75 percent of the CP fee schedule, which is 100 percent of the physician fee schedule.

NPs, CNSs and PAs can bill for mental health services consistent with their authority under law to furnish physician services. They may also bill for services furnished incident to their own professional services that fall under the State scopes of practice. Payment for these services is made at 85 percent of the physician fee schedule. Medicare will pay for medical nutrition therapy services provided by a registered dietitian or nutrition professional for a beneficiary with diabetes or renal disease. Based on a comment on our August 20, 2003 proposed rule (68 FR 50428), we understand that social worker services could involve different tasks (''helping patients with their health insurance, filling and refilling prescriptions'') than those that are explicitly paid for by Medicare. However, we believe Medicare does pay for these services indirectly through the practice expense RVUs for drug administration services. If these services are typically provided to cancer patients, we believe the RUC could consider whether it is possible for resource inputs for these types of staff to be incorporated into the new drug administration codes. We also believe that the RUC could consider whether these types of staff activities are unique to physicians who provide drug administration or if they apply to other physicians' services as well.

Comment: Current CPT code 96412 (infusion techniques, one to 8 hours, each additional hour) is an add-on code, billed in addition to the primary code, 96410 (the first hour of chemotherapy). There is no national coding policy that explains how this add-on code is to be reported if less than a full hour of chemotherapy infusion is provided. A commenter pointed out that the Medicare carriers have different policies for reporting this service. Some carriers require the infusion to extend at least 16 minutes into the subsequent hour before

an add-on code can be billed, and others impose a 31 minute requirement. The commenter asked that we establish a uniform policy for the carriers to follow.

Response: The CPT Editorial Panel addressed this issue as part of its review of the drug administration codes. Effective in 2006, the add-on code is to be used for ''infusion intervals of greater than thirty minutes beyond one hour increments''. We are adopting this policy for chemotherapy administration codes furnished on or after January 1, 2005.

Comment: The nonchemotherapy subcutaneous injection is currently reported and paid under CPT code 90782, while a chemotherapy subcutaneous injection is currently reported under CPT code 96400. Some commenters recommended that we permit billing for nonchemotherapy injections for cancer patients to be made under CPT code 96400. They believe this code more appropriately reflects the practice expenses related to supportive care for chemotherapy.

Response: The CPT Editorial Panel explicitly addressed this issue by creating separate drug administration codes for hydration, nonchemotherapy infusions and injections, and chemotherapy infusions and injections. It further expanded the definition of chemotherapy to include those drugs where the resource costs associated with the drug administration are similar to those administered as anti-neoplastics. Other drugs administered in support of chemotherapy, such as anti-emetics and drugs to prevent anemia, are billed using the injection code, G0351, which replaces CPT code 90782 (consistent with the CPT recommendations). We have reviewed the practice expense inputs for this code from the RUC and accepted their recommendation.

Comment: Some commenters asked that complex non-oncology infusions, such as Remicade, be paid at the same level as chemotherapy infusions. They indicate that these nonchemotherapy infusions have similar complexity and resource use as chemotherapy infusions.

Response: The CPT recommendations address this issue. The codes for chemotherapy administration are for reporting the administration of non-radionuclide, anti-neoplastic drugs, anti-neoplastic agents provided for treatment of noncancer diagnoses or substances such as monoclonal antibody agents, and other biologic response modifiers.

Comment: Some commenters inquired about the recognition of a severe drug reaction management code that could be used during the administration of high complexity biologic medications and less frequently during other drug administrations or chemotherapy services. While the CPT Drug Administration Workgroup supported the creation of a severe drug reaction management code, the CPT Editorial Panel did not approve this code.

Response: We recognize that considerable physician effort may be required to monitor and attend to patients who develop significant adverse reactions to chemotherapy drugs, or otherwise have complications in the course of chemotherapy treatment. Physicians may not be aware that these services can be billed using existing CPT codes. The following scenarios are examples where existing codes may be used in addition to the routine billing for the physician's care of a cancer patient:

- Bill for the Physician Visit. If a patient has a significant adverse reaction to drugs during a chemotherapy session and the physician intervenes, the physician could bill for a visit in addition to the chemotherapy administration services.
- Bill for the Higher-Level Physician Visit. If the patient had already seen the physician prior to a chemotherapy session for a problem that is unrelated to the supervision of the administration of chemotherapy drugs, the physician may bill a visit for a significant adverse drug reaction. The total time, resources, and complexity of the physician's interaction with the patient may justify a higher level of visit service.
- Bill for a Prolonged Service. If the patient had a physician visit prior to the chemotherapy session and experienced a significant adverse reaction to drugs on the same day, the physician can bill a prolonged service code in addition to the physician visit. There are several code combinations to use depending on the number of minutes involved. The physician must have a face-to-face encounter with the patient and must spend at least 30 minutes beyond the threshold or typical time for that level of visit for the physician to bill for the prolonged service code.
- Bill for Critical Care Service. If the patient had a physician visit prior to the chemotherapy session and experienced a life-threatening adverse reaction to the drugs, the physician could bill for a critical care service in addition to the visit if the physician's work involves at least 30 minutes of direct face-to-face involvement managing the patient's life-threatening condition. Examples of life-threatening conditions are: central nervous failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure.

These instructions are published here for informational purposes, and we anticipate that we will issue further instructions regarding the appropriate use of these G-codes including clarifications, interpretations and other modifications to the following guidance as part of any instructions issued through a subregulatory process.

Comment: The American Urological Association (AUA) commented in response to the January 7, 2004 interim final rule to ask us to include the following codes in the MMA-mandated evaluation of existing drug administration codes for physicians' services to ensure accurate reporting and billing for such services: CPT codes 11980, 11981, 11982, 11983, 51700, 51720, 54200, 54231, and 54235. The AUA asked that we consider applying the transitional adjustment payment to these codes for 2005.

Response: We presented these codes to the CPT Drug Administration Workgroup. After subsequent discussion with representatives of the AUA, the AUA withdrew these codes from consideration by the workgroup.

These codes are not subject to the ''transitional adjustment payment provision'' because they are not included in the definition of ''drug administration codes.''

Comment: Ophthalmologists frequently perform the procedure photodynamic therapy (CPT code 67221 and 67225) by infusing the drug Visudyne. While separate payment is allowed for the drug, the infusion is considered an integral part of the photodynamic therapy code. Thus, the physician is not allowed to bill a separate code for the infusion of the drug.

According to one commenter, Visudyne is also a drug used in cancer chemotherapy. The commenter pointed out that when Visudyne is provided for photodynamic therapy, ophthalmologists incur drug administration costs similar to oncologists who use infused drugs.

The AAO asked why we did not include CPT codes 67221 and 67225 among the drug administration codes that benefited under the MMA.

Response: In this instance, the infusion of the drug is an integral part of the surgical procedure and it was valued by the RUC and CMS that way. The code of which it is a part is not considered a drug administration code under section 303 of the MMA.

3. Blood Clotting Factor

For clotting factors furnished on or after January 1, 2005, we proposed to establish a separate payment of $0.05

per unit to hemophilia treatment centers, homecare companies and other suppliers for the items and services associated with the furnishing of blood clotting factor. Section 303(e)(1) of the MMA requires the Secretary, after review of the January 2003 report to the Congress by the Comptroller General of the United States, to establish a furnishing fee for the items and services associated with the furnishing of blood clotting factor.

Based on a review of the Government Accountability Office (GAO) report and data received from various clotting factor providers, we proposed a furnishing fee in order to cover the administrative costs associated with supplying the clotting factor. As outlined in the MMA, any separate payment amount established may include the mixing and delivery of factors, including special inventory management and storage requirements, as well as ancillary supplies and patient training necessary for the self-administration of these factors. The MMA states that, in determining the separate payment, the total amount of payments and these separate payments must not exceed the total amount of payments that would have been made for the factors if the amendments in section 303 of the MMA had not been enacted.

As indicated in the GAO report, ''[w]hen Medicare's payment for clotting factor more closely reflects acquisition costs, we recommend that the Administrator establish a separate payment for providers based on the costs of delivering clotting factor to Medicare beneficiaries.'' Effective upon implementation of the ASP-based payment rates, payment for blood clotting factors will more closely reflect acquisition costs, since payment will be based on the average sales price as reported by drug manufacturers plus 6 percent.

Therefore, we stated in the August 5, 2004 proposed rule that in the absence of additional data we believe that a furnishing fee of $0.05 per unit for the cost of delivering clotting factor is an appropriate amount. However, we also sought updated data and comments on the GAO report, as well as information on the fixed and variable costs of furnishing clotting factor. We recognized that there may be alternatives to a fee, which varies entirely based on the number of units of clotting factor furnished. We indicated we would closely examine all data and information submitted in order to make a final determination with respect to the appropriateness of the $0.05 per unit amount.

We received comments from various sources including, but not limited to, hemophilia treatment centers, hemophilia coalitions, and other suppliers of clotting factors regarding our request for additional data and information on the appropriateness of our proposed fee. The comments and responses are provided below.

Comment: Many commenters recommended that we incorporate cost information received from homecare providers and any updated cost data from hemophilia treatment centers in determining the separate furnishing fee payment amount for 2005. The commenters cited an industry-sponsored survey of full-service hemophilia homecare companies that recommended a furnishing fee of $0.20 per unit. This survey collected CY 2003 data from three hemophilia homecare suppliers that the commenter indicated supplied 42 percent of all Medicare hemophilia patients. Commenters also stated that the GAO report was inadequate to serve as the basis for determining the separate payment for clinically appropriate items and services related to furnishing blood clotting factor. They questioned the accuracy of the recommended payment range in the GAO report, given what they viewed as an insufficient sample size; that is, the GAO report received data from only 4 hemophilia treatment centers and lacked any cost data from national or regional full-service hemophilia homecare providers. These commenters also indicated that the GAO survey may have included homecare companies that purchase clotting factor at a lower price through the Public Health Service's 340B program. More information on the 340B program is available on the Health Resources and Services Administration's Web site at *http://bphc.hrsa.gov/opa/howto.htm.* The commenters also stated that the GAO report focused solely on estimating providers' blood clotting factor delivery costs, which the GAO defined as inventory management, storage, shipping, and the provision of ancillary supplies. According to the commenters, the MMA directed us to establish a separate payment for items and services related to the furnishing of blood clotting factor that takes into consideration a wider range of items and services than the delivery costs addressed in the GAO report, for example patient education.

Response: We agree with the commenters that full-service hemophilia homecare companies provide services that may be of benefit to Medicare beneficiaries with hemophilia, such as disease and patient management activities. However, we do not believe that the scope of the furnishing fee includes these services. As noted above, Section 303(e) specifies the items and services that may be taken into consideration in setting the furnishing fee. Disease and patient management activities are not included in the items and services specified in Section 303(e). However, these activities may be more appropriately addressed through a future phase of the new Medicare Chronic Care Improvement Program.

The new Medicare Chronic Care Improvement Program is an important component of the MMA and demonstrates a commitment to improving and strengthening the traditional fee-for-service Medicare program. This program is the first large-scale chronic care improvement initiative under the Medicare fee-for-service program. We will select organizations that will offer self-care guidance and support to chronically ill beneficiaries. These organizations will help beneficiaries manage their health and adhere to their physicians' plans of care, and help ensure that they seek or obtain medical care that they need to reduce their health risks. More information regarding this program is available on the CMS Web site at *http://www.cms.hhs.gov/medicarereform/ccip/.*

With regard to the other costs identified in the comments and in the industry-sponsored survey, we also do not believe the scope of a furnishing fee includes costs associated with sales and marketing. We do not believe it is appropriate to build an explicit profit margin into the furnishing fee, but rather have the margin associated with the furnishing fee result from efficient furnishing of clotting factor. We agree with the commenters that the GAO report did not include amounts for education and that these are appropriate for the furnishing fee. Therefore, after removing the costs associated with sales and marketing, an explicit profit margin, and patient management, the resulting figure from the homecare survey is $0.14 per unit of clotting factor. We are establishing the furnishing fee for 2004 at $0.14 per unit of clotting factor. For years after 2005, the MMA specifies that the furnishing fee for clotting factor must be updated by the percentage increase in the consumer price index for medical care for the 12-month period ending with June of the previous year.

Comment: One commenter recommended that the beneficiary's 20 percent coinsurance not be applicable to this separate payment. The commenter indicated that the additional financial

burden would limit many beneficiaries' access to this lifesaving product.

Response: Under provisions designed to protect the Medicare program from fraud and abuse, a broad waiver of beneficiary cost sharing of the type the commenter recommends would not be permitted. However, we make no statement regarding the applicability of existing statutory and regulatory provisions that may allow for the waiver of cost sharing in certain cases.

4. Supplying Fee

Section 1842(o)(6) of the Social Security Act requires the Secretary to pay a supplying fee (less applicable deductible and coinsurance) to pharmacies for immunosuppressive drugs described in section 1861(s)(2)(J) of the Act, oral anticancer chemotherapeutic drugs described in section 1861(s)(2)(Q) of the Act, and oral anti-emetic drugs used as part of an anticancer chemotherapeutic regimen described in section 1861(s)(2)(T) of the Act, as determined appropriate by the Secretary. In the interim final rule published on January 7, 2004 (69 FR 1084), we considered this fee to be bundled into the current payment for these drugs for 2004 and did not establish a separately billable supplying fee.

Effective January 1, 2005, we proposed to establish a separately billable supplying fee of $10 per prescription for immunosuppressive drugs, oral anti-cancer chemotherapeutic drugs and oral anti-emetic drugs. We based this proposed fee on information provided by retail chain pharmacies on the costs of supplying these drugs to non-Medicare patients combined with steps to reduce the administrative burden associated with billing Medicare.

We also sought data and information on the additional services pharmacies provide to Medicare beneficiaries, the extent to which oral drugs can be furnished without these additional services and the extent to which such services are covered under Medicare. Additionally, we requested comments concerning whether the supplying fee should be somewhat higher during the initial month following a Medicare beneficiary's transplant to the extent that additional resources are required for example, due to more frequent changes in prescriptions for immunosuppressive drugs.

Comment: Several commenters stated that they were not in a position to determine whether the proposed $10.00 supplying fee was adequate since they did not know the actual 2005 payment rates for Part B drugs. These commenters indicated that the supplying fee needed to cover return on investment, the costs of supplying the drugs, and make up for any differences between the product costs and the ASP based payment for the drug. Some commenters indicated that aside from the adequacy of the ASP-based payment for the drug, a $10.00 supplying fee appeared to be too low. These commenters indicated that the average cost to a retail pharmacy to dispense a non-Medicaid third party or cash paying prescription ranges anywhere from $7.50–$8.00. The commenters indicated that Medicare should pay at least $2.00–$2.50 more per prescription since costs associated with supplying Medicare prescriptions are higher.

We received a comment from a large retail pharmacy indicating that a supplying fee of $25 would be adequate to cover the higher costs of dispensing Medicare Part B oral drugs.

We received comments from specialty immunosuppressive pharmacies that included information from a recent survey of their supplying costs. The survey indicated that the cost for specialty pharmacies to dispense Medicare Part B immunosuppressants is $35.48 per prescription. The specialty immunosuppressive pharmacies indicated that they provide services not typically provided by retail chain drug stores or large mail-order pharmacy benefit management companies. These services include direct patient care through pro-active pharmacist contact, expeditious processing and turnaround of medication orders, direct billing of Medicare and coordination of benefits on behalf of transplant patients to reduce the costs to the patients, and maintaining expensive immunosuppressant in stock to ensure timely receipt when needed by beneficiaries. These pharmacies also indicated that the retail chains typically do not supply immunosuppressive drugs or file Medicare claims.

Several commenters indicated that the lack of on-line adjudication for Medicare claims was one of the major drivers, among other reasons, for the additional costs of supplying Medicare prescription.

Response: We agree that the cost of supplying Medicare Part B oral drugs is higher than many other payers because of the lack of on-line adjudication for Medicare Part B oral drug claims. Due to operational issues, we do not anticipate the establishment of an on-line adjudication system in the near future. Accordingly, we believe it is appropriate to establish a supplying fee higher than the fees paid by some other payers with on-line adjudication. We note that many other payers with on-line adjudication have fees in the range of $5–$10 per prescription. We note that this is consistent with the approximately $8 cost for non-Medicaid dispensing stated by some commenters and described earlier. Other than administrative costs associated with billing Medicare Part B for oral drugs, we do not agree with commenters that the supplying fee for these drugs should exceed the dispensing fees of other payers because we do not believe there are other significant differences between supplying Medicare Part B and other oral drugs. We also do not agree that the supplying fee should include product costs. Product costs are paid through the ASP + 6 percent drug payment system. For the additional burden associated with billing Medicare Part B for oral drugs, we note the commenters who suggested an additional fee of approximately $2 for Medicare billing costs. Added to the $8 non-Medicaid fee described above, this would result in a supplying fee of approximately $10. We also note the survey of the specialty immunosuppressive pharmacies that indicated Medicare claims processing costs of approximately $8. This same survey also indicated total personnel costs of approximately $9, a portion of which we assume is attributable to the additional work associated with Medicare billings because the comments indicated Medicare billing was labor-intensive. Using the $5 to $10 figures for payers with on-line adjudication described above, the specialty pharmacy data on Medicare claims processing costs and personnel costs, we developed a range of possible supplying fees based on the specialty pharmacy data. Depending upon the portion of the personnel costs associated with Medicare billings, this would result in a supplying fee between a minimum of $13 (= $5 + $8) and a maximum of $27 (= $10 + $8 + $9). The comment of the large chain pharmacy recommending a $25 supplying fee indicated that this amount would be adequate to cover the costs of supplying Medicare Part B drugs including the additional costs of processing Medicare claims; however, this amount included a margin for profit. We do not believe it is appropriate to build an explicit profit margin into the supplying fee, but rather have the margin associated with the supplying fee result from efficient supplying of these drugs. Although the profit margin included in the $25 was not explicitly stated in the comment, if we assume a 5 percent margin, then a supplying fee of approximately $24 would cover the large chain pharmacy's

costs of supplying Medicare Part B drugs. We are not indicating that 5 percent is an appropriate margin.

There was variability in the submitted comments with respect to an appropriate supplying fee. On the low end, analysis of the submitted comments would indicate a supplying fee of $10. On the high end, the analysis would indicate a supplying fee of $27. Given the variability in the values and assumptions included in various calculations, we do not think it is appropriate to simply take the rounded midpoint of this range, $19, as the supplying fee. However, we do not think it appropriate to take the maximum amount of this range, $27, given that it is unlikely that all of the personnel costs indicated in the specialty pharmacy survey are related to the costs of billing for oral Medicare Part B drugs. The amount in the comment from the large chain pharmacy, after adjusting for a possible profit margin, or $24, is consistent with our belief that not all of the additional personnel costs identified in the specialty pharmacy survey are related to the costs of billing for oral Medicare Part B drugs. We are therefore establishing a per prescription supplying fee of $24 as the value consistent with both the large retail pharmacy comment (after making an adjustment for built-in profit margins) and the higher end of the broad range of the specialty pharmacy survey. Although we believe that a $24 supplying fee coupled with the ASP-based drug payment will not result in any access problems for Medicare beneficiaries, we will monitor access as we implement the new ASP-based payment system.

Comment: Some commenters recommended that we update the supplying fee annually. Some commenters indicated this fee should be updated by the average annual increase in the costs of pharmacies supplying these drugs to Medicare beneficiaries (costs such as rent, utilities and salaries), but no less than the increase in the medical care inflation index for the most recent twelve months for which it can be calculated before the next calendar year.

Response: We will study the issue of appropriate future increases for the supplying fee and proceed, as necessary, through notice and comment rulemaking.

Comment: A specialty organization suggested that we develop a sliding supplying fee, which would be calculated as a percentage of the cost that the pharmacy incurred in acquiring a particular drug.

Response: We do not agree that the supplying fee should vary by product costs. Product costs are paid through the ASP-based drug payment system.

Comment: Several commenters agreed with our suggestion to increase the supplying fee in the first month following a transplant, but recommended that we extend this increase to at least the first 3 months following the transplant. One commenter suggested that extra resources are associated with frequent changes in prescriptions during the initial month following a beneficiary's organ transplant. One commenter recommended a fee of $50 for an initial prescription fill. However, one commenter advocated against a supplying fee that distinguished between new and refill prescriptions stating that it would be impractical, of questionable benefit and would discourage long-term pharmacy-patient relationships as pharmacy providers would only have an incentive to serve patients in the short term.

Response: We agree that additional costs are most likely to occur nearer the time when the beneficiary has a transplant. In order to recognize these costs, we are establishing a higher supplying fee of $50 for the supplying of the initial oral immunosuppressive prescription in the first month after a beneficiary has a transplant because the costs of supplying immunosuppressives are likely to be higher immediately following a transplant, when the practitioner is adjusting the dose of immunosuppressive drugs. With regard to the comment opposing higher supplying fees for new patients regardless of their transplant date, we agree with the commenter that it would result in inappropriate incentives and are not implementing any such fee.

Comment: Commenters recommended that the supplying fee should account for the different prices paid by pharmacies and physicians, recognizing that these are separate classes of trade that may not have access to comparable pricing. Thus, we should increase the supplying fee associated with providing and overseeing the use of oral anti-cancer drugs.

Response: We do not agree that the supplying fee should vary by product costs. Product costs are paid through the ASP based drug payment system.

Comment: Commenters recommended that we extend the supplying fee to physicians that directly supply covered oral anti-cancer, immunosuppressive and oral anti-emetic drugs to patients, as well as create a dose management and compliance fee for physicians that prescribe oral chemotherapy products. These commenters state that we could use the premise that the MMA does not provide a definition of the word ''pharmacy'' and we could permit payment of a supplying fee to include a physician acting in the capacity of a pharmacist. Alternatively, commenters suggested that we use its inherent reasonableness authority to extend the supplying fee to physicians.

Response: Given our current understanding of Congressional intent, we do not believe it would be appropriate to pay a supplying fee to physicians. Moreover, we do not have sufficient data to determine whether our inherent reasonableness authority would apply in this instance. However, we will study these issues further.

5. Billing Requirements

In the proposed rule, we proposed the following changes to certain billing requirements and clarified policy for other billing requirements in an effort to reduce a pharmacy's costs of supplying covered immunosuppressive and oral chemotherapy drugs to Medicare beneficiaries:

• *Original signed order.* We clarified Medicare's policy regarding the necessity of an original signed order before the filling of a prescription. According to the Medicare Program Integrity Manual (section 5.1 of Chapter 5), which addresses the ordering requirement for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), including drugs, most DMEPOS items can be dispensed based on a verbal order from a physician. A written order must be obtained before submitting a claim, but that written order may be faxed, photocopied, electronic, or pen and ink. The order for the drug must specify the name of the drug, the concentration (if applicable), the dosage, and the frequency of administration. The clarification of this requirement should reduce a pharmacy's costs of supplying covered immunosuppressive and oral drugs to Medicare beneficiaries to the extent that pharmacies are currently applying an original signed prescription requirement.

Comment: Commenters recommended that a prescription be filled and billed based solely on a verbal order from a physician and an actual signed written prescription should not be necessary before billing.

Response: The policy that allows dispensing based on a verbal order but requires a written order for billing applies to all DMEPOS items. This policy balances fraud and abuse concerns with prompt dispensing of DMEPOS items to beneficiaries. We

point out that the written order from the physician can be faxed, photocopied, electronic, or pen and ink. We currently allow pharmacies to accept electronic prescriptions from physicians.

• *Assignment of Benefits Form.* We proposed to eliminate use of the Assignment of Benefits form for Part B items and services, including drugs, where Medicare payment can only be made on an assigned basis. For Part B covered oral drugs, this would be a means of reducing a pharmacy's costs of supplying these drugs to Medicare beneficiaries. Currently, pharmacies must obtain a completed Assignment of Benefits form in order to receive payment from Medicare. This requirement increases a pharmacy's cost of supplying covered drugs to Medicare beneficiaries, as other payers do not impose this requirement. Thus, we do not believe that it is necessary for an assignment of benefits form to be filled out for drugs covered under Part B, since payment for them can only be made on an assignment-related basis.

Comment: Some commenters suggested that the Assignment of Benefits form be eliminated for diabetic supplies dispensed by pharmacy suppliers.

Response: Our proposal to eliminate the Assignment of Benefits form applied to services where Medicare payment can only be made on an assigned basis. That is not the case with diabetic supplies. Thus, we are not eliminating the AOB form for diabetic supplies.

• *DMERC Information Form (DIF).* The DIF is a form created by the DMERC Medical Directors that contains information regarding the dates of the beneficiary's transplant and other diagnosis information. This form is a one-time requirement that pharmacies must complete in order to receive payment. Since section 1861(s)(2)(J) of the Act no longer imposes limits on the period of time for coverage of immunosuppressive drugs, we believe that the information on transplant diagnosis can be captured through other means (for example, diagnosis codes on the Part B claim form).

Comment: Several commenters applauded our efforts to eliminate use of the DIF in an effort to reduce the cost that the billing requirements imposed. These commenters asked that we ensure that this requirement is applied uniformly by all the DMERCs.

Response: We appreciate the support regarding the elimination of the DIF form. Action is being taken to eliminate the DIF form, including accommodating systems issues and providing for notifications. We anticipate resolution of issues to occur soon and elimination would occur next year.

• *Other Billing Issues.* We also received other comments regarding other billing issues related to the supplying of immunosuppressive, oral anti-cancer, and oral anti-emetic drugs.

Comment: Commenters suggested that we allow physicians to bill the carrier when oral drugs are provided directly by the physician in his office rather than having the physician bill the DMERC for the oral anti-cancer drug. Others stated that we should allow for billing for pharmaceutical products to be conducted on current electronic platforms, because ''batch billing'' creates operational and patient care problems, and adds significant participation costs. Commenters also stated that we should eliminate the requirement for a diagnosis code to be present on the prescription; while, at the same time, adopt the usage of the physician's DEA number instead of the UPIN number when submitting claims.

Response: We thank the commenters for identifying these issues. We plan to examine these aspects of billing.

6. Shipping Time Frame

In the proposed rule, we highlighted the fact that the guidelines regarding the time frame for subsequent deliveries of refills of DMEPOS products had been revised. Effective February 2, 2004, the shipping of refills of DMEPOS products may occur ''approximately'' on the 25th day of the month in the case of a month's supply. In the proposed rule, we emphasized the word ''approximately''; while we indicated that normal ground service shipping would allow delivery in 5 days, if there were circumstances where ground service could not occur in 5 days, the guideline would still be met if the shipment occurs in 6 or 7 days. This change should eliminate the need for suppliers to utilize overnight shipping methods and would permit the shipping of drugs via less expensive ground service.

F. Section 952—Revision to Reassignment Provisions

As discussed in the August 5, 2004 proposed rule, section 1842(b)(6)(A)(ii) of the Act, as amended by section 952 of the MMA, allows, in many circumstances, a physician or NPP to reassign payment for Medicare-covered services, regardless of the site of service, providing there is a contractual arrangement between the physician or NPP and the entity through which the entity submits the bill for those services. Thus, the services may be provided on or off the premises of the entity receiving the reassigned payments. The MMA Conference Agreement states that entities that retain independent contractors may enroll in the Medicare program. The expanded exception created by section 952 of the MMA applies to those situations when an entity seeks to obtain the medical services of a physician or NPP.

Section 952 of the MMA states that reassignment is permissible if the contractual arrangement between the entity that submits the bill for the service and the physician or NPP who performs the service meets the program integrity and other safeguards as the Secretary may determine to be appropriate. The Conference Agreement supports appropriate program integrity efforts for entities with independent contractors that bill the Medicare program, including joint and several liability (that is, both the entity accepting reassignment and the physician or NPP providing a service are both liable for any Medicare overpayments). The Conference Agreement also recommends that physicians or NPPs have unrestricted access to the billings submitted on their behalf by entities with which they contract. We incorporated these recommended safeguards in a change to the Medicare Manual, implementing section 952 of the MMA that was published on February 27, 2004. In the August 5, 2004 rule, we proposed to revise § 424.71 and § 424.80 to reflect these safeguards, as well as the expanded exception established by section 952 of the MMA.

Section 952 of the MMA revises only the statutory reassignment exceptions relevant to services provided in facilities and clinics (section 1842(b)(6)(A)(ii) of the Act). Section 952 of the MMA does not alter an individual or entity's obligations under any other applicable Medicare statutes or regulations governing billing or claims submission.

In addition, physician group practices should be mindful that compliance with the physicians' services exception and the in-office ancillary services exception to the physician self-referral prohibition in section 1877 of the Act requires that a physician or NPP who is engaged by a group practice as an independent contractor may provide ''designated health services'' to the group practice's patients only in the group's facilities. See the definition of physician in the group at 42 CFR 411.351.

We also cautioned that parties must be mindful that contractual arrangements involving reassignment may not be used to camouflage inappropriate fee-splitting arrangements

or payments for referrals. In the August 5, 2004 proposed rule, we solicited comments on potential program vulnerabilities and on possible additional program integrity safeguards to guard against those vulnerabilities.

Comment: We received positive comments for the proposed changes to the reassignment rules from two physician associations and one association representing non-physician practitioners.

Response: We are pleased to receive positive feedback to the changes to the reassignment rules. We believe these changes balance the need to respond to the changing business arrangements in the delivery of health care services with the need to protect the Medicare trust funds from fraudulent and abusive billing practices.

Comment: An association representing emergency medicine physicians and numerous members of that association commented that requiring independent contractor physicians to have unrestricted access to the billings submitted on their behalf is not sufficient to ensure such access. The commenters requested that we revise our regulations to require the entity submitting the bills to provide duplicates of the Medicare remittance notices (which indicate the services billed and the amounts paid for those services) to the independent contractor physicians. Some of the commenters requested that we require independent contractor physicians to receive itemized monthly reports of the claims submitted and remittances received on their behalf.

Response: We believe that requiring independent contractors to have unrestricted access to the billings submitted on their behalf is sufficient to satisfy the independent contractors' need to review the claims information.

We recognize that some independent contractors may not wish to receive copies of all bills submitted on their behalf. It would place an unnecessary burden on entities if we require them to furnish duplicate remittance notices to independent contractors on a routine basis. Similarly, it would place a significant burden on our claims processing systems if we were obligated to provide duplicate remittance notices to those who have reassigned their payments. We note that the method and frequency of obtaining access to billing records is an issue that the independent contractor and the entity to which the independent contractor is reassigning payments can resolve in their written contract.

Comment: A commenter asked whether or not the new reassignment exception (which essentially expanded or revised the previous exceptions pertaining to independent contractors), established by section 952 of the MMA, is available when one entity contracts with a second entity, which in turn contracts with a physician or non-physician practitioner to furnish services for the first entity.

Response: We refer to this situation as an indirect contractual arrangement between the independent contractor furnishing the service and the entity doing the billing and receiving payment (excluding billing agents). Thus, the reassignment is between the individual furnishing the service and the entity receiving the reassigned benefits. Indirect contractual arrangements were permissible prior to passage of section 952 of the MMA and remain permissible. The CMS–855–R enrollment form would need to be completed by the entity receiving the reassigned benefits and the person furnishing the service. In accordance with section 952 of the MMA, the contractual arrangement and any program integrity safeguard requirements deemed appropriate by the Secretary are between the independent contractor and the entity receiving the reassigned payments, with the program integrity safeguards applying to both parties. If the parties involved also wish to include the intermediary entity in a similar contract, and apply standards identical or similar to the program integrity safeguards to their arrangement, they have that option; but, it is not required or necessary to comply with the exception to the reassignment prohibition for contractual arrangements.

Comment: Several members of the Congress urged us not to delay the enrollment process of providers or suppliers while implementing section 952 of the MMA.

Response: We do not expect any delays in provider or supplier enrollment to result from implementing the reassignment provisions of this regulation. We are sensitive to the need for an efficient and timely enrollment process. If the new reassignment exception results in the submission of a particularly high volume of claims, or if a Medicare contractor has to process a large number of new enrollment applications, it is possible that delays may occur in some cases. A provider or supplier whose enrollment was delayed must contact the appropriate Medicare contractor's provider or supplier enrollment office to discuss the reasons for the delay.

Comment: A trade association of physician specialists asked that we clarify our definitions of onsite and off-site services. This trade association also requested that we further describe the potential program vulnerabilities that the revised Medicare reassignment exception might create.

Response: We consider onsite services to be services of an independent contractor that are performed in space owned or leased by the entity billing and receiving the reassigned payments. We consider offsite services to be services of an independent contractor that are performed in space that is not owned or leased by the entity billing and receiving the reassigned payments, that is, services performed off the premises.

The Congress originally passed the prohibition on reassignment provision due to experience with fraudulent and abusive billing practices. As we discussed in the preamble to the August 5, 2004 proposed rule, the new reassignment exception for contractual arrangements will potentially permit myriad relationships and financial arrangements. Some of these relationships may have the potential to increase fraudulent and abusive billing practices that the reassignment rules were designed to prevent. We also stated in the proposed rule that the new reassignment exception does not alter an individual's or entity's obligations under existing Medicare statutes and regulations (for example, the physician self-referral prohibition, the anti-kickback statute, purchased diagnostic test rules, incident to rules, etc.).

Comment: Several commenters expressed concern over the recent growth of so-called pod, salon, turnkey, mini-mall, or condo labs, especially since section 952 of the MMA appears to liberalize the Medicare reassignment rules.

As we understand the situation, some entities have created a building or a floor of a building that contains a number of cubicles, each of which is equipped with a microscope and other supplies that enable a pathologist to go to a particular cubicle or pod to analyze any tissue sample that is submitted by the group practice that rents pod space on a full-time basis. Apparently, some of the owners of these anatomical laboratories assert that each pod is a centralized location for a laboratory that is owned by a group practice. Other owners assert that each pod serves as an offsite office of a pathologist who works for a group practice as an independent contractor.

These entities market their services to specialists in certain disciplines, such as gastroenterology, urology, and dermatology, which rely on a high

volume of anatomic pathology services. The commenters stated that these lab arrangements are subject to excess, waste, and abuse, including, but not limited to: (a) Generation of medically unnecessary biopsies; (b) kickbacks; (c) fee-splitting; and, (d) referrals that would otherwise be prohibited under the physician self-referral statute.

The commenters agree with us that safeguards are necessary to prevent the increased incidence of fraudulent and abusive billing practices resulting from the new reassignment exception for contractual arrangements. To reach the goal of closing any loophole for excess, waste, and abuse opened by the new independent contractor reassignment exception, the commenters provided several suggestions. One commenter recommends that we add language to proposed § 424.80(d) that would prohibit a physician from making a reassignment to another physician, under the independent contractor exception, if the physicians do not practice in substantially the same medical specialty. This limitation would not apply if the entity accepting the assignment is a bona fide multi-specialty physician practice, meaning that it employs (on a W–2 basis) physicians who regularly practice in two or more specialties of medicine.

The commenters believe that the regulations need to state more clearly that all requirements of the purchased diagnostic test rules and purchased test interpretation rules need to be met. In other words, the commenters want to prevent the new reassignment exception from applying to services furnished by independent contractor pathologists.

These commenters are urging us to review these practices to see if they fail to meet existing obligations under the physician self-referral prohibition or anti-kickback statute. The commenters believe that these business arrangements are exploiting the in-office ancillary services exception and other exceptions to the physician self-referral prohibition.

Response: We appreciate comments that specify situations where fraud and abuse may occur and propose solutions to prevent such occurrences. While we decline to incorporate the commenters' suggested regulatory revisions at this time, we share the commenters' concerns. We will be paying close attention to this issue, and may initiate future rulemaking to address arrangements that are fraudulent or abusive.

To respond to commenters' concerns, we are amending the regulations governing reassignment at § 424.80(a) to clarify that nothing in § 424.80 alters an individual or entity's obligations under other Medicare statutes or rules, including, but not limited to, the physician self-referral prohibition (section 1877 of the Act), the anti-kickback statute (section 1128(B)(b)(1) of the Act), the regulations regarding purchased diagnostic tests, and regulations regarding services and supplies provided incident to a physician's services.

In response to the concerns expressed by the commenters, we wish to further expand on the fact that section 952 of the MMA did not affect the obligation of an individual or entity to comply with the physician self-referral prohibition (section 1877 of the Act and the corresponding regulations). As stated in the proposed rule, ''physician group practices should be mindful that compliance with the in-office ancillary services exception to the physician self-referral prohibition requires that a physician who is engaged by a group practice on an independent contractor basis must provide services to the group practice's patients in the group's facilities. As noted in the Phase I physician self-referral final rule (66 FR 887), ''we consider an independent contractor physician to be 'in the group practice' if: (1) He or she has a contractual arrangement to provide services to the group's patients in the group practice's facilities; (2) the contract contains compensation terms that are the same as those that apply to group members under section 1877(h)(4)(iv) of the Act or the contract fits in the personal services exception; and, (3) the contract complies with the reassignment rules * * * '' See also 66 FR 886.'' This test is specified at § 411.351 in the definition of physician in the group practice, which contains a premises requirement independent of the reassignment rules.

In addition, the use of independent contractors at off-premises locations may impact the ability of a group practice to meet the definition of a group practice at § 411.352 for purposes of complying with section 1877 of the Act. Accordingly, some group practices may need to be careful about the number of physician-patient encounters that independent contractors perform off-premises to ensure that they meet the 75 percent patient-physician encounters test as set forth in § 411.352(h).

We will continue to monitor compliance with the reassignment rules and we will analyze the impact of the physician self-referral prohibition on ''pod'' labs. If we determine that changes to the physician self-referral prohibition are necessary, these changes will be made in a separate rulemaking document.

Comment: We received a number of comments and recommendations from three organizations that utilize the services of independent contractor emergency department physicians. One of the three organizations represents management companies that employ independent contractor emergency department physicians. The commenters believe that the changes to the reassignment rules necessitated by section 952 of the MMA should be implemented in a manner that does not impose additional burdens on the Medicare enrollment process. They believe that implementation of the proposed regulations could impede the enrollment process. They expressed concern that amendments to current contracts might be necessary to incorporate the program integrity safeguards included in the proposed regulations. Since they believe requiring contract amendments would be burdensome and costly to hospitals, they are urging us not to require parties to amend their contracts to reflect the program integrity safeguards that we proposed.

Response: We do not believe that implementation of the proposed regulations will impede the enrollment process. Our proposed regulations would not require parties to amend their contracts to reflect the program integrity safeguards. We plan to include the program integrity safeguard requirements on the CMS–855–R enrollment form. The program integrity safeguards will apply to arrangements entered into pursuant to the new reassignment exception for contractual arrangements, regardless of whether the parties reference the safeguards in their contracts.

Comment: Three commenters representing groups that utilize independent contractor emergency physicians strongly oppose our implementation of the two proposed program integrity safeguard requirements: (1) Joint and several liability/responsibility for Medicare overpayments; and (2) unrestricted access to the billings for services provided by independent contractors. The commenters believe that establishing program integrity safeguards is premature and that we should first formally assess the need for such safeguards. These commenters also ask us to clearly define joint and several liability/responsibility. They express concern over our attempt to impose joint and several liability/responsibility on both the contracting entity and practitioner furnishing the services and

note that the CMS–855–R enrollment form certification holds the enrolling provider or supplier responsible for any Medicare overpayments. The commenters argue that we should impose these program integrity safeguards on employer/employee relationships if we are going to impose them on contractual arrangements. The commenters ask how we would monitor compliance with joint and several liability/responsibility. The commenters also have concerns about regulating access to claims submitted by an entity for services furnished by an independent contractor. In their view, this type of requirement should be part of the compliance programs of entities and employers rather than mandated as part of the reassignment rules.

Response: We disagree with the commenters' assertion that it is premature to implement the proposed program integrity safeguards. Section 952 of the MMA specifically authorizes the Secretary to implement program integrity safeguards. Further, in the Conference Report to the MMA, the Congress specifically highlighted the two program integrity safeguards that we have proposed.

Our assessment of the need for program integrity safeguards is based upon prior experience with certain types of entities and their subsidiary billing companies. For example, on April 6, 2000, Lewis Morris, Assistant Inspector General for Legal Affairs, Office of Inspector General (OIG), U.S. Department of Health and Human Services, testified before the House Committee on Commerce, Subcommittee on Oversight and Investigations regarding Medicare and third-party billing companies. Mr. Morris of the OIG detailed the upcoding activities of two firms that provided billing services for entities contracting with emergency department physicians. One firm paid $15 million and the other paid $15.5 million to settle their respective liabilities. Moreover, as we have noted, we have received numerous comments from physicians stating that they have been prevented from seeing the Medicare remittance notices for services they furnished, on penalty of termination.

In addition, we understand the commenters' concerns that if the Agency plans to implement the two proposed program integrity safeguards, we should apply these same program integrity safeguards to employees, as well as to independent contractors. Joint and several responsibility/liability and unrestricted access to billings may or may not be appropriate for employees and employers as it is for the parties involved in contractual arrangements. CMS will study this issue further, and if necessary will address it in a separate rulemaking document.

We use the words responsibility and liability interchangeably, and in the context of claims filing and payment, they both have the same meaning. We define joint and several liability/responsibility to mean that both the person furnishing a service and the entity billing for that service (and to which payments have been reassigned) can be held liable or responsible for any errors in billing that result in a Medicare overpayment, including, but not limited to, upcoding and billing for services never rendered.

We will monitor the program integrity safeguards as we monitor all other program integrity requirements. We also believe that entities and independent contractors will report violations to us, since both may be held responsible for any Medicare overpayments. If an independent contractor is refused access to the billings submitted on his or her behalf, the independent contractor may report this to the appropriate Medicare contractor.

Comment: An organization representing entities that use independent contactor emergency department physicians believes if we retain the proposed program integrity requirements, then these requirements should be clarified and included in other reassignment exceptions and in other Medicare conditions of participation.

Response: It is our goal to have the program integrity requirements identified and included on the appropriate CMS–855–R enrollment form. As we have discussed above, while we will study whether it is appropriate to extend the program integrity safeguards to employer/employee relationships, we do not believe it is necessary to include the program integrity requirements in other reassignment exceptions (or in other Medicare conditions of participation) at this time.

Comment: Three commenters representing organizations that use independent contractor emergency physicians recommend that we revise our definition of entity to specifically identify the types of entities that are listed in the Conference Report to section 952 of the MMA. They believe that our existing definition which defines entity as a person, group or facility enrolled in the Medicare program is ambiguous and inconsistent with Congressional intent. Therefore, they are recommending that we add the language to the definition that specifies that an entity includes but is not limited to, a hospital, clinic, medical group, a physician practice management organization, or a staffing company. One of the commenters opposes stating that entities need to be enrolled in Medicare in the definition of entity because the commenter believes it is not necessary to include such information in the regulations on reassignment. This commenter believes that instructions on enrollment should be addressed in an enrollment regulation. The commenter also states that our current reassignment regulation does not define facility as a hospital or other institution enrolled in the Medicare program. These groups believe that their proposed definition of entity more accurately reflects the language from the Statement of the Managers filed by the MMA Conference Committee and is included in the Conference Report (Conference Agreement). Finally, these groups do not believe that a definition of entity is necessary, since we do not define employer in the reassignment regulations definition section.

Response: We continue to believe that our definition of entity in the proposed rule is appropriate. We believe that defining entity as a person, group, or facility that is enrolled in Medicare encompasses all entities that are allowed to bill and receive payment from Medicare, and does not prevent those entities that were specifically identified in the Conference Report from benefiting from the new contractual arrangement reassignment exception. We will not specifically include a staffing company in the definition of entity because a staffing company cannot enroll in Medicare as a staffing company. Staffing companies can enroll as either a group practice or clinic, depending on how they are licensed or allowed to do business in the state where they are located. We further believe that a definition of entity is necessary to distinguish between entities that are allowed to reassign their right to payment and to receive reassigned payments from entities that are not allowed to reassign their right to payment or to receive reassigned payments (for example, billing agents, entities that provide services under arrangements, and substitute physicians, (for example, locum tenens physicians or physicians working on a reciprocal basis) all of which are not required to enroll in Medicare).

Comment: Three commenters representing organizations that use independent contractor emergency physicians found our use of the term supplier confusing when denoting the physician or non-physician practitioner

that contracts with an entity and reassigns his or her right to bill and receive payment. Specifically, the commenters found the proposed revision to § 424.80(c) (Prohibition on reassignment of claims by suppliers) confusing because it refers to a hospital or facility as the supplier of services for purposes of the reassignment revision when Medicare already has regulations that separately define provider and supplier. The commenters recommend that we clarify our intent regarding the use of the term supplier.

Response: In instances of reassignment, the supplier is the person furnishing the service and reassigning his or her right to bill and receive payment to another entity. This is consistent with our definition of supplier in § 400.202. In our proposed revision to § 424.80(c), we state that the employer or entity is considered to be the supplier of the services for subparts C, D, and E of this part, subject to the provisions of paragraph (d) of the section. Once a supplier reassigns his or her right to receive Medicare payments, the entity receiving the reassigned payments essentially takes the place of the supplier. We have revised § 424.80(c) to reflect the new contractual arrangement reassignment exception. The existing § 424.80(c) includes the same formulation and we have simply proposed to replace the words ''facility'' and ''system'' with ''entity,'' because the new exception for payment to an entity under a contractual arrangement now replaces the previous exceptions for payment to a facility or health care delivery system.

Comment: Three commenters that use independent contractor emergency physicians expressed concern about our statement in the preamble to the proposed rule that the new reassignment exception may create fraud and abuse vulnerabilities, which may not become apparent until the program has experience with the range of contractual arrangements permitted by the new reassignment exception. These groups do not believe that the new reassignment exception will result in an increase in violations of the types addressed in the preamble to the proposed rule. The groups also disagree with our statement in the preamble to the proposed rule that contractual arrangements with independent contractor physicians may be used to camouflage inappropriate fee-splitting arrangements or payment for referrals. These groups state that Medicare does not govern fee-splitting arrangements, that policing such arrangements is a matter of State law, and that Medicare reassignment policy has no direct effect on this issue. They question why we have expressed concern over potential violations of the physician self-referral prohibition, because section 952 of the MMA does not affect or otherwise change the obligation of providers and suppliers to comply with the physician self-referral prohibition and its accompanying regulations.

Response: The Congress originally passed the prohibition on reassignment provision because of increasing fraud and abuse in billing practices. Since the new reassignment exception has expanded the circumstances under which suppliers can reassign their right to receive Medicare payments, we are concerned that the potential exists for an increased incidence of fraud and abuse, which may not become apparent until the program has experience with the range of contractual arrangements permitted by the new reassignment exception. Fee-splitting arrangements may violate the physician self-referral prohibition and the anti-kickback statute. Preventing fraudulent and abusive billing practices continues to be the primary purpose of the reassignment rules, even as they are amended to reflect changing practices in the delivery of health care.

We agree that section 952 of the MMA does not change the obligations of providers and suppliers under the physician self-referral prohibition, and all other Medicare statutes and regulations. We are incorporating this clarification in § 424.80(a).

Comment: Three organizations that use independent contractor emergency physicians raised procedural concerns regarding the timing of the final rule, which is effective January 1, 2005. The commenters claim that providers and suppliers do not have time to comply with the new program integrity safeguards. They are asking us to provide providers and suppliers with an additional time frame of at least six months for compliance with the program integrity safeguards, if they are finalized. They recommend that we make the new safeguards applicable to enrollment applications submitted on or after the effective date of the final rule.

Response: We do not believe additional time is necessary for compliance with the program integrity safeguards. Providers and suppliers will not have to amend contracts to include the proposed program integrity requirements. Thus, enrollment applications are not affected by this regulation. The program integrity safeguards will be effective on the effective date of this final rule and these requirements will be applicable to all Medicare providers and suppliers affected by the section 952 change to the reassignment rules.

Comment: One commenter believes that the public comment period for this rule was shortened to 50 days instead of the 60-day comment period required by statute. The proposed rule was published in the **Federal Register** on August 5, 2004 and the public comment period ended at 5 p.m. on September 24, 2004.

Response: While the law requires that we provide a 60-day public comment period and that the notice of proposed rulemaking be published in the **Federal Register**, it does not require that the date of **Federal Register** publication be the first day of the comment period. The two requirements are independent. We post the proposed rule on our Web site on the date of display of the proposed rule at the Office of the Federal Register, satisfying the requirement for a 60-day comment period. By making the proposed rule available on the CMS Web site (as well as at the Office of the Federal Register), we provided the public with access to not only the proposed rule, but also to all of the supporting files and documents cited in the proposed rule in a manner that can be used for analysis. We note that the computer files posted on the Web site can be used for independent analysis. Therefore, we believe that beginning the comment period for the proposed rule with the display date at the Office of the Federal Register, and posting the proposed rule and data files on the CMS Web site on the display date, fully complies with the statute and provides a far better opportunity for the public to have meaningful input than the past practice under which the comment period began with the publication date in the **Federal Register**, a week or longer after the display date and no other data in any other form was furnished.

G. Section 642—Extension of Coverage of IVIG for the Treatment of Primary Immune Deficiency Diseases in the Home

In the August 5, 2004 proposed rule, we stated that for dates of service beginning on or after January 1, 2004, Medicare would pay for IVIG administered in the home. The benefit is for the drug and not for the items or services related to the administration of the drug when administered in the home, if deemed medically appropriate. The implementing instructions for this benefit were provided in a transmittal released on January 23, 2004. We received several comments regarding this new benefit. The comments and our responses are provided below.

Comment: Several commenters expressed concern regarding the lack of coverage for the items and services needed to administer IVIG. These commenters urged us to use our authority to pay for the items that are necessary for the effective use of IVIG.

Response: The MMA provided coverage for the approved pool plasma derivative for treatment in the home; however, new section 1861(zz) of the Act specifically precludes coverage for the items and services related to the administration of the derivative.

Comment: The commenter stated that on January 23, 2004, we released a transmittal implementing the new IVIG coverage. The transmittal contained the following language: ''for coverage of IVIG under this benefit, it is not necessary for the derivative (IVIG) to be administered through a piece of durable medical equipment.'' Commenters stated that this language has resulted in the denial of coverage of IVIG for patients because providers are using the rationale that it is medically unnecessary to infuse IVIG through an infusion pump and therefore IVIG is medically unnecessary. The commenters recommended that we issue a new transmittal stating that IVIG is to be covered even when administered through durable medical equipment (DME), as determined necessary by a physician.

Response: It was not our intention to deny any beneficiary the coverage of IVIG in the home. It appears that the sentence that references the use of DME for the administration of IVIG is both confusing and misleading. Therefore, we will issue a new transmittal removing the apparent DME restriction.

Result of Evaluation of Comments

We are finalizing the proposed revisions to § 410.10 without alteration.

H. Section 623—Payment for Renal Dialysis Services

Section 623 of the MMA amended section 1881(b) of the Act and directed the Secretary to revise the current renal dialysis composite rate payment system. The MMA included several major provisions that require the development of revised composite payment rates for ESRD facilities.

The following is a summary of the proposed revisions to the composite payments rate methodology implementing provisions in section 623 of the MMA that are required to be effective January 1, 2005.

- The proposed rule provides for a 1.6 percent increase to the current composite payment rates effective January 1, 2005.
- The proposed rule included an add-on to the composite rate for the difference between current payments for separately billable drugs and payments based on a revised drug pricing methodology using acquisition costs. For purposes of this adjustment, in the proposed rule, we defined acquisition costs as the ASP minus 3 percent. We proposed a single adjustment to the composite payment rates for both hospital-based and independent facilities, equal to 11.3 percent.
- In the proposed rule, we discussed the reinstatement of the ESRD exceptions process for pediatric facilities as provided in section 623(b) of MMA. The statute defines pediatric ESRD facilities as renal facilities at least 50 percent of whose patients are under age 18. Since April 1, 2004, we have accepted ESRD composite rate exception requests from ESRD facilities that believe they qualify for exceptions as pediatric ESRD facilities.
- Section 1881(b)(12)(D) of the Act, added by section 623(d)(1) of the MMA gives the Secretary discretionary authority to revise the current wage indexes and the urban and rural definitions used to develop them. In the proposed rule, we proposed to take no action at this time to revise the current composite rate wage indexes. Because of the potential payment implications of recently revised definitions of urban areas, we believe further study is required.
- The proposed rule described the proposed methodology for a case-mix adjustment to a facility's composite payment rate based on the statutorily required limited number of patient characteristics. We used co-morbidity data for all Medicare ESRD patients obtained from the Form CMS–2728, supplemented with co-morbidity information obtained from Medicare claims. We measured the degree of the relationship between specified co-morbidities and ESRD facility per treatment costs, controlling for the effects of other variables, using standard least square regression. The source of the per treatment costs was the Medicare cost report. The result, after all necessary statistical adjustments, was a set of eight case-mix adjustment factors based on age, gender, AIDS, and peripheral vascular disease (PVD). Section 623(d)(1) of the MMA requires that aggregate payments under the case-mix adjusted composite payment system be budget neutral. Therefore, the proposed rule provided an adjustment 0.8390 to be applied to a facility's composite payment rate to account for the effects of the case-mix adjustments.

A. Composite Rate Increase

The current composite payment rates applicable to urban and rural hospital-based and independent ESRD facilities were effective January 1, 2002. Section 623(a)(3) of the MMA requires that the composite rates in effect on December 31, 2004 be increased by 1.6 percent. The updated wage adjusted rates were published in Tables 18 and 19 of the proposed notice.

The tables reflected the updated hospital-based and independent facility composite rate of $132.41 and $128.35, respectively, adjusted by the current wage index. The rates shown in the tables do not include any of the basic case-mix adjustments required under section 623 of the MMA.

Comment: Although there were no specific comments on the 1.6 percent adjustment, several commenters wanted to emphasize the importance of providing an annual adjustment to the composite rate in order to recognize the increased costs that face renal dialysis facilities. They stated that failure to increase the composite rate on a regular basis has caused dialysis providers to suffer a significant loss of income from their Medicare reimbursement and that dialysis facilities are the only Medicare entities that do not receive a statutorily mandated annual increase in their reimbursement rates.

Response: We do not have the authority to establish an annual update to the composite payment rates. Section 4201(a)(2) of Pub. L. 101–508 effectively froze the methodology for calculation of the rates, including the data and definitions used as of January 1, 1991. Since that time, the Congress has set the composite payment rate for ESRD services furnished to Medicare beneficiaries. As a result, we do not have the authority to update the composite payment rate.

B. Composite Rate Adjustments To Account for Changes in Pricing of Separately Billable Drugs and Biologicals

Section 623(d) of MMA provides for an add-on to the composite rate for thedifference between current payments for separately billable drugs and payments based on a revised drug pricing methodology using acquisition costs.

In the proposed notice we proposed to pay for separately billable ESRD drugs using ASP minus 3 percent based on the average relationship of acquisition costs to average sales prices from the drug manufacturers as outlined in the OIG report. We developed the proposed drug add-on adjustment using the ASP minus

3 percent drug prices. As discussed below, the drug add-on adjustment for this final rule is based on average acquisition costs for the top ten ESRD drugs updated to 2005 and ASP plus 6 percent for the remaining separately billable ESRD drugs. *See* section III.E, Payment for Covered Outpatient Drugs and Biologicals, for a discussion of the final payment methodology for ESRD separately billable drugs.

In the proposed notice, we outlined the methodology and data used to develop the proposed drug add-on adjustment to the composite rate of 11.3 percent for both hospital-based and independent ESRD facilities. Since the composite rate payment for hospital-based facilities is higher than the composite rate for independent facilities, the proposed adjustment results in a higher payment rate for hospital-based facilities. The 2005 composite rates (including the 1.6 percent increase) would be $132.41 for hospital-based facilities and $128.35 for independent facilities with the hospital-based facilities' rate higher by $4.06. We found this result consistent with section 1881(b)(7) of the Act, which requires that our payment methods differentiate between hospital-based facilities and others. We also indicated that the proposed methodology for making this drug add-on adjustment to the composite rate is designed to ensure that the aggregate payments to ESRD facilities for separately billable drugs would be budget neutral with what would have been paid absent the MMA provisions.

The proposed rule also discussed an alternative approach that produced separate adjustments to the composite rate of 2.7 percent for hospital-based and 12.8 percent for independent facilities. In contrast to a single add-on, separate add-on adjustments would result in a significantly higher composite payment rate for independent facilities than hospital-based facilities, of $8.79 more per treatment.

Comment: We received many comments from independent facilities, chain organizations and groups objecting to our proposal to establish a single add-on adjustment to the composite payment rate. Several commenters expressed concern that since hospital-based facilities are paid reasonable cost for their separately billed drugs other than EPO, those facilities should receive an adjustment based only on the spread related to EPO payments. They stated that our proposal to spread the drug savings to all facilities does not comply with the provision in the statute that they believe is intended to hold facilities harmless with respect to their drug payment profit margins. The commenters also contend that since hospital-based facilities already receive about $4.00 per treatment more than independent facilities, they should not share in the drug add-on adjustment for other than their specific EPO usage.

Response: As we indicated in the proposed rule, we believe that the statutory language supports one uniform drug add-on adjustment to composite payment rates set forth in section 1881(b)(7) of the Act after updating by 1.6 percent. The provision speaks of one ''difference between payment amounts'' and ''acquisition costs * * * as determined by the Inspector General.'' It is reasonable to infer that the Congress intended us to compute one ''difference'' based only on the payment amounts under sections 1842(o) and 1881(b)(11) of the Act.

Although the language of section 1881(b)(7) contemplates differential composite rates for hospital-based facilities and 623(d) contemplates existing composite rates as the starting point for application of the new rate adjustments prescribed under section 1881(b)(12)(A) of the Act, the MMA language does not suggest that these adjustments would be applied differentially across facilities. Otherwise, all of the adjustments, including case-mix and budget neutrality would have to be developed separately based on facility type.

We note that the amount of the drug add-on has decreased significantly from the proposed rule as a result of our revised policy of paying for ESRD drugs for 2005. Since the drug payment amounts increased, the amount of the drug add-on to the composite rate decreased. The resulting drug add-on amount is now 8.7 percent.

We also note that there is not a significant difference in composite rates for independent facilities under single and separate add-ons. With a single add-on of 8.7 percent, the 2005 composite rate for independent facilities would be $139.52. Under a separate add-on approach, the 2005 composite rate for independent facilities would be $140.93, a difference of $1.41 or about 1 percent before taking other considerations into account. This difference is about 27 percent less than the difference based on the approach and figures in the proposed rule.

While a composite rate difference of $1.41 is important, such difference does not take into account two other factors: (1) Since Medicare's 2005 payments for ESRD drugs will be a weighted average of the acquisition costs determined by the Inspector General, the payment amounts for the most utilized ESRD drugs (such as EPO) will be significantly higher than payment based on ASP–3 percent; and (2) Beginning with 2005, Medicare will pay separately for syringes that are currently included in the EPO payments.

With separate add-ons, the composite rate for the independent facilities would be $7.33 higher than the composite rate for hospital-based facilities. However, the composite rate for hospital-based facilities would be $10.33 lower under separate add-ons than under a single add-on approach. We believe the current difference in composite rates where the hospital-based rate is about $4.00 higher than the independent facility rate would effectively be preserved with a single add-on and significantly reversed with separate add-ons.

Finally, we note that a key purpose of the MMA legislation was to eliminate the cross-subsidization of composite rate payments by drug payments. If the composite rate was inadequate before the MMA provision, it was inadequate for both hospital-based and independent facilities. As such, increasing the composite rate by relatively greater amounts for independent facilities than hospital-based facilities would place the latter facilities at a competitive disadvantage relative to the former facilities.

Comment: One comment from a drug manufacturer suggested that in order to preserve high quality care to ESRD patients and prevent cost shifting behavior, we should require a facility to provide the full range of separately reimbursable drugs and biologicals in order to receive the drug add-on adjustment.

Response: We do not believe the statute permits imposing such a requirement as a condition for receiving the add-on adjustment to the composite rate. However, other regulations require that ESRD facilities provide appropriate care to each patient based on a plan of care that would include the administration of medically necessary drugs as prescribed by the patient's dialysis physician.

1. Growth Factors Used To Update Drug Expenditures and Prices

Comment: One commenter noted that, in the proposed rule, we updated the 2004 ASP drug prices to 2005 prices by using the projected annual growth factor for National Health Expenditures prescription drugs of 3.39 percent. This commenter wanted to know why we did not use the actual growth factors for separately billable drugs that are furnished by ESRD facilities to ESRD

patients. The commenter states that this factor is currently running about 39 percent.

Response: After consideration of the available price data, as discussed in the section on payment for ESRD separately billable drugs, we have determined that the Producer Price Index (PPI) for prescription preparations is the most appropriate price measure for updating EPO and other separately billable drugs from 2003 to 2005. The PPI for prescription preparations is released monthly by the Bureau of Labor Statistics, and reflects price changes at the wholesale or manufacturer stage. By comparison, the Consumer Price Index (CPI) for prescription drugs reflects price changes at the retail stage. Because EPO and many of the separately billable drugs used by dialysis facilities are purchased directly from the manufacturer, the use of a price index that measures wholesale rather than retail prices is more appropriate. The PPI for prescription drugs is the measure used in the various market baskets that update Medicare payments to hospitals, physicians, and skilled nursing facilities, and home health agencies. In addition, the PPI for prescription drugs was recommended for use in the proposed composite rate market basket detailed in the 2003 Report to the Congress.

Based on historical data through the second quarter of 2004, we used the Global Insight Inc. forecast of the PPI for prescription drugs to determine the update factors for 2004 and 2005. We feel the use of an independent forecast, in this case from Global Insight Inc., is superior to using the NHE projections for drug prices (which is the CPI for prescription drugs) and is consistent with the methodology used in projecting market basket increases for Medicare prospective payment systems.

Comment: One comment questioned the 3 percent growth rate that we used in the proposed rule to estimate 2005 Medicare AWP payment amounts for purposes of calculating the drug add-on amount. Specifically, the commenter asked whether the 3 percent figure represented the AWP growth trends for all drugs as opposed to the AWP growth trends for only ESRD separately billable drugs and biologicals. The commenter also asked for clarification of the timeframe used to establish the historical trend.

Several comments also expressed concern that we used a 10-quarter average as an approximation for 2002 expenditures, and as a result, the projected 2005 drug expenditures were understated. These comments strongly recommended that we establish an accurate baseline using actual 2002 expenditures. A study performed for commenters by an industry consultant was cited as confirming that our base year estimate is materially below actual drug spending computed using CMS's 2002 Outpatient Five Percent Standard Analytic File (SAF). Commenters were also concerned that the drug add-on does not reflect the true difference between payments under the current system and acquisition costs described by the OIG.

Response: We have taken all these comments into consideration and have re-evaluated our 2005 projection of aggregate ESRD facility drug expenditures. We did not use an average over 10 quarters to determine aggregate drug payments. The 10 quarters of data were used only to establish historical growth trends. However, we determined that our estimates of aggregate drug payment amounts were in fact understated because they did not include deductibles and coinsurance. Since drug payment rates are set at 100 percent of the allowable payment, we incorrectly calculated the aggregate drug payment for 2005. We revised our calculation to ensure that we capture the allowable payment before deductible and coinsurance are removed. In addition, we updated our estimates to incorporate the June 2004 update to the 2003 standard analytical file. The 3 percent growth represents our best estimate of the expected growth rate in AWP prices. In addition, due to numerous coding changes for the various ESRD drugs, we were unable to do direct comparisons for each of the AWP prices from year-to-year. Therefore, we believe the 3 percent inflation factor we used to update the AWP prices is appropriate.

Comment: One comment expressed concern that the projected number of dialysis treatments in 2005 would be overstated if home peritoneal dialysis (PD) treatments for home patients are included because facilities do not bill for non-EPO drugs in that setting.

Response: Since ESRD facilities also receive composite rate payments for their Method I home patients, the drug add-on would also apply to composite rate payments for those patients. Therefore, it is appropriate for us to count those treatments in projecting the number of dialysis treatments for computation of the drug add-on amount. We did not, however, count treatments attributable to Method II home patients since payment for these patients is made based on reasonable charges as opposed to the composite rate.

Comment: One comment from a patient organization raised concern that the add-on provision would remove any incentives the current payment policy creates for facilities to provide separately billable drugs and biologicals to dialysis patients. This comment suggested that we establish new clinical guidelines or indicators to ensure that dialysis patients receive necessary drugs and biologicals. This commenter also asked whether we have longer term plans to revise payment for dialysis treatment and ancillary services.

Response: We share this commenters concern that changes in payments to dialysis facilities could produce perverse incentives for dialysis facilities to skimp on care to ESRD patients. In order to ensure that patients continue to receive quality care, we are revising the ESRD facility conditions for coverage so that they are more patient-centered and outcome-oriented. We will publish proposed ESRD conditions by the end of 2004. We note that section 623 of MMA also requires us to develop a bundled, case-mix adjusted payment system and report to the Congress by October 1, 2005. This section also requires the establishment of a demonstration to test the revised payment system over a 3-year period beginning January 1, 2006.

2. Update Methodology for Drug Add-on Adjustment in 2006

Comment: Several commenters recommended that we publish the methodology that we intend to use to update the drug add-on component of the basic case-mix adjusted payment amounts, beginning in 2006, and that we provide the opportunity for public comment.

Response: We did not propose a mechanism for updating the 2006 payments in this document since this rule addresses payment for 2005. It is our intent to publish a proposed rule in mid-2005 to address payment changes for 2006. The public will be given an opportunity to comment on those proposals at that time.

3. Computation of Final Drug Add-On Adjustment to the Composite Payment Rate

To develop the final drug add-on adjustment we used historical total aggregate payments for separately billed ESRD drugs for half of 2000 and all of 2001, 2002 and 2003. For EPO, these payments were broken down according to type of ESRD facility (hospital-based versus independent). We also used the 2003 data on dialysis treatments performed by these two types of facilities over the same period.

I. 2005 Average Acquisition Payment (AAP) Amounts

The OIG report contained 2003 average acquisition costs for the top ten drugs supplied by the four largest dialysis chain organizations and by a sample of those facilities not managed by the four largest chain organizations. According to the OIG report, these ten drugs accounted for about 98 percent of total expenditures for separately billed drugs furnished by ESRD facilities. The report also indicated that payment to the four largest dialysis chains accounted for 73 percent of Medicare drug reimbursement in 2002. Therefore, we weighted the average acquisition costs using a 73–27 split. As discussed earlier, we then updated the 2003 weighted average acquisition costs to arrive at the 2005 AAP amounts by using the PPI for prescription drugs. These factors were 4.81 percent and 3.72 percent for 2004 and 2005, respectively.

TABLE 9:

	2003 Average Acquisition Costs	2005 Average Acquisition Payment Amounts
Epogen	$8.98	$9.76
Calcitriol	0.88	0.96
Doxercalciferol	2.39	2.60
Iron dextran	10.07	10.94
Iron sucrose	0.34	0.37
Levocarnitine	12.53	13.63
Paricalcitol	3.68	4.00
Sodium ferric glut	4.55	4.95
Alteplase, Recombinant	29.19	31.74
Vancomycin	2.74	2.98

II. Estimated 2005 Medicare Payment Amounts Based on 95 Percent of AWP

We estimated what Medicare would pay for ESRD drugs in 2005 if the MMA had not been enacted. We adjusted the first quarter 2004 Medicare payment amounts (95 percent of AWP), based on the prices from the January 2004 Single Drug Pricer, for drugs other than EPO, to estimate 2005 prices by using an estimated AWP growth of 3 percent. As discussed earlier, these growth factors are based on historical trends of AWP pricing over years. We did not increase the price for Epogen since payment was maintained at $10.00 per thousand units prior to MMA.

TABLE 10:

Drugs	Estimated 2005 Pre-MMA Medicare Payment Amounts
Epogen	$10.00
Calcitriol	1.42
Doxercalciferol	5.67
Iron dextran	18.45
Iron sucrose	0.68
Levocarnitine	35.23
Paricalcitol	5.49
Sodium ferric glut	8.42
Alteplase, Recombinant	37.80
Vancomycin	7.24

III. Dialysis Treatments

We updated the number of dialysis treatments based on 2003 data by actuarial projected growth in the number of ESRD beneficiaries. Since Medicare covers a maximum of three treatments per week, utilization growth is limited, and therefore any increase in the number of treatments will be due to enrollment. In 2005, we project there will be a total of 34.8 million treatments performed.

IV. Estimated Drug Spending

We updated the total aggregate 2003 Epogen drug spending for hospital-based and independent facilities using historical trend factors. For 2004 and 2005, we increased the 2003 spending levels by trend factors of 1.0 percent for hospital-based facilities and by 10.0 percent for independent facilities based on historical growth from 2000 to 2003.

We also updated the aggregate AWP based spending for separately billed drugs, other than EPO, for independent facilities by using the 10 percent growth factor for Epogen. Since aggregate spending in this category show extremely varied growth in recent history, we could not establish a clear growth trend. For this reason we decided to apply the Epogen growth rate to the other separately billed drugs. Given the problems establishing growth trends for the other drugs, plus the fact the expenditures for Epogen account for about 70 percent of the total spending for the top ten ESRD drugs, we believe this approach to updating all of the separately billed drugs is appropriate.

Additionally, we deducted 50 cents for each administration of Epogen from the total Epogen spending for both hospital based and independent facilities, to account for payment for syringes that is currently included in the EPO payments. Payment for syringes used in administering EPO will be made separately beginning January 1, 2005. In 2005, we estimate that the total spending for syringes associated with the administration of Epogen will amount to $1.6 million for hospital-based facilities and $27 million for independent facilities. For 2005, we estimate that the total spending for Epogen provided in hospital-based facilities will be $210 million, and $2.913 billion for drugs provided in independent facilities ($2.003 billion for Epogen and $910 million for other drugs).

V. Add-On Calculation and Budget Neutrality

For each of the ten drugs in the previous tables, we calculated the percent by which 2005 AAP amounts are projected to be different from the payment amounts under the pre-MMA system. For Epogen, this amount is 2 percent. We applied this 2 percent figure to the total aggregate drug payments for Epogen in hospital-based facilities, resulting in a difference of $5 million.

Since the top 10 ESRD drugs will be paid at 2005 AAP amounts and the remainder will be paid at ASP plus six percent, we then calculated a weighted average of the percentages by which AAP amounts would be below current Medicare prices, for the top 10 drugs, and the percentage by which ASP plus 6 percent would be below current Medicare payment amounts. For other than the top ten drugs, we do not have detailed data on expenditures for drugs billed by ESRD facilities. Therefore, we computed the percentage by which ASP plus 6 percent is below the estimated 2005 pre-MMA payment amounts for those drugs, using the average of the comparable ASP prices for the top 10 ESRD drugs. This procedure resulted in a weighted average of 13 percent by which the overall revised 2005 drug payment amounts applicable to independent facilities is projected to be less than the 2005 estimated pre-MMA system (that is, 95 percent of AWP). We then applied the 13 percent weighted average to total aggregate drug spending projections for independent facilities, producing a projected difference of $385 million.

Combining the 2005 estimates of $5 million and $385 million, for a total of $390 million and then distributing this over a total projected 34.8 million treatments would result in an add-on to the per treatment composite rate of 8.7 percent. We estimate that an 8.7 percent adjustment to the ESRD composite payment rate would be needed to achieve budget neutrality with respect to drug expenditures for ESRD facilities.

A. Patient Characteristic Adjustments

As explained in the proposed rule, the current ESRD composite payment rates are not adjusted for variation in patient characteristics or case-mix. Section 623(d)(1) of the MMA added section 1881(b)(12)(A) of the Act to require that the outpatient dialysis services included in the composite rate be case-mix adjusted. Specifically, the statute requires us to establish a basic case-mix adjusted prospective payment system for dialysis services. Also, the statute requires adjustments under this system for a limited number of patient characteristics. In the proposed notice, we described the development of the methodology for the proposed patient characteristic case-mix adjusters required under the MMA.

In summary, we proposed to use a limited number of patient characteristics that explain variation in reported costs for composite rate services, consistent with the legislative requirement. The proposed adjustment factors are as follows:

TABLE 11:

	Age	Adjustment factor
Female	<65 years	1.11
	65-79 years	1.00
	>79 years	1.16
Male	<65 years	1.21
	65-79 years	1.17
	>79 years	1.23
AIDS		1.15
PVD		1.07

Although the magnitude of some of the patient-specific case-mix adjustments appears to be significant, facility level variation in case-mix is limited because of the overall similarity of the distribution of patients among the eight case-mix classification categories across facility classification groups.

We received a significant number of comments regarding the case-mix adjustment factors, which are summarized in this section with our corresponding responses.

1. Sample Data Used To Develop the Basic Case-Mix System

Comment: Comments regarding the sample or universe used to derive the proposed basic case-mix adjustments in the proposed rule expressed concerns about the size of the sample, the number of hospitals and freestanding facilities included, as well as the number of facilities excluded from the data.

Response: We used the database established by our contractor to develop the basic case-mix system in the proposed rule. Facility cost report data were matched to the corresponding facility billing data to insure that the sample reflected the most valid and reliable data available. The specific methodology used to develop the database is discussed in Kidney Epidemiology and Cost Center's (KECC's) Phase I report. The Phase I report entitled: ''An Expanded Medicare Outpatient End Stage Renal Disease PPS—Phase I'' is available on the University of Michigan Web site: *http://www.sph.umich.edu/kecc.* The contractor has been updating the data files for subsequent phases of their research and is beginning to analyze these data for the bundled prospective payment system. The data used for the basic case-mix proposed system were also assessed in terms of consistency. Data from 2000, 2001, and 2002 were examined separately as well as combined to determine if there were consistent trends over the 3-year period. The data were updated to include the latest 2002 data that was available as of September 2004. The updated data reflect an increase of approximately 10 percent in the number of facilities represented in the database.

Comment: Several comments expressed concerns regarding the timeliness of the data used to develop the proposed case-mix measures. These concerns focused on the availability of cost reports for 2002. In the proposed notice we acknowledged we were delayed in obtaining cost reports for 2002 and that the final rule would reflect the most recent data on the number of cost reports available.

Response: Table 12 indicates the number of dialysis facilities with at least one cost report for 2000 to 2002. This table also reflects the availability of the most recent cost reports data for 2002 and reflects an increase from the proposed rule of an additional 564 cost reports for the independent facilities in 2002.

TABLE 12:

	2000	2001	2002
Independent Facilities	3034	3067	3072
Hospital-based Facilities	476	470	456

The availability of cost reporting data may be delayed because of a number of factors including late submissions by facilities and necessary reconciliation and verification of data by fiscal intermediaries prior to submission to our data systems. The comment on delays and availability of data is also related to concerns expressed by other comments regarding the reporting of co-morbid conditions. Several comments addressed potential inconsistencies in

facility reporting of co-morbid conditions, specifically with the impact of the variation of the reporting of AIDs noted in the 2000 data compared to other years. This variation, coupled with the potential incompleteness of the 2002 data, led us to examine options for selecting the time period to be used for determining the case-mix adjustments.

In this final rule, we have decided to use combined data for the 3-year period 2000–2002, to determine the case-mix adjustment factors. The use of combined data enables us to eliminate any impact caused by annual variation in reporting, delays in the availability of administrative files, and overemphasizing the predictive significance of selected variables, because case-mix variables are combined and averaged over a 3-year period, thus representing a more stable database.

Comment: Several comments focused on the number of facilities that were excluded from the study sample in the development of the proposed case-mix adjustments. For the proposed regulation, we excluded from our sample facilities where cost report data could not be matched to claims data and vice versa, or where key data elements were missing. In addition we excluded outlier facilities (those with high or low average costs, or high or low proportions of co-morbid conditions.) Data from small facilities (fewer than 20 patients) and those with existing composite rate exceptions were also excluded.

Response: We concurred with the recommendation to reassess the sample. For the final rule, we are including, within the sample, data for facilities with existing exceptions. However, we have continued to exclude data for small facilities, outliers, and facilities with missing or unusable data. Missing data excluded approximately 11 percent of the sample, and not including small facilities or outlier facilities eliminated approximately 9 percent of the study sample.

We did not accept the suggestion that smaller sized facilities were proxies for rural facilities, however, and we will continue to study the rural and urban issue in future research and in updates to the wage index.

Overall, including those facilities with exceptions provides a more robust study sample. In this way any effects on the case-mix values due to fluctuations in the data from year to year are greatly diminished.

Comment: Several commenters objected that the database used to develop the basic case mix was not available. One commenter indicated that not having the data made it difficult to evaluate the impact of the proposed case-mix variables on specific facilities.

Response: The database developed for the basic case-mix system is the same database that was developed by the University of Michigan for the ongoing research project to develop a bundled payment system. This database was compiled using our administrative data. We make available for purchase data available in the form of public use files or standard analytic files. Commenters can use the same data files that were used by the University of Michigan to develop the database used. The proposed rule provides the factors necessary to determine impact on individual facilities based on the case-mix within that facility. In addition, we have expanded our discussion of the impact of the case-mix adjustments and have provided a more detailed example to assist facilities in evaluating the impact of the case mix on their specific facilities.

2. Including Co-Morbid Conditions in the Case-Mix Adjustment

Comment: A number of comments expressed concerns regarding the coding of co-morbid conditions. Some comments acknowledged that limited time has been spent by ESRD facilities in coding multiple conditions. Some stressed that training should be provided to ensure that facilities understand this reporting requirement. One commenter attributed the proposed delay in implementation of the case-mix adjustments to potential difficulties in coding co-morbid conditions and in integrating these coded conditions into the payment.

Response: We considered the commenters concerns regarding incorporating co-morbid conditions and the findings from analyzing more recent data. Although our regression modeling suggests that the inclusion of co-morbidities in the case-mix system would be appropriate, we are concerned that the data available to determine patient level co-morbidities may not accurately reflect diagnoses relevant to the dialysis patient population. Therefore, in this final rule we are not including co-morbidities as case-mix adjustments. As discussed later in this section, we are establishing the case-mix adjustments based on the following variables: age, body mass index (BMI) and body surface area (BSA). More recent analysis of the data and clinical concerns expressed regarding the inclusion of AIDs and selected PVD diagnoses support this decision. However, while co-morbid conditions are not currently part of the basic case-mix system, we encourage all facilities to more thoroughly report and code co-morbid conditions on their claims. This will enable appropriate refinements to the basic case-mix adjustments and also provide a better database from which we can develop case-mix measures for a bundled payment system.

Comment: One commenter representing a chain of ESRD facilities stated that we overstated the prevalence of patients with peripheral vascular disease (PVD). The commenter maintained that overstating the incidence of PVD in the ESRD outpatient population results in an overstatement of the offset for budget neutrality because of the proposed 1.07 case-mix adjuster for PVD patients, thereby decreasing the otherwise applicable composite payment rate prior to case-mix adjustments. The commenter identified 51 diagnoses from the list of PVD diagnosis codes included in the proposed rule that he believed were either not reflective of PVD in ESRD patients, were not usually considered as a cause of PVD in ESRD patients, or were poorly differentiated clinically and could occur even in the absence of PVD. The commenter believed that these 51 diagnoses should be excluded from our list of PVD diagnoses for purposes of determining the case-mix and budget neutrality adjustments to the composite payment rates. Another commenter pointed out that there is substantial clinical disagreement about the definition of PVD and that the ESRD claims data presently do not contain sufficient information to implement the proposed PVD adjustor.

Response: The selection of specific co-morbid conditions for purposes of adjusting the composite payment rates to reflect the patient characteristics associated with cost differences across facilities is an important issue, and we appreciate the commenter's suggestions. However, we disagree with the recommendation that we exclude certain diagnoses because they are not usually considered a cause of ESRD in patients. We believe that whether a particular co-morbid condition caused the onset of ESRD is irrelevant. The important factor is whether a particular co-morbid condition is associated with facility differences in composite rate costs, regardless of their role in the etiology of ESRD.

We agree with the commenter's suggestion that diagnoses which can occur in the absence of PVD will be excluded for purposes of applying a case mix adjustment based on PVD. In addition, there is apparent disagreement among clinicians as to whether certain

diagnoses are reflective of PVD in ESRD patients, and we will try to achieve as much consensus as possible before proceeding to implement a case mix adjuster which purports to reflect PVD. Accordingly, we are eliminating the case mix adjustment for PVD as set forth in the proposed rule. We point out that further analyses with more restricted sets of diagnostic codes revealed that the omitted codes were still strong predictors of costs. We intend to revisit the issue of appropriate co-morbidity adjustments as we continue our research to develop the bundled ESRD payment system.

We point out that our case mix model that included PVD explained about 35.7 percent of the variation in facility composite rate costs. By comparison, our model using five age groups without co-morbidities explains about 35.6 percent of the cost variations. Although PVD was a statistically significant case mix variable, its contribution to the model's performance overall in explaining facility differences in costs was minimal. While co-morbidity adjustments will be excluded under the basic case mix adjusted composite payment system, accuracy in the reporting of co-morbid conditions on the bills will become increasingly important because of the likelihood that a bundled ESRD payment system will include co-morbidities associated with differences in patient resource consumption.

Comment: Two commenters recommended that we exclude AIDS as a co-morbidity warranting case-mix adjustment. These commenters stated that because of State laws requiring that a patient's AIDS status be kept confidential, most facilities do not know whether their patients have AIDS. This does not pose a risk to other patients or caregivers because of the universal precautions which dialysis facilities are required to use in order to prevent exposure and infection.

Response: Because the claims data contain primarily the patient's primary diagnosis, AIDS is not likely to be recorded as a claims diagnosis for outpatient dialysis patients. Requiring the recording of the AIDS diagnosis on the bills would create powerful incentives for ESRD facilities to circumvent confidentiality restrictions. In those States with AIDS confidentiality requirements, the diagnosis is not likely to be recorded at all. Given the relatively low incidence of AIDS patients in the outpatient dialysis population, the fact that facilities in States with AIDS confidentiality requirements would be potentially disadvantaged if AIDS were included as a payment adjuster, and the fact that the relationship between AIDS and dialysis costs was not stable from year to year, we have decided to eliminate AIDS as a basis for case-mix adjustment to the composite payment rates at the present time.

3. Case-Mix Adjustment for Gender

Comment: One commenter suggested that we eliminate gender as one of the patient characteristic variables used to case-mix adjust the composite payment rates. The commenter stated that gender was essentially a surrogate for differences in height and weight measures that would yield a superior case-mix adjustment.

Response: Although height and weight are much better predictors of facility variation in composite rate costs, these data were only available on the Form CMS 2728, not on the bills submitted for payment. Accordingly, we used gender as a surrogate measure in proposing adjustments, because gender is reported on the outpatient bill (for example, UB92 or the equivalent electronic form). However, the National Uniform Billing Committee has approved the use of two new value codes for reporting weight and height (A8—weight in kilograms, A9—height in centimeters) on the billing forms effective January 1, 2005.

The mandatory reporting of height and weight permits the development of case mix measures that reflect both variables, such as BMI and BSA, each of which are superior to weight alone as predictors of resource use. Given the impending availability of height and weight data on the outpatient dialysis bill, we examined the predictive power of weight, BMI, and BSA in lieu of gender based on data reported on the Form 2728 from 2000 through 2002. We found that both BMI and BSA are superior predictors to weight alone and that BSA, coupled with a variable for low BMI, is the best predictor of facility differences in composite rate costs. Accordingly, we have eliminated gender in this final rule as a patient classification variable for purposes of case mix adjustment. Instead we are substituting BSA, and a variable for low BMI, each of which are explained in another section of this final rule.

4. Age Groupings Used in Proposed Case-Mix Adjustment

Comment: Several comments indicated that the proposed age groups were too broad. Some of the comments recommended that we create more age categories for purposes of the case-mix adjustments.

Response: In the proposed rule we established three age categories for example: less than 65, 65–79, and greater than 79. In reassessing the study sample and the proposed case mix adjusters, we also explored the age categories. We concur with the comments to expand the number of age categories. For the final rule, there will be five age groupings. These are: 18–44, 45–59, 60–69, 70–79, and 80+. Patients under 18 are discussed in the following section on pediatrics. We believe that the revisions to the age groupings more accurately describe the distribution of the patient population and reflect more refined predictors of age for payment purposes.

Comment: One commenter asked what would happens under our proposed adjustment if during the course of a month, an ESRD patient's age changed and they cross the line into another case-mix adjustment factor. For example, on August 15 a 64-year-old ESRD patient turns 65. They questioned how is this situation is handled and is the age used as of the last day of the month.

Response: We believe it is appropriate to handle this situation as it is handled for enrollment. Thus, for a month when the patient has a birthday that puts him or her into another age category, the first of the month would be the effective date of the patient's new age category.

5. Case-Mix Adjustment for Pediatric Patients

Comment: Several commenters expressed concern over the lack of a case-mix adjustment for pediatric ESRD patients. The commenters stated that although section 623(b) of the MMA provided for an exception process for pediatric ESRD facilities, qualification for a pediatric exception is limited to those facilities where pediatric patients (those under age 18), comprise at least 50 percent of the caseload. The commenters pointed out that ESRD pediatric patients are unusually resource intensive and costly and are widely scattered among facilities, most of which would not qualify as pediatric facilities under the definition set forth in the statute. The commenters recommended that we develop a case-mix adjuster for pediatric ESRD patients using other data sources.

Response: Using the same regression methodology described in the proposed rule, we attempted to develop a case-mix adjuster for outpatient ESRD patients under age 18. However, based on the approximately 600 Medicare patients for whom bills were available each year from 2000 through 2002, the results were highly variable, statistically

unstable, and therefore inappropriate for development of a case-mix adjuster in accordance with the proposed rule's methodology. However, because of the costliness of pediatric ESRD patients, we believe that an alternative case-mix adjustment is warranted, particularly for those facilities, which do not meet the definition of a pediatric facility under section 623(b) of the MMA.

As the commenter correctly pointed out, some facilities would not qualify for consideration for the pediatric exception provided in the law because their pediatric caseload does not constitute 50 percent of their patients. These facilities may still incur substantial costs for the treatment of pediatric ESRD patients. Pending the development of more refined case-mix adjustments that are more sensitive to individual variation in treatment costs under a fully bundled ESRD PPS, we are providing for a single adjustment to a facility's otherwise applicable composite payment rate, developed based on the methodology described below, for outpatient ESRD pediatric treatments. We want to emphasize that the pediatric adjustment factor resulting from this methodology is intended to be a temporary measure. It will only apply until we can develop an adjustor under the bundled ESRD PPS that is more similar with the case-mix adjustments that would apply to non-pediatric ESRD patients.

During the period from November 1, 1993 to the present time, we identified 19 hospital-based and one freestanding ESRD facility, each of which sought and received an atypical services exception based on the higher costs incurred for the treatment of outpatient pediatric patients. For each of these facilities we obtained the number of treatments at the time the exception was submitted and determined the unadjusted composite payment rate that would have applied beginning January 1, 2005 without regard to any exception amount, that is, each facility's unadjusted composite payment rate was inflated to January 1, 2005 to reflect the statutory increases of 1.2 percent effective January 1, 2000, 2.4 percent effective January 1, 2001, and 1.6 percent effective January 1, 2005.

We then subtracted the inflated January 1, 2005 unadjusted composite rate from each facility's composite payment rate, including the exception amount granted, to obtain the estimated amount of the exception projected to 2005. This amount was multiplied by the number of treatments previously provided, summed for all 20 facilities, and then divided by the number of treatments for all 20 providers to yield an average atypical services exception amount per treatment. The average exception amount for ESRD facilities that received exceptions due to their pediatric caseload, adjusted to 2005, was $86.79 per treatment. The average unadjusted composite payment rate for these same 20 facilities projected to 2005, similarly weighted by the number of treatments, was $139.32. Thus, the average composite payment rate adjusted to January 1, 2005, including the average exception amount of $86.79, was $139.32 + $86.79 or $226.11. Because the average exception amount was calculated from facilities located in areas with differing wage levels, we converted the average pediatric exception amount to a ratio, $226.11/$139.32 or 1.62.

This is the case-mix adjustment factor that will be applied to each facility's composite payment rate per treatment for outpatient maintenance dialysis services furnished to pediatric patients. This includes both in-facility and home dialysis. Applying the adjuster multiplicatively in this manner recognizes the wage index variation in labor costs among urban and rural areas built into the composite rates. Notwithstanding this case-mix adjustment per treatment for ESRD pediatric patients, facilities who otherwise qualify as a pediatric facility under section 623(b) of the MMA will be permitted to seek an exception to this rate if they believe their circumstances warrant a higher payment rate under the atypical services exception provisions set forth in the regulations. We intend the pediatric adjustment factor of 1.62 to be a temporary measure. We anticipate its elimination once the case-mix methodology that will apply in the context of the bundled ESRD PPS is developed. We want the same methodology to apply to both pediatric and non-pediatric ESRD patients.

6. Facility Level Control Variables Used in the Proposed Regression Model

In developing the regression model used to derive the case-mix adjustments, we included variables reflective of facility characteristics. Because facility characteristics do account for differences in facility composite rate costs, we included them in the regression model through the use of facility control variables, so that the patient characteristic case-mix adjusters are not distorted. The facility control variables included the wage index, facility size (based on the annual number of treatments), facility status as hospital-based or freestanding, percent of patients with urea reduction ratios greater than or equal to 65 percent, chain ownership, year of cost report, and percent of pediatric patients treatments. These variables were not used to calculate the basic case-mix adjustment factors.

Comment: One comment questioned the inclusion of the proportion of patients with urea reduction ratios (URRs) greater than 65 as a facility control variable in the least squares regression model used to develop the case-mix adjustment factors. The comment maintained that because a patient's URR may be correlated with other co-morbid conditions, the coefficients for the variables tested in the model might be distorted. The comment recommended an evaluation of the degree of association between URR and the main co-morbid conditions to determine the extent of any multicolinearity. The comment further stated that if URR is appropriate as a facility control variable, then other surrogates of dialysis efficiency, such as standardized mortality ratio and proportion of patients with hemoglobin readings above specified target levels, should also be considered as control variables.

Response: We believe that case-mix adjustments to the composite payment rate must be determined by patient and not by facility characteristics. To the extent that facility differences in costs are statistically explained by facility and not patient characteristics, we account for them in the regression model through the use of control variables, so that the potential case-mix adjusters are not distorted. Facility control variables were not used to develop the adjustment factors to the composite payment rates.

For example, chain affiliation, facility size, and status as a hospital-based or freestanding facility were associated with statistically significant differences in facility costs. However, it would be inappropriate to object to the payment rates based on a facility belonging to a particular chain, or based on the number of annual treatments.

To test for multicolinearity, that is, to ensure that each co-morbidity tested for inclusion in the regression model was not correlated with other variables, we ran a correlation matrix. The correlation matrix included URR. URR was found not to correlate with any of the co-morbidities tested; in statistical parlance, it was orthogonal. Accordingly, low URR was not a surrogate of co-morbidity. Therefore, we believe it was appropriate to treat URR as a quality of care outcome measure at each facility. The effect of using URR as a facility control variable was to ensure that the case-mix adjustment factors were not distorted for facilities with similar URR outcomes. For example, if

larger patients receive lower doses of dialysis, not controlling for URR could impart a downward bias on the coefficient for patient size. The comment also suggested the use of other variables as facility control variables such as standardized mortality ratio (SMR) and hemoglobin count. Because SMR standardizes or controls for the effect of case mix on the ratio, we would have to ensure consistency in the reporting of specified co-morbidities on the bills in order to ensure the validity of each facility's SMR. That consistency currently does not exist. Facilities are only required to report hematocrit/hemoglobin on the claims available for those patients receiving erythropoeitin (EPO). However, because the proportion of patients receiving EPO is high, the use of hematocrit/hemoglobin as another outcome facility control variable is feasible, but mainly in the context of the bundled payment system. Since the drugs and lab tests associated with anemia management are paid outside the composite payment rate, hematocrit/hemoglobin level would not be appropriate as a control variable applicable to composite rate costs.

7. Propriety of Case-Mix Adjustment

Comment: Several commenters expressed reservations about our proceeding with the implementation of a case-mix adjustment to the composite payment rates using the methodology set forth in the proposed rule. One commenter cited the May 19, 2004 report prepared by the KECC of the University of Michigan, which pointed out that the proposed case-mix variables collectively explained less than 1 percent of the facility variation in composite rate costs, although the addition of facility control variables increased this proportion to about 33 percent. One commenter stated that the low explanatory power of the proposed case-mix variables indicated that they do not accurately predict cost variation and are flawed. The commenter suggested that we defer applying a case-mix model until the results of the demonstration project mandated under section 623(e) of the MMA are available.

Response: We would have preferred to develop a case-mix adjustment in the context of a bundled outpatient ESRD PPS. In a fully bundled PPS, which section 623(f) of the MMA anticipates, routine and separately billable dialysis related services, drugs, and clinical laboratory tests would be included in the payment bundle. KECC's previous research revealed that, for separately billable services, case-mix explained about 23 percent of the variation in cost across dialysis facilities. (*See* Hirth, *et al.*, Is Case-Mix Adjustment Necessary for an Expanded Dialysis Bundle?, Health Care Financing Review, 2003, 24, pages 77–88).

However, the enactment of Pub. L. No. 108–173 foreclosed the option of deferring implementation of a casemix adjusted composite rate based on a limited number of patient characteristics effective January 1, 2005. We do not believe that the statutory directive set forth in section 623(d) of the MMA permits us to defer the development of a basic case-mix measure, one based on a ''limited number of patient characteristics.''

We do not agree with the statement that, because the proposed case-mix adjusters collectively account for about 1 percent of the facility variation in composite rate costs, the variables used are fundamentally flawed. In fact, when data is combined over three years, each of the proposed case-mix variables is highly significant statistically, despite the low proportion of facility variation in costs explained. A more important indicator of the importance of the case mix factors identified is the size of the adjustments. If the identified case mix variables did not have a meaningful relationship with costs, the magnitude of the adjustment factors would be insignificant or trivial. They are not. As explained in this final rule, based on our analysis of the comments we received, we have revised the case-mix variables used to adjust the composite payment rates. Our research to develop a statistically robust clinically coherent case-mix measure in the context of the fully bundled ESRD PPS will continue.

8. Alternative Case-Mix Variables

Comment: Several commenters suggested alternative case-mix variables which they believe account for patient differences in resource consumption and would better distinguish facility differences in composite rate costs. The patient characteristics proposed by commenters included quarterly serum albumin values, cancer, limb amputation, gastrointestinal disorders, body mass index, weight, revised age groupings, hypertension, duration of dialysis treatment, and others. The commenters indicated that, based on their clinical judgment, the suggested factors were more likely to be predictors of variability in the cost of care than the proposed AIDS and PVD co-morbidities. A few commenters recommended a delay in the implementation of the case-mix adjusted composite payment rates pending evaluation of the suggested variables. A number of comments indicated that BMI was a significant predictor of cost and recommended that BMI be included in the case-mix adjustment. Another commenter recommended BSA be examined as a potential case-mix predictor.

Response: We appreciate all of the comments we received proposing alternative case-mix variables. We welcome suggestions for case-mix refinement based on sound clinical judgment, especially when analyses including separately billable ESRD services are performed as our research for development of the bundled ESRD payment system progresses. However, we point out, that unless the existence of a suggested co-morbidity or patient characteristic could be determined from either the Form CMS 2728 or claims data which could be linked to a specific ESRD dialysis patient, we were unable to evaluate its potential to predict facility differences in composite rate costs. Furthermore, unless a patient characteristic can be reported on the UB 92 claim form (or the equivalent electronic version), it cannot be used to adjust a facility's composite payment rate. These limitations eliminate for consideration many of the commenters' suggested alternative patient characteristic variables.

Nonetheless, our regression model evaluated 35 patient characteristics including weight, BMI, BSA, seven types of cancer, diabetes, chronic obstructive pulmonary disease, four types of heart disease, and race. Co-morbidities selected for inclusion in the model with significant negative coefficients were removed from subsequent iterations of the stepwise regression model. The inclusion of such co-morbidities would have resulted in reductions in the otherwise applicable composite rate payments. Because we can now require the reporting of height and weight on the claim form beginning January 1, 2005, we have adopted the commenters' suggestions to use either BMI or BSA as a predictor variable. We selected BSA and low BMI because they improve the model's ability to predict the costs of composite rate service compared to using BMI or weight alone. In addition, we have increased the number of age groups from three to five and eliminated gender as a payment variable entirely.

As explained later in the ''Implementation Date'' section, we do not believe it would be appropriate to further delay the implementation of the basic case-mix adjustment. We proposed delaying implementation of the case-mix payments until April 1, 2005 in order to ensure all systems, programming, and other operational requirements are in place. Between publication of this final rule and the

implementation date, we will conduct training programs to ensure that facilities understand both the payment methodology and reporting requirements necessary to ensure appropriate payment to ESRD facilities.

9. Continuing Research To Develop a More Fully Bundled Case-Mix System

Comment: Several comments requested additional detail regarding the continuing research for the development of a more fully bundled system.

Response: The research activities for the fully bundled system have focused on updating the database. Research efforts since the passage of MMA have focused on supporting the Congressional mandate for the development of a limited number of case-mix variables. Following the publication of this rule, we anticipate that the emphasis will return to the development of a bundled prospective payment system that includes bundling of drugs, clinical laboratory tests, and other items that are separately billed by such facilities. This research will be reflected in an October 1, 2005 Report to the Congress.

In addition, the MMA requires us to establish the fully case-mix adjusted demonstration which will bundle into the payments both separately billable drugs and biologicals and clinical labs. Both the Report to the Congress and the demonstration will be supported by continuing research.

10. Body Measurements as Case-Mix Adjusters

In the proposed rule, we had discussed the importance of the BMI as a measure of resource consumption related to the composite payment rate. At that time, our analysis indicated that patients with very low or high BMI were more costly to treat. At the time of the publication of the proposed rule, we had no mechanism to obtain indicators for height and weight on the claims form. We had indicated that we would be exploring adding height and weight to the bills.

Comment: A number of commenters endorsed the use of low BMI as an appropriate surrogate for the severity of morbid conditions associated with malnourishment in the dialysis population, and some suggested that a BMI below 20.0 kg/m^2 is generally considered in the underweight range. In addition, we also received comments regarding the inclusion of a measure of BSA.

Response: We concur with the comments to include BMI and BSA as case-mix adjusters reflecting patient characteristics that explain variation in the reported costs for composite rate services. We have obtained approval to collect both height and weight on the bill through the use of two new value codes. ESRD facilities will be required to report height and weight using these value codes, so that payment can be based on the case-mix adjusted composite rate payment system on April 1, 2005.

For the implementation of the basic case-mix payments, we are providing an adjustment for low BMI, that is, any patient with a BMI less than 18.5 kg/m^2. We included this variable because our regression analysis indicated that those patients who are underweight and malnourished consume more resources than other patients. Although we received one comment suggesting defining low BMI as 20 kg/m^2, we chose the measure of low BMI that is consistent with the CDC and NIH definition for malnourishment. Furthermore, our exploration of alternative BMI thresholds did not improve the model's ability to predict the costs of composite rate services.

In addition, we are providing case-mix adjustments based on BSA. Our research into this body measurement indicated that BSA (meters^2) is a good predictor of composite rate resource consumption. We examined all of the formulas for BSA. While we found very little differences between the formulas in predictive power, we are adopting the Dubois and Dubois formula for BSA since our literature search revealed that this particular formula was the most widely known and accepted. This formula is: $BSA=W^{0.425} * H^{0.725} * 0.007184$ (DuBois D. and DuBois, EF. ''A Formula to Estimate the Approximate Surface Area if Height and Weight be Known'': Arch. Int. Med. 1916 17:863–71.), where w and h represent weight in kilograms and height in centimeters, respectively.

In addition, we explored a number of options for setting the reference values for the BSA. We examined the distributions for both the midpoint of the BSA and the count of dialysis patients by age, body surface and low BMI. Based on this analysis, we are setting the reference point at a BSA of 1.84 (the average BSA among dialysis patients in 2002). By setting the reference point at the average BSA, the adjusters will reflect the relationship of a specific patient's BSA to the average BSA of all patients. Therefore, some adjusters will be greater than 1.0 and some will be less than 1.0. In this way, we are able to minimize the magnitude of the budget neutrality offset to the composite payment rate.

The following presents an example of the method for calculating patient level multipliers that were derived from the coefficients resulting from the regression model that includes control variables, expanded age groups, BSA, and an indicator for low BMI (<18.5 kg/m^2). The model excluded small facilities, and outliers.

Case-mix adjuster = Age factor * low BMI factor * BSA factor

Although we could have selected any increment, we believed an increment of 0,1 provided and appropriate degree of precision of the calculation of the exponent used to compute the BSA case-mix adjustment. The BSA factor is defined as an exponent equal to the value of the patient's BSA minus the reference BSA of 1.84 divided by 0.1. The BSA adjustment factor of 1.037 is then exponentiated based on the calculated BSA factor as 1.037 ((BSA - 1.84)/0.1)

For Example: The case-mix adjuster for a 47-year old person who is underweight (BMI<18.5 kg/m^2) and has a body surface area of 2.0 m^2 is calculated by using the 1.84 BSA reference point:

Age Factor = 1.055
Low BMI Factor = 1.112
BSA Factor = $1.037\ ((2.0-1.84)/0.1) = 1.037^{(1.6)} = 1.060$
Case-Mix Adjuster = 1.055 * 1.112 * 1.06 = 1.244

The resulting case-mix adjustment factor of 1.244 for this patient would be applied to the facility's composite payment rate that is adjusted for area wage index, drug add-on, and budget neutrality.

11. Budget Neutrality for Case-Mix Adjustment

Section 1881(b)(12)(E)(i) of the Act, as added by section 623(d)(1) of the MMA, requires that the basic case-mix adjusted composite rate system be designed to result in the same aggregate amount of expenditure for such services, as estimated by the Secretary, as would have been make for 2005 if that paragraph did not apply. Therefore, the patient characteristics case-mix adjustment required by section 623(d)(1) of the MMA must result in the same aggregate expenditures for 2005 as if these adjustments were not made.

In order to account for the payment effect related to the case-mix adjustment, we proposed to standardize the composite rate by dividing by the average case-mix modifier of 1.1919. The proposed budget neutrality adjustment to the composite rate was 0.8390. However, we were not able to simulate case-mix effects at the bill level

because co-morbidities are generally not reported on the ESRD bill. We still intend to refine our case-mix adjustments once we have more complete patient data on the ESRD bill. In this final rule, we have refined our adjustment for budget neutrality related to the case-mix factor. We simulated payment for each ESRD provider by applying a facility-specific case-mix multiplier to the composite rate applicable for that facility. Since the pediatric case-mix adjustment was developed outside the regression model, we simulated payments separately for those treatments. The results of these tow computations were then combined to arrive at the total case-mix adjusted payments. We also simulated payment for each provider as if they did not receive any case-mix adjustments. We then compared the total simulated payments with case-mix adjustment to total simulated payments without case-mix adjustment. The resulting budget neutrality adjustment to the composite rate is 0.9116.

B. Revised Patient Characteristic Adjustments

The following section discusses in detail the final case-mix adjustments to the ESRD composite rate payment.

In summary, based on the comments that we received on the proposed case-mix and additional analyses prepared by our contractor, KECC, in this final rule, we are modifying the proposed case-mix adjustments. We have broadened the number of age groups to include five age categories and added low BMI and BSA as measures. We have also included a specific case-mix adjustment for pediatric patients under age 18. We excluded the proposed categories gender and co-morbid conditions. We will be using a limited number of patient characteristics for the basic case mix system; however, we believe that these adjustments adequately explain variation in the reported costs per treatment for the composite rate services consistent with the legislative requirement. The adjustment factors for the basic case mix are listed in Table 13 below.

TABLE 13:

Variable		Multiplier
Age	Pediatrics <18 **	1.62
	18-44	1.223
	45-59	1.055
	60-69	1.000
	70-79	1.094
	80+	1.174
Body Surface Area (per 0.1 Δ BSA of 1.84)		1.037
Low BMI (<18.5 kg/m^2)		1.112

** BSA and BMI adjustment do not apply to pediatric patients.

The following table illustrates the average case-mix adjustment by type of provider based on the 2002 data that was used to develop the adjustment factors.

Table 14:

Facility Type	Average Case-Mix Adjustment
All	1.0967
Independent	1.0963
Hospital-Based	1.0990
Urban	1.0957
Rural	1.1009
Small (<5k treatments/yr.)	1.1027
Medium (<5-10k treatments/yr.)	1.0995
Large (>10k treatments/yr.)	1.0947
Non-Profit	1.1004
For-Profit	1.0957

As illustrated in table 14, regardless of the type of provider, the projected average case-mix adjustments for patient characteristics do not vary significantly.

C. Rural Facilities

Comments: Some commenters focused on the potential impact the revised composite rate payment system could have on rural facilities. They were initially concerned that excluding small facilities from the overall sample actually reflected the elimination of rural facilities from the sample. As a means of resolving this issue, they suggested that a rural facility exception be restored.

Response: The MMA provision for composite rate exceptions limited the availability of exceptions only to pediatric facilities. To the extent that a qualifying pediatric facility is located in a rural area, it would be able to apply for an exception to its composite payment rate.

D. Dual Eligible Dialysis Population

Comment: One commenter expressed concerns regarding potential impact on the dual eligible population, specifically with respect to coverage of deductibles and coinsurance amounts. Concern was expressed regarding the impact of this proposal on the Medicaid population on a state-by-state basis.

Response: We recognize that this is an important issue for ESRD facilities and can be particularly problematic for chain organizations that own facilities in multiple States. While we cannot direct States for payment for dual eligible beneficiaries, we will take appropriate action to ensure that States are aware of the changes we are implementing so they can take steps to adjust their payments for dual eligible dialysis patients.

E. Budget Neutrality

Section 623(d)(1) of the MMA added section 1881(b)(12)(E)(i) of the Act, which requires that the basic case-mix adjusted composite rate system be designed to result in the same aggregate amount of expenditure for services, as estimated by the Secretary, as would have been made for 2005 if that paragraph did not apply. Therefore, the drug add-on adjustment and the patient characteristics case-mix adjustment required by section 623(d)(1) of the MMA must result in the same aggregate expenditures for 2005 as if these adjustments were not made.

For the proposed drug payment add-on adjustment, we indicated in the proposed rule that the methodology we used to estimate the difference between the current and proposed drug payments was designed so that aggregate payments would be budget neutral.

In addition, the proposed rule provided for a budget neutrality adjustment to the composite payment rate of 0.8390 to account for the effects of the proposed case-mix adjustments on aggregate expenditures.

Comment: We received a number of comments concerning our application of the budget neutrality provision of section 623 of MMA. Specifically, many comments suggested that we did not comply with Congressional intent that facilities would be held harmless by this provision, that is, that facilities would not receive lower payments then they otherwise would have.

Response: Section 623 of MMA requires that aggregate payments in 2005 not exceed payments that would otherwise be paid. The budget neutrality provision is to ensure that total aggregate payments from the Medicare trust fund will not increase or decrease as a result of changes in the payment methodology. As with other Medicare payment systems, changes in the payment mechanism will result in the redistribution of Medicare dollars across facilities. There is no provision (nor any implication) in section 623 of the MMA that guarantees that individual facilities would receive the same amount of payment under a case-mix adjusted system as they did previously.

The final budget neutrality adjustment to the ESRD composite payment rate applicable to the case mix adjustments (including the pediatric adjustment) is 0.9116. Also in the proposed rule, the calculation of the drug add-on adjustment was designed to ensure budget neutrality with respect to aggregate drug payments.

F. Geographic Index

Comment: Several comments expressed disappointment that we did not propose revisions to the current outdated wage indexes reflected in the composite payment rates, despite the discretionary authority set forth in section 623(d)(1) of the MMA to replace them. These comments stated that this decision likely would have the greatest impact on facilities located in high cost and high wage areas, where competitive labor market pressures are more

pronounced. Comments generally were in favor of using the most up-to-date information available for developing a revised composite rate wage index.

Response: The wage index currently used in the composite rates is a blend of two wage index values, one based on hospital wage data from fiscal year 1986 and the other developed from 1980 data from the Bureau of Labor Statistics. The wage index is calculated for each urban and rural area based on 1980 U.S. Census definitions of metropolitan statistical areas (MSAs) and areas outside of MSAs. Restrictions apply to the wage index values used to develop the composite payment rates. Payments to facilities in areas where labor costs fall below 90 percent of the national average, or exceed 130 percent of that average, are not adjusted below the 90 percent or above the 130 percent level. This effectively means that facilities located in areas with wage index values less than 0.90 are paid more than they would receive if we fully adjusted for area wage differences. Conversely, facilities in locales with wage index values greater than 1.30 are paid less than they would receive if we fully adjusted payment for these higher wage levels.

We agree that the current ESRD composite rate wage indexes, and the definitions of the geographic areas on which they are based, need to be updated. On June 6, 2003, OMB issued Bulletin 03–04, which announced new geographic areas based on the 2000 Census. The extent to which we use the new OMB geographic definitions, incorporate them into the various prospective payment systems (PPSs) we administer, and whether we rely on hospital wage and employment data to develop new composite rate wage index values will have the potential to significantly redistribute payments among ESRD facilities.

In the August 11, 2004 **Federal Register** (69 FR 48916), we announced how we were revising the hospital wage index used in connection with inpatient PPS. Although one comment stated that we should adopt the same wage index used in connection with the inpatient PPS, several of the hospital wage index revisions stem from specific provisions of law (for example, geographic reclassification of hospitals) and would not necessarily be appropriate to apply to a revised ESRD wage index for the composite payment rates. Because of the discretion afforded the Secretary in developing a new wage index for ESRD payment purposes, we are carefully assessing the propriety and payment implications of policy options before recommending revisions to the current measure. We will not take action to replace the current composite rate wage index at this time. We point out that, in accordance with section 623(d)(1) of the MMA, any revisions to the wage index ultimately adopted must be phased in over a multiyear period.

G. Payment Exceptions and the Revised Composite Payment Rate

1. Application of Statutory Increases to Exception Amounts

Comment: Several comments were critical of our policy of not applying increases to composite rates, mandated by the Congress, to amounts paid under exceptions. The comments maintained that this policy is inequitable, precludes the proper application of inflation updates to costs that we had recognized as appropriate in granting the exception, and over time erodes the value of the exception because of the cumulative impact of an effective ''historical freeze.''

Response: The commenters are correct that we have only applied the Congressionally mandated statutory increases to the basic wage index adjusted composite payment rates, not to exception payments. For example, a provider which was authorized a $12.00 atypical services exception amount per treatment in addition to its otherwise applicable composite payment rate of $125.00 effective August 12, 2000 would not be entitled to the 2.4 percent increase applicable to composite rate payments on January 1, 2001, because its exception rate of $137.00 exceeded its basic rate of $125.00 increased by 2.4 percent or $128.00. While the commenter believes that our policy of not applying the Congressional mandated increases to exception amounts is unfair, we believe that the policy is consistent with the law. Section 422(a)(2)(C) of SCHIP, enacted December 21, 2000, states as follows in pertinent part:

> Any exception rate under such section in effect on December 31, 2000 * * * shall continue in effect so long as such rate is greater than the composite rate as updated * * *.

Thus, the statute seems to distinguish between an exception rate and the composite rate, as ''updated'' by the Congress. The clear implication of the text is that the exception rate is not so updated. Accordingly, we believe that our policy of not applying mandated composite rate increases to exception amounts is consistent with the statute. Moreover, we point out that section 422(a)(2) of SCHIP prohibited the granting of new exceptions and that we are providing facilities the option of either retaining their exception rates, or at any time, electing payment under the case-mix adjusted composite payment rates. We do not believe providers, given this option, will be disadvantaged.

2. Home Dialysis Training Exceptions

Comment: We received comments asking for clarification concerning home dialysis training exceptions since the proposed rule only addressed exceptions in a very general way. They stated that the rule proposes that each facility with an exception rate would compare their exception rate to the new basic case-mix adjusted prospective payment and then decide if it wishes to withdraw the exception rate and be subject to the basic case-mix adjusted composite rate. The commenters stated that this language does not consider a facility that would choose to accept the basic case-mix adjusted prospective payment for its chronic treatments, but continue its exception rates for the training of home patients. The home training exception is the most widely used exception and provides a higher rate for the higher cost of training a patient in fewer than the maximum number of allowed treatments.

Response: We agree and are providing that a home training exception rate may be continued. Facilities with home training exceptions will be able to retain their current exception training rates as well as take advantage of the case-mix adjusted rate for non-training dialysis.

3. New Exception Window

Comment: One commenter requests that a new ''exceptions window'' for pediatric facilities be opened in early 2005. It will not be until after this rule is final that its members will be able to determine the exact impact of this new methodology on their operations.

Response: Section 623(b) of MMA reinstated exceptions for qualifying pediatric facilities defined as facilities with at least 50 percent of their patients under 18 years of age. The current exception window for pediatric facilities closed on September 27, 2004. At this time, future exception windows will be open only for pediatric facilities. The exceptions process is opened each time there is a legislative change in the composite payment rate or when we open the exception window. The fiscal intermediary will notify the ESRD pediatric facilities when a new exception window opens. However, it is our intent to open pediatric exception windows on an annual basis.

4. Home Dialysis Training Rates

Comment: One commenter asked if the training rate add-on to the composite rate would still be applied.

Response: Yes, the following rates will apply for self-dialysis or home dialysis training sessions:

- For intermittent peritoneal dialysis (IPD), continuous cycling peritoneal dialysis (CCPD) and hemodialysis training, the facility's case-mix adjusted payment excluding any approved exception rates will be increased by $20 per training session, furnished up to three times per week.
- For continuous ambulatory peritoneal dialysis (CAPD), the facility's case-mix adjusted payment excluding any approved exception rates will be increased by $12 per training session, furnished up to three times per week.

Based on the example for John Smith in section L (Example of Payment Calculation Under the Case-Mix Adjusted Composite Rate System), the hemodialysis (IPD & CCPD) training rate would be his case-mix adjusted rate of $170.80, increased by the training add-on of $20 for a total training rate of $190.80. For CAPD training, the training rate would be $182.80 ($170.80+$12)

H. Implementation Date

Comment: We received a number of comments supporting our proposed delay in implementing the case-mix portion of the revised composite payment methodology. Many comments maintained that the proposed April 1, 2005 effective date was overly ambitious, and some suggested that a July 1, 2005 implementation date would be more realistic given the need for facility and fiscal intermediary training and education.

Response: The MMA requires that the basic case-mix adjusted composite payment rates be effective for services beginning January 1, 2005. Despite the statute's specificity, we pointed out in the proposed rule that all of the numerous systems, programming, and operational changes necessary to implement the case-mix adjusted payments cannot be completed in time for a January 1, 2005 implementation date.

As presented in the proposed rule, we considered two options that we believed effectively complied with the statute's January 1, 2005 implementation date. While we stated in the proposed rule that either of these options substantively complies with the January 1, 2005 implementation date requirement of the statute, we rejected both alternatives.

The likelihood of payment error, potential disruption of facility payments, and the cost of reprocessing bills militated against either option. We proposed instead an April 1, 2005 implementation date for the basic case-mix adjustments to the composite payment rates, including the budget neutrality reduction. This option avoids the need for reprocessing of bills and applies the budget neutrality adjustment applicable to the case-mix adjustments effective April 1, 2005. Although we agree with the comment that a July 1, 2005 effective date would be ideal in light of the systems and operational changes required to implement the case-mix provisions, we believe that an April 1, 2005 effective date for the case-mix adjustments is feasible, and have decided not to revise that date. We have concluded based on our evaluation of ESRD claims processing systems that the April 1, 2005 implementation date is achievable. As we stated in the proposed rule, the 1.6 percent increase to the composite payment rates and drug add-on will be effective January 1, 2005.

I. Summary of Final Rule Implementing Changes to the ESRD Composite Payment Rate (Section 623 of MMA)

As set forth in this final rule, we will increase the ESRD composite payment rates by 1.6 percent effective January 1, 2005 in accordance with section 623(a) of the MMA. Also, the composite payment rates will be increased January 1, 2005 by 8.7 percent to reflect revisions to the drug pricing methodology for separately billable drugs, as discussed previously in this rule (Composite Rate Adjustments to Account for Changes in Pricing of Separately Billable Drugs and Biologicals). This section explains the development and computation of the revised drug add-on, which differs from the 11.3 percent amount described in the proposed rule, and our response to comments which advocated separate add-on amounts for hospital-based and independent facilities.

Despite the discretionary authority set forth in section 623(d)(1) of the MMA to replace the current outdated wage index used in the composite payment rates, we are taking no action to revise the wage index at the present time. A revised wage index will potentially significantly redistribute ESRD payments. We believe that further study is warranted before we revised the current index. Those assessments are presently underway.

We have also adopted a revised basic case-mix methodology for adjusting the composite payment rates based on a limited number of patient characteristics, as prescribed in section 623(d) of the MMA. The development and application of the revised case-mix adjusters were previously explained in the ''Revised Patient Characteristic Adjustments'' section of this final rule. The variables for which adjustments will be applied to each facility's composite payment rate include age, BSA, and low BMI. In response to comments, we eliminated gender in this final rule as a patient classification variable for purposes of case-mix adjustment, substituting BSA and a low BMI variable instead. We have also increased the number of age categories from three to five, and eliminated co-morbidities pending further study. Because height and weight are necessary to compute each patient's BSA and BMI, those measurements, in centimeters and kilograms, respectively, will be required on the UB 92 for outpatient ESRD services furnished on and after January 1, 2005. This final rule also provides for a case-mix adjustment of 1.62 to a facility's composite payment rate for pediatric ESRD patients (that is, under age 18). The methodology used to develop the pediatric case-mix adjustment factor of 1.62 is described in the ''Case-Mix Adjustment for Pediatrics Patients'' section of this rule. Although the MMA requires that the basic case-mix adjusted composite payment rates be effective for services beginning January 1, 2005, the systems and operational changes necessary to implement them cannot be completed in time for a prospective January 1, 2005 effective date. The case-mix adjustments and the applicable budget neutrality adjustment of 0.9116 will be effective April 1, 2005.

Example of Payment Calculation Under the Case-Mix

Example 1

Adjusted Composite Rate System

The following example presents 2 patients dialyzing at Neighbor Dialysis, an independent ESRD facility located in Baltimore, MD.

Calculation of Basic Composite Rate for Neighbor Dialysis

Wage adjusted composite rate for independent facilities in Baltimore, MD: $134.93

Wage adjusted composite rate increased by drug add-on adjustment $134.93 × 1.087: $146.67

Adjusted Facility Composite Rate after budget neutrality adjustment ($146.67 × 0.9116): $133.70

Patient #1

John Smith attains age 18 on April 10, 2005 and undergoes hemodialysis. John

weighs 75.5 kg. and is 181.5 cm. in height. Because John Smith attains age 18 April 10, he is considered age 18 for the entire month of April, and would not be classified as a pediatric patient.

Calculation of Case Mix Adjusted Payment

The BSA and BMI for John Smith will be calculated by the PRICER program used to compute the composite payment for each patient based on the height and weight reported on the UB 92. However, the computations of the BSA and BMI for John Smith are shown below:

BSA = $0.007184 \times (\text{height})^{0.725} \times (\text{weight})^{0.425}$

BSA = $0.007184 \times 181.5^{0.725} \times 75.5^{0.425}$

BSA = $0.007184 \times 43.4196 \times 6.2824 = 1.960$

BMI = $\text{weight}/\text{height(m)}^2$

John Smith is 181.5 cm. in height, which converts to 1.815 meters.

BMI = $75.5/1.815^2 = 22.919$

The case mix adjustment factor for John Smith, an 18 year old whose BMI exceeds 18.5 kg/m^2 and has a BSA of 1.960 is calculated as follows:

Age adjustment factor (age 18–44) 1.223

BMI adjustment factor (BMI ≥ 18.5 kg/m^2) 1.000

BSA adjustment factor ($1.037^{1.960-1.84/0.1}$) 1.0446

Case mix adjustment factor ($1.223 \times 1.000 \times 1.0446$) 1.2775

Basic case mix adjusted composite payment ($133.70 \times 1.2775) $170.80

Patient 2

Jane Doe is a 82 year old malnourished patient who undergoes hemodialysis. Jane is 158.0 cm. in height.

Calculation of Case Mix Adjusted Payment

The BSA and BMI for Jane Doe, which will be automatically computed by the PRICER program, are calculated as follows:

BSA = $0.007184 \times (\text{height})^{0.725} \times (\text{weight})^{0.425}$

BSA = $0.007184 \times 158.0^{0.725} \times 31.25^{0.425}$

BSA = $0.007184 \times 39.2669 \times 4.3183 = 1.2182$

BMI = $\text{weight}/\text{height(m)}^2$

Jane Doe is 158 cm. in height, which converts to 1.580 meters.

BMI = $31.25/1.580^2 = 12.5180$

The case mix adjustment factor for Jane Doe, an 82 year old whose BMI is less than 18.5 kg/m^2 and has a BSA of 1.2182, is calculated as follows:

Age adjustment factor (age 80+) 1.174

BMI adjustment factor (BMI ≤ 18.5 kg./m^2) 1.112

BSA adjustment factor ($1.037^{1.2182-1.84/0.1}$) 0.7978

Case-mix adjustment factor ($1.174 \times 1.112 \times 0.7978$) 1.0415

Basic case mix adjusted composite payment ($133.70 \times 1.0415) $139.24

Example 2

Linda Jones is age 16 and undergoes peritoneal dialysis at Community Hospital, a hospital-based facility in New York City. Linda weighs 35 kg and is 160.0 cm in height. The basic composite rate for Linda Jones is calculated as follows:

Wage adjusted composite rate for hospital-based facilities in New York, New York: $146.35

Wage adjusted composite rate increased by drug adjustment factor ($146.35 × 1.087): $159.08

Adjusted Facility Composite Rate after budget neutrality adjustment ($159.08 × 0.9116) $145.02

Because Linda is a pediatric ESRD patient, the automatic pediatric adjustment factor of 1.62 applies. Neither the age, BMI, nor BSA adjustments are applicable because Linda is less than age 18.

Pediatric adjusted composite rate ($145.02 × 1.62) $234.93

If Community Hospital were entitled to a composite rate exception, then the provider could elect to retain its exception rate in lieu of receiving the otherwise applicable pediatric payment rate of $234.93.

Impact Analysis

Comment: One commenter observed that the budgetary impact on the Medicare program of proposed section 623 changes (impact table) generally indicates an ''overall'' neutral or modest reimbursement increase for all types of dialysis facilities (independent and rural, for profit and non-profit, urban and rural). This commenter requested data that indicate the number of dialysis facilities that are operating at a loss in the U.S., by corresponding facility characteristics shown in the impact table.

Response: The purpose of the impact table is to simulate what ESRD facilities will receive in payments under the MMA section 623 changes compared to what ESRD facilities would receive without any changes to the current composite payment rates. We do not have data to determine whether or not a facility may operate at a loss under MMA section 623.

J. Section 731—Coverage of Routine Costs for Category A Clinical Trials

Before the enactment of the MMA, Medicare did not cover services related to a noncovered Category A device. The MMA authorizes Medicare to cover the routine costs associated with certain Category A clinical trials for services furnished on or after January 1, 2005. For a trial to qualify for payment, it must meet certain criteria to ensure that the trial conforms to appropriate scientific and ethical standards. In addition, the MMA established additional criteria for trials initiated before January 1, 2010 to ensure that the devices involved in these trials are intended for use in the diagnosis, monitoring, or treatment of an immediately life-threatening disease or condition. Seven commenters were in favor of this provision. Of them, four had additional comments. One commenter was against the provision.

Comment: One commenter stated that this provision would result in money being taken away from the pool of money for physician payments of non-experimental procedures.

Response: We considered this issue in determining the SGR for 2005. Since we have made a regulatory change to allow for coverage of routine costs associated with Category A clinical trials, we are required by statute to reflect any increased costs of this policy in the 2005 SGR. At this time, we are estimating that the costs associated with coverage of routine costs of Category A clinical trials will increase Medicare spending for physicians' services by less than 0.1 percent. However, we are reviewing this issue and we will adjust our estimates once we have actual spending data for 2005.

Comment: One commenter specifically requested that we define routine costs.

Response: We discuss and define routine costs in section 310.1 of the Medicare National Coverage Determination Manual (pub 100.3). We will take this comment into consideration if we decide to revise section 310.1 in the future.

Comment: Two commenters recommended that we adopt a definition of ''immediately life-threatening'' that would allow contractors some level of flexibility when they apply this criteria to evaluate trials.

Response: We will consider the importance of some level of flexibility in defining ''immediately life-threatening.'' Although we are not defining this term in our regulation, we intend to provide guidance through implementing instructions.

Comment: Another commenter suggested that contractors determine in advance if trials satisfy the immediately life threatening requirement.

Response: We are considering implementation requirements and will take this suggestion under advisement.

Result of Evaluation of Comments

We are finalizing the changes to § 405.207 as proposed.

K. Section 629—Part B Deductible

Section 629 of the MMA provides for regular updates to the Medicare Part B deductible in consideration of inflationary changes in the nation's economy. Since 1991, the Medicare Part B deductible has been $100 per year. The MMA stipulates that the Medicare Part B deductible will be $110 for calendar year 2005, and, for a subsequent year, the deductible will be the previous year's deductible increased by the annual percentage increase in the monthly actuarial rate under section 1839(a)(1) of the Act, ending with that subsequent year (rounded to the nearest dollar). Section 1839(a)(1) of the Act requires the Secretary of Health and Human Services to calculate the monthly actuarial rate for Medicare enrollees age 65 and over.

We proposed to update § 410.160(f), ''Amount of the Part B annual deductible,'' to conform to the MMA and to reflect that the Medicare Part B deductible is $100 for calendar years 1991 through 2004.

Comment: Commenters stated that they understand that we are following the statute in implementing this provision, but encouraged us to educate Medicare beneficiaries regarding this change.

Response: We agree that it is important to educate beneficiaries about the deductible, as well as the other provisions of the MMA, such as the new screening benefits, and we will be using publications such as the ''Medicare and You Handbook'' for this purpose.

Result of Evaluation of Comments

We are finalizing the proposed changes to § 410.160(f).

L. Section 512—Hospice Consultation

1. Coverage of Hospice Consultation Services

As discussed in the proposed rule published August 5, 2004, effective January 1, 2005, section 512 of the MMA provides for payment to a hospice for specified services furnished by a physician who is either the medical director of, or an employee of, a hospice agency. Payment would be made on behalf of a beneficiary who is terminally ill (which is defined as having a prognosis of 6 months or less if the disease or illness runs its normal course), has not made a hospice election, and has not previously received the pre-election hospice services specified in section 1812(a)(1)(5) of the Act as added by section 512 of the MMA. These services comprise an evaluation of an individual's need for pain and symptom management, counseling the individual regarding hospice and other care options, and may include advising the individual regarding advanced care planning.

We believe that most individuals will seek this type of service from their own physicians. Thus, we do not expect that the services of a hospice physician would be necessary for all individuals who elect hospice. However, a beneficiary, or his or her physician, may seek the expertise of a hospice medical director or physician employee of a hospice to assure that a beneficiary's end-of-life options for care and pain management are discussed and evaluated.

Currently, beneficiaries are able to receive this evaluation, pain management, counseling, and advice through other Medicare benefits. For example, physicians who determine the beneficiary's terminal diagnoses can provide for these E/M services as well as for pain and symptom management under the physician fee schedule. Beneficiaries may also obtain assistance with decisions pertaining to end-of-life issues through discharge planning by social workers, case managers, and other health care professionals. To the extent that beneficiaries have already received Medicare-covered evaluation and counseling for end-of-life care, the hospice evaluation and counseling would seem duplicative. We plan to monitor data regarding these services to assess whether Medicare is paying for duplicative services.

In the proposed rule, we proposed to cover the services described above for a terminally ill beneficiary when the services are requested by a beneficiary or the beneficiary's physician. The service would, in accordance with the statute, be available on a one-time basis to a beneficiary who has not elected or previously used the hospice benefit, but who might benefit from evaluation and counseling with a hospice physician regarding the beneficiary's decision-making process or to provide recommendations for pain and symptom management. The beneficiary or his or her physician decides to obtain this service from the hospice medical director or physician employee. Thus, the evaluation and counseling service may not be initiated by the hospice, that is, the entity receiving payment for the service.

The statute specifies that payment be made to the hospice when the physician providing the service is an employee physician or medical director of a hospice. Therefore, other hospice personnel, such as nurse practitioners, nurses, or social workers, cannot furnish the service. The statute requires that the physician be employed by a hospice; therefore, the service cannot be furnished by a physician under contractual arrangements with the hospice or by the beneficiary's physician, if that physician is not an employee of the hospice. Moreover, if the beneficiary's physician is also the medical director or physician employee of a hospice, that physician already possesses the expertise necessary to furnish end-of-life evaluation, management, and counseling services and is providing these services to the beneficiary and receiving payment for these services under the physician fee schedule through the use of E/M codes.

In the event that the individual's physician initiates the request for services of the hospice medical director or physician, we indicated in the proposed rule that we would expect that appropriate documentation guidelines would be followed. The request or referral would be in writing, and the hospice medical director or employee physician would be expected to provide a written note on the patient's medical chart. The hospice employee physician providing these services would be required to maintain a written record of this service. If the beneficiary initiates the services, we would expect that the hospice agency would maintain a written record of the service and that communication between the hospice medical director or physician and the beneficiary's physician would occur, with the beneficiary's permission, to the extent necessary to ensure continuity of care.

We proposed to add new § 418.205 and § 418.304(d) to implement section 512 of the MMA.

Comment: Several commenters requested that this provision be extended to contracted physicians and nurse practitioners.

Response: Section 1812(a)(5) of the Act explicitly indicates that a physician employed by a hospice agency must provide the services under this provision. We recognize that contractual relationships are permitted by hospice agencies for medical director and physicians' services under the hospice benefit as described in section 1861(dd) of the Act. However, the plain language of section 1812(a)(5) provides only for employees of the hospice to furnish the service.

Section 1812(a)(5) of the Act also requires that this service be provided by a physician as defined in section 1861(r)(1) of the Act. While nurse practitioners may serve as attending physicians for beneficiaries who have elected the hospice benefit, this provision does not permit non-physicians to provide this pre-hospice service.

Comment: We received several comments that supported this provision as beneficial for end-of-life care.

Response: We believe that this provision supports and supplements options available to beneficiaries as they make end-of-life decisions when the individual's health care provider and community resources are not able to provide the expertise and information.

Comment: We received a comment suggesting that the certification of a terminal illness, with a 6-month prognosis if the disease runs its normal course, be eliminated and that this service should be available to any individual deemed to be terminal.

Response: Section 1812(a)(5) of the Act explicitly indicates that this one-time service is available to Medicare beneficiaries who are terminally ill and have not previously elected the hospice benefit. Section 1861(dd)(3)(A) of the Act defines the phrase ''terminally ill'' as denoting a medical prognosis that the individual's life expectancy is 6 months or less. Since section 1812(a)(5) of the Act specifies that the beneficiary must have a terminal illness, which includes the 6-month prognosis, we have no authority to eliminate this definition.

Since the benefit is a pre-hospice one, we have not required that a certification be completed before this service is provided. Nonetheless, in the judgment of the individual's physician, the individual must be terminally ill, that is, having a 6-month or less life expectancy if the disease or illness runs its normal course.

2. Payment for Hospice Consultation Services

Section 512(b) of the MMA amends section 1814(i) of the Act and establishes payment for this service at an amount equal to an amount established for an office or other outpatient visit for E/M associated with presenting problems of moderate severity and requiring medical decision-making of low complexity under the physician fee schedule, other than the portion of such amount attributable to the practice expense component. No existing CPT or HCPCS code specifically represents these services. We proposed establishing a new HCPCS code, G0337 (proposed as G0xx4) *Hospice—evaluation and counseling services, pre-election.* The hospice would use this new HCPCS code to submit claims to the Regional Home Health Intermediary (RHHI) for payment for this service. Utilization of the code would allow us to provide payment for the service, as well as enable us to monitor the frequency with which the code is used and assess its appropriate use. Payments by hospices to physicians or others in a position to refer patients for services furnished under this provision may implicate the Federal anti-kickback statute.

In accordance with the statute, we proposed that the payment amount for this service would be based on the work and malpractice expense RVUs for CPT code 99203 multiplied by the CF (1.34 Work RVU + 0.10 Malpractice RVU) * (CF). The CPT code for an office or outpatient visit for the E/M of a new patient represents a detailed history, detailed examination and medical decision making of low complexity. We believe that this E/M service is quite similar to the components of the new service provided by a medical director or physician employed by the hospice agency. Assuming that there are no changes in RVUs for CPT code 99203, and that the CY 2005 update to the physician fee schedule is the 1.5 percent specified in the MMA, the national payment amount for this service would be $54.57 for this service (1.44 * $37.8975).

Comment: We received several comments indicating that CPT Code 99203, a mid-level office visit with a new patient, does not accurately reflect the complexity associated with the hospice consultation. One commenter suggested using CPT code 99205. In addition, commenters stated that payment for this benefit should reflect the length and intensity of each consultation.

Response: Section 1814(i)(4) of the Act explicitly states that the payment for this service be equal to an amount established for an office or outpatient visit with presenting problems of moderate severity and requiring low complexity medical decision-making. We believe that CPT code 99203, rather than CPT code 99205, most closely conforms to the statutory language. However, in order to establish a payment rate that excludes the practice expense component and to ensure that we pay for the service only once, we established a G code.

Comment: We received one comment that indicated that existing consultation codes coupled with a place of service should be used.

Response: We appreciate the concern about introducing another code into a complex system of codes. While the title of the provision indicates that this is a consultative service, we believe that, unlike other consultations, beneficiaries are able to seek this service without a referral. Moreover, we need to be able to distinguish this service so that we can ensure that it is furnished only once to an individual. In addition, existing E&M codes are billed by physicians. This provision is billed by the hospice agency and is not a result of reassignment of payment by a physician to a hospice agency. Finally, the G code will allow us to track utilization of this new benefit.

Result of Evaluation of Comments

We are adopting our proposed policy and revising the regulations at § 418.205 and § 418.304(d). We are also finalizing our proposal to pay for this service using a G code (G0337) *Hospice—evaluation and counseling services, pre-election,* with the payment based on the work and malpractice expense RVUs for CPT code 99203.

M. Section 302—Clinical Conditions for Coverage of Durable Medical Equipment (DME)

Section 1832(a)(1)(E) of the Act, as added by section 302(a)(2) of the MMA, requires the Secretary to establish clinical conditions of coverage standards for items of DME. The statute requires the Secretary to establish types or classes of covered items that require a face-to-face examination of the individual by a physician or specified practitioner. Due to the timeframe and the extensive number of public comments received, we will implement this provision at a later date. We will address all public comments in a future **Federal Register** document.

N. Section 614—Payment for Certain Mammography Services

Medicare covers an annual screening mammogram for all beneficiaries who are women age 40 and older and one baseline mammogram for beneficiaries who are women age 35 through 39. Medicare also covers medically necessary diagnostic mammograms. Payment for screening mammography, regardless of setting, is paid under the physician fee schedule, but diagnostic mammography performed in the hospital outpatient department is currently paid under the hospital outpatient prospective payment system (OPPS).

As stated in the August 5, 2004 proposed rule, section 614 of the MMA amended section 1833(t)(1)(B)(iv) of the

Act to exclude payment for screening and diagnostic mammograms from the OPPS. Beginning January 1, 2005, we will pay for diagnostic mammograms under the OPPS based on the payments established under the physician fee schedule. Thus, both diagnostic and screening mammography services provided in the OPPS setting will now be paid based on the physician fee schedule.

Comment: Commenters expressed support for this proposed change in payment and believe it will assist in ensuring that these services are available to women at risk for breast cancer.

Response: We agree that it is important to ensure access to these services. Additional discussion of the MMA provision can also be found in the OPPS final rule, ''Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and CY 2005 Payment Rates'' currently under development.

O. Section 305—Payment for Inhalation Drugs

The August 5, 2004 proposed rule contained the ASP plus 6 percent payment amounts based on data received from manufacturers' ASP for the first quarter of 2004 for albuterol sulphate and ipratropium bromide. We indicated that such payment amounts were not the payment rates for 2005 and specified that Medicare payment rates for the first quarter of 2005 would be based on data submitted by manufacturers from the third quarter of 2004.

We proposed to establish a separate dispensing fee for inhalation drugs. We noted that Medicare currently pays a monthly dispensing fee of $5 for each inhalation drug used in a nebulizer. We requested information about an appropriate dispensing fee amount.

We also proposed to make several changes related to billing for inhalation drugs. We proposed to allow a prescription for inhalation drugs written by a physician and filled by a pharmacy to be increased from 30-day to a 90-day period. We indicated that we had recently revised the guidelines regarding the time frame for delivery of refills of DMEPOS products to occur no sooner than ''approximately five days'' prior to the end of usage for the current product. We emphasized the word ''approximately'' in this time frame. The change allows shipping of inhalation drug refills on ''approximately'' the 25th day of the month in the case of a 30-day supply and on ''approximately'' the 85th day in the case of a 90-day supply. We indicated our belief that such revision eliminates the need for suppliers to use overnight shipping of inhalation drugs and allows shipping of inhalation drugs by less expensive ground service.

We also clarified the ordering requirements for DMEPOS items, including drugs. Drugs, including, inhalation drugs, can be dispensed with a verbal physician order and without a written prescription. Although a written prescription must be obtained before submitting a claim, we reiterated that we allowed photocopied, electronic, or pen and ink prescriptions. We pointed out the recent revision to the Program Integrity Manual of acceptable proof of delivery requirements for DMEPOS items. Finally, we proposed to eliminate the requirement that pharmacies have a signed Assignment of Benefits (AOB) form from a beneficiary in order for Medicare to make a payment. Our proposal would eliminate a billing requirement for all drugs, including inhalation drugs and other items where Medicare payment is only made on an assigned basis.

Comment: A number of commenters, particularly retail pharmacies, indicated that they are not able to obtain albuterol sulfate at the $0.04 per milligram and ipratropium bromide at the $0.30 per milligram rates specified in the proposed rule based on manufacturer submissions of data for the first quarter of 2004. A large company indicated that the ASPs stated in the proposed rule for albuterol sulfate and ipratropium bromide were extremely close to its own acquisition costs and inferred that the payment amount would be below smaller providers' purchase prices. A commenter questioned the suggestion in the proposed rule that because albuterol sulfate and ipratropium bromide are generic drugs with multiple manufacturers a pharmacy might be able to obtain them at a price below the average. The commenter suggested that this is highly speculative because we have not yet received the information from manufacturers to set the ASP for the first quarter of 2005.

Response: The ASP plus 6 percent prices for drugs in the proposed rule were calculated based on manufacturer submissions of data covering the first quarter of 2004. We indicated that such ASP plus 6 percent figures were not actual payment rates for the first quarter of 2005. ASP data submitted by manufacturers for the second quarter of 2004 show some significant changes for inhalation drugs. The data show that the ASP plus 6 percent would be $0.05 per milligram for albuterol sulfate, a 25 percent increase, and $0.45 per milligram for ipratropium bromide, a 50 percent increase. We also note that in its recent study, ''Medicare: Appropriate Dispensing Fee Needed for Suppliers of Inhalation Therapy Drugs'' (GAO–05–72), the GAO found that acquisition costs of inhalation drugs varied widely. The GAO found that acquisition costs of albuterol sulfate ranged from $0.04 to $0.08 and ipratropium bromide ranged from $0.23 to $0.64. Based on the submission of manufacturer's average sales price data for the second quarter of 2004, Medicare's payment rates for ipratropium bromide and albuterol sulfate are within the acquisition cost range found by the GAO. The GAO also found that acquisition cost was not necessarily related to the size of the supplier.

Comment: One commenter suggested that we should consider delaying the implementation of cuts in Medicare reimbursement for inhalation drugs until 2006. The commenter suggested that a delay would ensure that physicians and beneficiaries have a range of options available for managing respiratory diseases.

Response: We do not believe that we can delay the implementation of the ASP payment system until 2006 because the MMA provides for the implementation of the ASP payment system in 2005.

Comment: Commenters strongly supported our proposal to pay a separate dispensing fee for inhalation drugs, but we received varied comments on the scope of services appropriately included in a dispensing fee. Commenters indicated that an appropriate dispensing fee is necessary because the costs associated with dispensing these drugs typically exceed ASP plus six percent. Without adequate compensation, commenters argued that Medicare beneficiary access to inhalation drugs would be harmed. Commenters referenced an August 2004 report prepared for the American Association of Homecare (AAH) by a consultant that surveyed 109 homecare pharmacies between the end of May and the middle of July 2004. Commenters cited survey results from the report suggesting that 89 percent of suppliers would discontinue providing inhalation drugs to Medicare beneficiaries in the absence of adequate compensation. One commenter believes it is reasonable to expect that reducing Medicare payment for inhalation drugs will trigger an increase in emergency room visits, doctor visits, and hospital admissions. Other commenters suggested a dispensing fee that is too low would result in a concentrated market, thereby adversely affecting beneficiary choice and access.

The AAH study indicated that in order to maintain 2004 levels of service to Medicare beneficiaries and provide an operating margin of 7 percent, Medicare would have to pay an additional payment of $68.10 per service encounter. This figure includes an average of the costs reported as being incurred during the first quarter of 2004 for the pharmacies that responded to the AAH survey. The study defined a service encounter as each instance one or more billing codes were submitted to Medicare for payment. The study reported that the typical Medicare beneficiary has 8.8 service encounters each year, or one service encounter every 42 days. Most commenters who cited the AAH study supported a fee of $68.10 per service encounter.

Commenters also cited another AAH report, dated September 2001 (and updated to 2003) from a different consultant, who surveyed a sample of 19 homecare pharmacies and found that drug acquisition costs accounted for 26 percent of costs incurred by homecare pharmacies. Facility, labor, delivery, patient care and education, billing and collection costs and other direct costs were found to account for 46 percent; indirect costs such as management information systems, regulatory compliance programs, professional liability insurance and field and corporate administration was 25 percent; and bad debt was 3 percent. The study concluded that homecare pharmacies generated after-tax returns of 9.2 percent.

A retail pharmacy commented that a dispensing fee five to six times the current dispensing fee of $5 is necessary to cover its costs. Another retail pharmacy indicated that a dispensing fee of $25 would be an adequate dispensing fee, including the additional costs of processing Medicare claims and instructing the patient on using the drugs, and would be profitable for it.

A manufacturer urged CMS to conduct a study of the appropriate pharmacy activities and their costs in calculating a dispensing fee. The commenter believes such a study would yield a more accurate amount than data and information provided as part of comments to proposed rules does. One inhalation company indicated that the costs of rent, delivery and salary had recently increased by specific percentages. Several commenters opposed the inclusion in the dispensing fee of a transitional payment. Another commenter strongly urged establishing a dispensing fee that include an appropriate transitional payment, given the significant payment reductions scheduled to begin in 2005.

On the scope of services, commenters indicated that various services involved with dispensing inhalation drugs to Medicare beneficiaries such as: (i) Training beneficiaries and caregivers on proper use of drugs with nebulizers; (ii) establishing and revising a plan of care and coordinating care; (iii) providing in-home visits; (iv) providing 24-hours/7-days a week on-call personnel; (v) contacting physicians and beneficiaries regarding dispensing of inhalation drugs; (vi) providing follow-up contact with beneficiaries, including compliance monitoring and refill calls. Commenters indicated that they felt CMS has the authority to pay for costs associated with delivering inhalation drugs under the durable medical equipment (DME) benefit.

An association representing pharmacists recommended an expansion of Part B to include compensation for therapy management services furnished by pharmacists. An association representing respiratory therapists recommended a separate payment for beneficiary training by practitioners with documented evidence of education, clinical training and competency testing, such as respiratory therapists. A company suggested that we establish a basic dispensing fee and separately reimbursable codes for those who provide additional services, reflecting the range of management services involved with inhalation drugs. Another association acknowledged that although limited peer reviewed studies exist on the role of homecare providers and the respiratory practitioners in furnishing care to COPD patients, significant anecdotal data and a consensus within the pulmonary medicine and respiratory therapy professional communities support the role and contribution of home respiratory care providers. Several commenters indicated that training a beneficiary on using a nebulizer should also be reimbursed. However, they pointed out that training cannot be done by the physician or physician's staff because many physicians do not have a nebulizer on which to train the beneficiary and the Medicare payment is not sufficient to cover the physician's staff time.

Response: We appreciate the support for our proposal to establish a dispensing fee as well as the information about the levels and components of such a fee.

The October 12, 2004 GAO report is based on a survey of 12 companies representing 42 percent of the inhalation therapy market. The GAO found wide variation in suppliers' monthly costs associated with dispensing inhalation drugs. In addition, the GAO found that large suppliers do not necessarily have lower costs and do not necessarily realize economies in costs associated with dispensing inhalation therapy drugs. The GAO indicated that the wide range is due in part to the range of services offered by suppliers and that some costs incurred by suppliers may not be necessary to dispense inhalation drugs, for example marketing, overnight shipping, and 24-hour hotlines for beneficiary questions. The GAO report indicates that the range of costs suppliers are incurring is a good starting point for a dispensing fee amount, but that the appropriate dispensing fee Medicare pays must take into account how excess payments affect the costs.

We note the extreme variation that the GAO found in the costs of dispensing nebulized drugs to Medicare beneficiaries: GAO found that per patient monthly costs of dispensing these medications ranged from a low of $7 to a high of $204 in 2003. Because it appears that the GAO survey and the 2004 AAH survey may have included different costs and services, further research is needed to understand these differences. In addition to the GAO and AAH studies, we note the wide range of comments indicating what services a dispensing fee should cover. We believe that before a determination can be made as to an appropriate dispensing fee for inhalation drugs after 2005, we need to more fully understand the components of and the reasons behind the current variability in the costs of furnishing of these drugs and the services being provided. We intend to work with the AAH, others concerned with inhalation therapy and our partners in the Department of Health and Human Services to explore these issues more fully.

In the interim, for 2005, we are establishing a $57 monthly fee and an $80 90-day fee for furnishing inhalation drugs using data in the AAH study and the GAO report. We established the monthly fee based on the weighted average of the costs for new and established patients from the 2004 AAH study after excluding sales and marketing, bad debt, and an explicit profit margin. Because the AAH study did not establish a fee for the 90-day period, we applied the methodology used in the GAO report to the data in the AAH study to calculate the 2005 90-day fee. Accordingly, we assumed that direct costs associated with a monthly fee are similar to the direct costs associated with the 90-day fee and then we tripled the indirect costs. We intend to further examine the conversion of per

encounter costs as reported in the AAH study to comparable monthly and 90-day cost figures.

We note that although the AAH study contained costs related to services that may be of potential benefit to our beneficiaries, and many commenters indicated that we should provide payment for these and the other services described above, we are concerned that these services may be outside the scope of a dispensing fee. We are continuing to study these services and associated cost categories as the new payment systems are implemented and we gain experience with them. We intend to revisit this issue and proceed through notice and comment rulemaking in order to establish an appropriate dispensing fee for 2006.

Comment: A commenter suggested that the dispensing fee be established on a per dose basis. It was argued that this would provide Medicare with protection against pharmacies dispensing partial shipments or shipments more frequently than 30 or 90 days in order to increase the number of dispensing fees. We received comments in support of a need-based dispensing fee to accommodate additional drugs when beneficiaries suffer from disease flare-ups. We also received comments indicating that beneficiary's prescriptions change, often during the first month. Other commenters cited the AAH study, which calculated different costs associated with dispensing inhalation drugs for new patients and established patient.

Response: The dispensing fee we are establishing covers all drugs shipped to a beneficiary during a month (or 90-day period) regardless of the number of times a supplier ships inhalation drugs to a beneficiary. If a supplier does not supply the prescription in full, it is the supplier's responsibility to fill and deliver the remainder of the prescription, but Medicare will not pay additional monthly dispensing fees. We will monitor the issue about partial shipments and potentially erroneous billing for multiple monthly dispensing fees. We also are concerned that a per-dose dispensing fee could provide an incentive to supply more drugs.

The 2005 fee is an average across all beneficiaries, new and established, and covers additional drugs shipped during a month if a beneficiary's prescription changes. We will study the issue further of different dispensing fees for new and established beneficiaries and the frequency that additional drugs are shipped for prescription changes.

Comment: A manufacturer recognized that compounded products can be covered under certain circumstances and that compounding could be included appropriately in a dispensing fee. Another manufacturer expressed concern about including compounding in the activities that a dispensing fee covers. A suggestion was made that a HCPCS modifier be used for inhalation drugs that are compounded.

Response: The costs of compounding are included in the AAH study but are not separately identified in the direct cost line items. Because the 2005 fee is based on the AAH study, we need to avoid duplicate payment. With compounding bundled into the fee for 2005, we have concerns about paying separately for compounding in 2005.

Comment: A commenter recommended that we address compounding circumstances that might be inconsistent with FDA's policy prohibiting pharmacy compounding of two or more separate FDA-approved products when a combination product approved by the FDA is commercially available and compounding that might be done without the necessary controls to ensure drug product sterility and potency.

Response: The fact that we consider compounding to be included in the 2005 fee to furnish inhalation drugs does not in any way support practices that are inconsistent with FDA guidelines.

Comment: The commenter also suggested that we consider creating a HCPCS modifier for drugs that a prescribing physician intends to be compounded but which a pharmacy dispenses separately in non-compounded form. The commenter believes that such a modifier would help discourage pharmacies from leaving the responsibility for compounding to the beneficiary who would be combining the drugs in non-sterile, uncontrolled conditions.

Response: We understand the commenter's concerns and will study this issue.

Comment: We received comments suggesting that the actual savings attributable to MMA section 305 may be both higher and lower than the November 20, 2003 Congressional Budget Office (CBO) estimate for MMA section 305. One company suggested that the actual savings could be less than estimated by CBO because the ASP model potentially motivates drug manufacturers to increase drug costs, which will be directly passed on to the government. Other commenters cited two different estimates from the AAH report. Using one calculation, the commenters argued that a dispensing fee of $68.10 per encounter would still enable Medicare to achieve savings of $350 million per year or more than $4 billion over 10 years. Using another calculation, the commenters argued that the savings would be $7 billion over the 10-year budget-scoring window. The commenters indicated that the $4 billion savings figure was comparable to the initial projections made by the Congressional Budget Office (CBO) in 2003 and the $7 billion figure was in excess of the CBO estimated savings. Commenters cited these figures to argue that establishment of a per service encounter fee of $68.10 would set the payment at the level originally envisioned by Congress. Another commenter suggested that a dispensing fee of $0.85 per 2.5 mg dose for albuterol sulfate and $0.97 per dose for a blended mix of other inhalation drugs including ipratropium bromide would be consistent with what they believe are the 17.7 percent savings assumed by CBO. One commenter indicated that CBO underestimated the savings from section 305.

Response: MMA specifically requires the use of the ASP methodology to establish more appropriate payment rates for drugs. MMA explicitly requires the establishment of a supplying fee for Part B covered oral drugs as determined to be appropriate by the Secretary. MMA also explicitly requires establishment of a furnishing fee for blood clotting factors. However, MMA does not specify a particular dispensing fee amount for inhalation drugs, nor does MMA specify a method to determine a dispensing fee for inhalation drugs. Accordingly, CMS used existing authority to propose in the NPRM that an appropriate dispensing fee be established. Because MMA did not require a specific method or amount for a dispensing fee for inhalation drugs, we find the arguments unpersuasive that a dispensing fee of a particular amount was envisioned by Congress or consistent with Congressional intent as reflected in a CBO estimate.

Comment: We received comments that supported and opposed the use of 90-day prescriptions. One commenter supporting the proposed change indicated that most beneficiaries who receive nebulized medications suffer from chronic lung diseases and will require medication to manage their disease for prolonged periods. The commenter indicated that allowing a prescription for 90-days would reduce paperwork and redundant effort for beneficiaries, physicians and DME suppliers. A commenter indicated that there would be modest savings in dispensing, billing and shipping costs with allowance of a 90-day supply of

refills. One company suggested savings of 12.5 percent, most notably in shipping. Commenters opposing 90-day prescriptions gave various reasons, including that beneficiaries may experience side effects and change prescriptions within the first month and a certain percent of beneficiaries die each month resulting in non-returnable product. In addition, some argued that pharmacy savings for a 90-day shipment would not be significant because shipping costs account for only an estimated 16 percent of supplier's non-acquisition costs associated with providing inhalation drugs. Another company argued that a 90-day shipment would substantially increase provider's expenses for boxes and shipping. Some commenters agreed that certain chronic use medications should be provided in larger quantities, but urged caution due to the practices of some suppliers who automatically ship additional product without knowing whether the patient's current supply is exhausted. Some comments suggested that a 60-day supply might be more cost-effective in the long-term because there would be a reduced risk that large quantities of medications might be wasted. Another commenter suggested that the policy be defined to cover only drugs that are proven to be stable for at least 90 days following dispensing.

Response: As we indicated in the proposed rule, we believe that reasonableness should govern filling a monthly vs. 90-day prescription depending on the circumstances of the beneficiary. We agree with the commenter that the initial prescription for a new patient should be written for a 30-day period because of the potential for adverse reactions or changes in the treatment regimen. We would expect prescriptions for new patients to be for 30-day periods. In addition, we believe that it is reasonable for physicians to write a 30-day prescription for those beneficiaries who they believe are less stable. Similarly, we believe that refill prescriptions for 90-day periods are reasonable, particularly for stable beneficiaries. Although the Medicare program would achieve savings from the appropriate use of 30-day and 90-day prescriptions, we believe that given the comments it would be prudent for us to monitor the 90-day supply issue. Section 4.26.1, the Proof of Delivery Methods section of the Program Integrity Manual, instructs that suppliers of DMEPOS product refills contact the beneficiary prior to dispensing the refill to ensure that the refilled item is necessary and confirm any changes or modifications to the order. Suppliers who ship either a 30-day or 90-day supply of inhalation drugs without knowing the beneficiary's current supply is exhausted would be in violation of this policy. The 90-day period should not be of concern for inhalation drugs because most of these drugs are stable for at least 90-days and thus can be dispensed for such period. We would revisit this issue if additional inhalation drugs that are unstable after 90-days become available.

Because we received limited data on costs of furnishing a 90-day supply, it is more difficult to determine a 2005 fee for furnishing a 90-day supply of inhalation drugs. However, given that this is an optional payment arrangement for beneficiaries whose course of treatment has stabilized to the point that the required dosage can be predicted with a reasonable degree of certainty over a 90-day period, we believe that it is important to establish a 90-day fee. As described earlier, we are establishing a 90-day fee for furnishing inhalation drugs by applying the methodology from the GAO report to the data in the AAH study. We assumed all of the direct costs associated with a monthly fee are similar to the direct costs associated with a 90-day fee and we tripled the indirect costs. We plan to study this issue further.

Comment: Many commenters acknowledged that most DMEPOS items, including drugs, can be dispensed based on verbal orders. Several commenters objected to the requirement that a written order from the physician still must be obtained before billing. They suggested that we revise policy so that a prescription could be both filled and billed based solely on a verbal order from a physician. They pointed out that the requirement that a pharmacy still obtain a written order for a prescription in order to be able to bill Medicare creates a significant administrative burden for a pharmacy because it often requires persistent follow-up with a physician. Another commenter suggested that we consider accepting electronic transmissions of prescriptions, for example, e-scripts. Another commenter requested clarification of the rule for dispensing based on a verbal order for inhalation drugs and the proposed requirement that an order for an item of DMEPOS be signed and dated within 30 days of a face-to-face examination of a beneficiary.

Response: The policy that allows dispensing based on a verbal order but requires a written order for billing applies to all DMEPOS items. This policy balances fraud and abuse concerns with prompt dispensing of DMEPOS items to beneficiaries. Written orders from the physician can be faxed, photocopied, or provided via electronic or pen and ink forms. In accordance with current policy, pharmacies may accept electronic prescriptions from physicians.

Beneficiaries receiving inhalation drugs are having face-to-face exams routinely and generally do not need additional visits to re-order their drugs. A single face-to-face exam is generally sufficient for items ordered, that is, we would not require a separate face-to-face exam for the nebulizer and for the inhalation drugs. We assume that physicians would order them at the same time because they are used together.

Comment: One commenter supported the revision made earlier this year that provides flexibility regarding the timeframe for refilling Medicare prescriptions. The commenter noted that most third party plans allow pharmacies to refill prescriptions within five days of the end of usage for the previous prescription quantity dispensed. Another commenter recommended that the time frame for subsequent deliveries be expanded beyond five days. The commenter indicated that they believe a five-day time frame is too short a period for ground service and would not eliminate the need for overnight shipping. This is based on the commenter's experience that beneficiaries do not respond to calls to confirm that they need additional supply until the beneficiary has only a few days' supply left.

Response: As we indicated in the proposed rule, the revised time frame for delivery of refills of DMEPOS products provides for refills to occur no sooner than ''approximately five days prior to the end of the usage for the current product.'' In the proposed rule we emphasized the word ''approximately.'' While we believe that normal ground service would allow delivery in five days, if there were circumstances where ground service could not occur in five days, the guideline would still be met if the shipment occurs in six or seven days. As another commenter noted, the five-day standard is consistent with the time frame for shipping used by most third party plans. Given the consistency with private sector plans, because the requirement applies to all DMEPOS product refills, and because the standard is not a firm five-day limit, we do not believe that it is necessary to lengthen the standard. We will study further the ability of a supplier to contact beneficiaries for refills compared with its ability to provide

beneficiary and caregiver training on a monthly basis.

Comment: One commenter indicated that the DMERCs have not consistently implemented the revised proof of delivery provisions but that they are engaged in dialogue with CMS and the DMERCs to clarify the requirements and standardize their interpretation across the four DMERCs. Other commenters suggested that the proof of delivery requirement be eliminated.

Response: We encourage dialogue to ensure consistent understanding and application of the proof of delivery requirements. The proof of delivery requirements have recently undergone an extensive review and revision and, based on the need to prevent fraud and abuse, we see a need to continue them.

Comment: Those commenters who addressed our proposed elimination of the Assignment of Benefits (AOB) form for items and services, including drugs, where assignment is required by statute, supported our proposed change. Commenters agreed that obtaining an AOB in each instance is redundant because the supplier is required by statute to accept the assignment. Some commenters suggested that a onetime AOB be obtained from the beneficiary that will be valid for every DMEPOS item he or she receives during the period of his or her medical necessity.

Response: We appreciate the support for our proposal. As discussed in section IV of this final rule, we are adopting our proposal to eliminate the requirement for AOB form for items and services, including drugs, where assignment is required by statute. We do not agree with the suggestion to allow for a one-time AOB form to cover items and services provided in the future because there could be fraud and abuse issues.

Comment: We received conflicting comments about the impact of the changes and clarifications relating to billing requirements on the costs of dispensing inhalation drugs.

Commenters differed on the impact of the revisions to the proof of delivery requirements that we pointed out in the proposed rule that went into effect in early 2004. One company that currently uses automated systems indicated that the revision to the proof of delivery requirements would not generate savings for them. Commenters indicated that the DMERCs have not consistently implemented the changes, and that consequently there has not been significant administrative relief and subsequent savings.

We received conflicting comments about the impact of the revised time frame for shipping guidelines. While one commenter indicated that savings had already been achieved because the provision had already been implemented, another commenter indicated that the revision would have negligible effect because the commenter would not change its existing business practice of using overnight shipping.

One commenter said it had already adopted the provision of prescriptions being filled by verbal order, followed up by a written order for the claim submission and that these changes did not generate any additional savings for the commenter. Some suggested that the elimination of the AOB form for drugs would have limited savings because some suppliers currently obtain the AOB form at the same time that they obtain other forms that would be continued. Retail pharmacies agreed that elimination of the AOB form and verbal prescription order would reduce their paperwork. However, inhalation companies did not agree.

Response: We understand the commenters concerns and will study the impact of these billing changes on the different suppliers' costs as the new payment system is implemented.

Comment: Several commenters suggested that we review and consider changing several aspects of billing that might have cost-savings potential for suppliers of drugs. Several commenters indicated that Medicare's lack of on-line adjudication represented a significant cost and burden to them. One retail pharmacy commented that pharmacies face higher than normal rejection rate on claims because Medicare claims are not processed on-line, resulting in higher administrative costs. Others commented that pharmacies that dispense Medicare prescriptions must obtain documentation that is typically provided by the physician. For example, one company indicated that suppliers are held responsible for the appropriate medical necessity documentation in the patient's medical record but that the supplier has no control over physician records. Some suggested that we consider eliminating the requirement that a diagnosis code be required on the prescription. One pharmacy commented that pharmacies should not be expected to verify that the physician has in fact performed a face-to-face exam for the purpose of treating and evaluating the patient's medical condition or whether the physician has created appropriate documents in his records. Rather, the pharmacy believes that this responsibility should be left to the physician, and the creation of a prescription should be all that is needed to verify that the physician has complied with all Medicare requirements. A commenter noted that Medicare requires that suppliers submit claims with the physician's Unique Physician Identification Number (UPIN) while most third party plans require the physician's DEA number and suggested that we consider adopting usage of the physician's DEA number instead of UPIN. A pharmacy commented that dispensing units are different than current National Council for Prescription Drug Programs (NCPDP) standards; Medicare reimburses products based on a per mg price while the NCPDP standard suggests reimbursement on a per ml price. The pharmacy indicated that this makes it more difficult for the pharmacy to calculate proper reimbursement for these Medicare claims. Other commenters suggested that the Medicare enrollment and reenrollment process for suppliers be significantly streamlined. A retail pharmacy indicated that Medicare requires pharmacy suppliers to submit extensive and often duplicative pharmacy-specific paperwork that is more voluminous than any other third party plan in which retail pharmacies participate. One inhalation company suggested certain aspects of billing such as the requirement that the supplier query the physician and beneficiary to find out if the beneficiary had already received a same or similar item from another supplier. The company also identified what it claimed are several other labor-intensive, costly aspects of Medicare billing including electronic claims filing requirements; information system programming and testing; paperwork and new business procedures required to be compliant with HIPAA; Medicare and secondary insurance benefits verification and qualification; responding to significantly increased pre-payment audit activities; administering the Patient Financial Hardship Waiver prior to billing deductible and coinsurance amounts; billing and writing off beneficiary cost-sharing as bad debts; and differing DMERC policies concerning documentation needed to support home inhalation therapies.

Response: We thank the commenters for identifying these items. We plan to examine these aspects of billing. To the extent that there are different interpretations or applications of national policy by DMERCs, our goal is increased standardization.

Comment: A comment from a group focused on respiratory care indicated that there may be over utilization of albuterol sulfate. The comment indicated that a large amount of scientific evidence concludes that high albuterol sulfate use is indicative of

poor overall disease management. The commenter further indicated that Medicare's costs related to the use of albuterol sulfate may result from the fact that alternative drug treatment regimes are not adequately considered in the management of the patient's disease. The commenter urged us to examine the underlying causes of high utilization rates of albuterol sulfate.

Response: Our goal is to ensure that Medicare beneficiaries have access to the appropriate drugs to treat their diseases. We believe that the availability of discounts through the Medicare drug card and the implementation of the Part D drug benefit beginning in 2006 promote treatment decisions being made based on the best clinical evidence, rather than being influenced by differential coverage.

Comment: We received many comments addressing the issue of nebulizers versus metered dose inhalers (MDIs). Most commenters questioned whether a significant shift of Medicare beneficiaries to MDIs would occur when MDIs are covered in the Part D drug benefit beginning in 2006. We received many comments, studies and literature reviews on nebulizers and MDIs. Some commenters identified the specific disadvantages of MDIs and holding chambers or spacers. Some commenters questioned the conclusion of the literature review mentioned in the proposed rule that nebulizers are not clinically superior in delivering inhalation drugs than MDIs and the commenters asserted that the two are not fully substitutes. Some commenters quantified the costs to beneficiaries of nebulizers and MDIs. One commenter pointed out that MDIs would increase in 2006 based on the ban of the propellent chlorofluorocarbon. Another commenter questioned the point in the proposed rule that MDIs are more portable than nebulizers since advances in nebulizer technology have included additional portability. The commenter noted that since Medicare covers only one standard nebulizer, many of their patients have purchased portable nebulizers on an out-of-pocket basis to use as a second device while outside of their home.

Response: A number of drugs are available to treat the persons with asthma or who develop COPD. These include drugs, often inhaled, that expand the bronchial tubes and allow the patient to breathe more freely. Depending on the needs of the individual patient, these medications can be delivered using nebulizers or MDIs. Although nebulizers have long been covered under Medicare Part B, the MMA expanded access to MDIs beginning in 2006 through the new Medicare Part D drug benefit. While two meta-analyses cited by one commenter are consistent with the literature review mentioned in the proposed rule that found a lack of overall clinical superiority of MDIs over nebulizers, we recognize that even after coverage of MDIs begins in the Part D drug benefit in 2006, due to their particular circumstances, many beneficiaries will require the use of nebulizers and that nebulizers will continue to play an important role in inhalation therapy. Part B does not currently cover MDIs and we will gain experience with the costs of MDIs as the Part D drug benefit is implemented.

Comment: Comments were received from respiratory drug distributors and homecare providers addressing drugs that are supplied from the manufacturer in more than one form. One company suggested that since inhalation drugs are provided by the manufacturer in two forms, a premixed solution or as a powder (or other concentrate) that is diluted by the pharmacist, the ASP should be calculated separately for each of these two forms in order to reflect the different acquisition costs to the pharmacy for the different forms. The company suggested use of a modifier for the J-code to distinguish between these two forms for reimbursement purposes.

Response: We disagree. Consistent with the statute, the ASP is calculated by the HCPCS codes rather than the NDC code. This allows flexibility in appropriate drug delivery.

Comment: We received letters from individual beneficiaries and their family members indicating that the beneficiary has tried MDIs unsuccessfully and that inhalation drugs administered through a nebulizer were a successful treatment. They asked us not to assume that everyone on a nebulizer could be switched to inhalers and asked that we allow inhalation medications administered through nebulizers to remain funded by Medicare.

Response: We recognize that nebulizers are required by many beneficiaries due to their particular health circumstances. We did not propose to eliminate Medicare funding for inhalation medications administered through nebulizers.

Comment: Several commenters questioned why there should be public funding for COPD treatments for persons who chose to smoke cigarettes. The commenters indicate that it may be too harsh a policy to cease all reimbursement for COPD treatments, but they suggested two alternatives: (1) No individual who currently smokes should receive any Medicare benefit for the treatment of any respiratory condition, and (2) Any individual who historically smoked heavily and receives treatment for respiratory disorders should face an annual deductible equal to the cost of smoking a pack of cigarettes a day.

Response: As we indicated in the proposed rule, smoking has been linked to a large number of health problems and is the leading cause of cancer and pulmonary disease. The Department of Health and Human Services (HHS) has been actively encouraging Americans to quit smoking through its smoking cessation initiatives. Americans who quit smoking will enjoy longer, healthier lives and avoid diseases such as COPD. However, the Medicare law does not limit benefits to persons who do not currently smoke, nor does the Medicare law impose a deductible that is different for smokers and non-smokers. This regulation implements the law as it is currently written.

Result of Evaluation of Comments

In the proposed rule, we requested comments on the appropriate separate dispensing fee for inhalation drugs used in a nebulizer. In this final rule we are establishing 2005 fees of $57.00 for furnishing a 30-day prescription and $80.00 for furnishing a 90-day prescription for inhalation drugs. This fee would be paid in addition to the Medicare payment amount for the drug.

As discussed in section IV, we are finalizing our proposal to eliminate the Assignment of Benefits (AOB) form for items and services, including drugs, where assignment is required by statute. We reiterate language in the recently updated guidelines for DMEPOS refills, emphasizing the word ''approximately''. This allows for refill prescriptions to be shipped by ground service on ''approximately'' the 25th or 85th day of the respective prescription period. In addition, we clarified the ordering requirements for DMEPOS items, including drugs, which can be dispensed with just a verbal physician order.

P. Section 706—Coverage of Religious Nonmedical Health Care Institution Services Furnished in the Home

1. Background

Section 706(a) of the MMA amended section 1821(a) of the Act by adding home health services to the list of services furnished to an individual by a religious nonmedical health care institution (RNHCI). Section 706(b) added section 1861(aaa) to the Act to expand the term ''home health agency'' (HHA) to include a RNHCI. However,

this expansion is limited to RNHCI items (specified durable medical equipment) and services furnished in the beneficiary's home when the items and services are comparable to those provided by a HHA that is not a RNHCI. Moreover, payment may not be in excess of $700,000 per calendar year, and may not be made after December 31, 2006. Accordingly, we are implementing changes to the RNHCI regulation to include services furnished in the home that result from the enactment of the MMA and that are becoming effective January 1, 2005.

The new time-limited home health services benefit will be referred to as ''home benefit'' or ''home services'' throughout this rule. The RNHCI home benefit may only be provided to an eligible beneficiary who is confined to the home for health reasons and who has a condition that makes the beneficiary eligible to receive services under Medicare home health. Additionally, the beneficiary must have an effective RNHCI election and receive his or her home services from the RNHCI. The home benefit is not a substitute for hospice care. As in the original RNHCI benefit, Medicare will pay only for nonmedical services in the home, but not for those religious items or services provided by the RNHCI. Additionally, RNHCI home service patients who have a documented need for a specified DME item can obtain that item with the applicable deductible and coinsurance.

2. Legislative History

In 1965, payments to Christian Science sanatoria (inpatient nonmedical care facilities for bedfast patients) were included in the initial provisions of Medicare under title XVIII of the Act. In 1996, in *Children's Healthcare Is a Legal Duty, Inc.* v. *Vladeck,* 938 F. Supp. 1466 (D. Minn. 1996) (''*CHILD I*''), a Federal district court held that some of the provisions pertaining to Christian Science sanatoria were unconstitutional on the grounds that they were sect specific, in violation of the Establishment Clause of the U.S. Constitution.

Section 4454 of the BBA amended section 1861(a)(1) of the Act, deleting Christian Science sanatoria from the Act and creating instead the RNHCI benefit to provide Medicare Part A and Medicaid access for all religious groups whose belief structure does not include medical intervention. We note that, in the Conference Report to the BBA (H.R. Conference Report, No. 105–217, at 768 (1997)), the Congress specified that the RNHCI provisions were a sect-neutral accommodation available to any person who is relying on a religious method of healing and for whom the acceptance of medical health services would be inconsistent with his or her religious beliefs. Further, the Congressional conferees were convinced that the RNHCI provisions fully responded to and satisfied the constitutional concerns that had been addressed by the district court in CHILD I.

Besides adding the new RNHCI benefit, section 4454 of the BBA also added sections 1861(ss) and 1821 to the Act. Section 1861(ss) sets forth:

- The ten requirements that a provider must meet in order to be considered a RNHCI;
- Parameters for oversight and monitoring;
- Authority for Federal review of items and services provided for excessive or fraudulent claims; and
- Parameters for ownership/affiliations.

As in the past, the new provisions do not mention the use of a religious counselor or practitioner; we consider that to be the responsibility of the patient.

Section 1821 of the Act provides for conditions for coverage of RNHCI services including:

- The election, revocation, and limitations of the RNHCI benefit (section 1821(b));
- The monitoring and safeguarding against expenditures (section 1821(c)); and
- The sunset provisions for the RHNCI benefit (section 1821(d)).

Section 1821(a) of the Act, as amended by the MMA, provides for Part A payment for inpatient hospital services, post-hospital extended care services, or home health services furnished to a beneficiary in, or by, a RNHCI only when the beneficiary has:

- A valid election for the RNHCI benefit in effect; and
- A condition that would qualify for inpatient hospital, extended care services, or home health if the beneficiary were an inpatient or resident in a hospital or skilled nursing facility, or was a patient residing at home under the care of a HHA that was not a RNHCI.

The election of the RNHCI benefit becomes effective immediately after execution and remains in effect for a lifetime or until revoked. As described in section 1821(b) of the Act, the election is a written statement signed by the beneficiary or the beneficiary's legal representative which states that:

- The individual is conscientiously opposed to the acceptance of nonexcepted medical treatment;
- The individual's acceptance of that nonexcepted treatment would be inconsistent with the individual's sincere religious beliefs; and
- The individual's receipt of nonexcepted medical care constitutes a revocation of the election.

The RNHCI election may be revoked by voluntarily notifying the Secretary in writing of the revocation or the election may be revoked by simply receiving nonexcepted medical care for which payment is sought under Medicare. Once a RNHCI election is revoked twice, the next election may not take place until a date that is at least one year from the date of the most recent revocation. Any election thereafter does not become effective before a date that is at least five years after the date of the previous revocation. The receipt of excepted medical care does not result in a revocation of the election. As stated in § 403.702 of the regulations, the following definitions apply—

- *Excepted medical care or treatment* for purposes of the RNHCI benefit is defined as medical care or treatment (including medical or other health care services) received involuntarily (for example, following an accident), or required by any level of government (for example, immunizations).
- *Nonexcepted medical care or treatment* refers to all medical care or treatment that is not defined as excepted medical care or treatment. The beneficiary always retains the right to receive medical care under Medicare based on his or her level of coverage (for example, Part A, Parts A and B). However, using nonexcepted care will result in the revocation of the RNHCI election.

On November 30, 1999, we published the RNHCI interim final rule with comment period in the **Federal Register** (64 FR 67028), effective on January 31, 2000. The final RNHCI regulations were published on November 28, 2003 (68 FR 66710). There are currently 16 RNHCIs in the United States: Three in California; two each in Florida and Ohio; and one each in: Colorado, Illinois, Indiana, Massachusetts, New York, Texas, Virginia, Washington, and Wisconsin.

3. Summary of Section 706 of the MMA

Section 706 of the MMA amended the Act to extend Medicare coverage of RNHCI items and services to the RNHCI beneficiary's home when the items and services are comparable to those provided by a HHA that is not a RNHCI.

Specifically, section 706(a) of the MMA amended section 1821(a) of the Act by adding home health services to the list of services furnished to an individual by a RNHCI. Section 706(b) of the MMA added section 1861(aaa) to the Act to expand the term ''home

health agency'' to include a RNHCI as defined in section 1861(ss)(1) of the Act, but only for items and services that are ordinarily furnished by a RNHCI to individuals in their homes, and that are comparable to items and services furnished to individuals by a HHA that is not a RNHCI. Section 1861(aaa)(2)(A) of the Act states that, subject to section 1861(aaa)(2)(B), payment may be made for services provided by a RNHCI only to the extent and under the conditions, limitations, and requirements that are in regulations consistent with section 1821 of the Act. Section 1861(aaa)(2)(B) states that payment may not be made for RNHCI home services under section 1861(aaa)(2)(A) of the Act in excess of $700,000 per calendar year, or after December 31, 2006.

This interim final rule amends the existing RNHCI regulations in Subpart G to implement section 706 of the MMA.

4. Discussion

a. Implementation of Section 706 of the MMA

As stated above, section 706 of the MMA added section 1861(aaa)(1) to the Act to expand the term ''home health agency'' to include a RNHCI, as defined in section 1861(ss)(1) of the Act, but only for items and services that are ordinarily furnished by that institution to individuals in their homes, and that are comparable to items and services furnished by a HHA that is not a RNHCI. This posed a number of implementation challenges as a RNHCI does not conform to the statutory definition or requirements of a HHA in section 1861(m) of the Act, which is based on a medical model. Some of these challenges result from the fact that—

- RNHCIs were established to accommodate those religious groups that do not believe in the use of physicians to direct or supervise health care; and
- RNHCI nursing does not correspond to the statutory or regulatory parameters established by Medicare for ''skilled care'' in the home setting.

In addition, the RNHCI payment methodology does not readily lend itself to payment to the RNHCI for items and services under the RNHCI home benefit. Therefore, in an effort to implement the intent of the amendment, we will generally use the definition and requirements for a RNHCI, rather than a HHA (with some exceptions), in order to extend RNHCI services into the home environment. However, in order to aid in determining comparability, we are also utilizing, when appropriate, some of the home health requirements set forth in section 1861(m) of the Act.

The presence of physician orders and oversight is a keystone in the operational viability of a HHA and nonexistent in the RNHCI, where the religious practitioner (noncovered by Medicare) is the primary focal person in establishing the course for the religious method of healing. In addition, the RNHCI nurse further assists the patient in navigating the course established for the religious method of healing. To address the need for oversight for the RNHCI home benefit as with the current inpatient RNHCI benefit, we are implementing section 706 of the MMA by continuing to require that the RNHCI utilization review committee review the need for care (expanded now to include both admission to the home benefit and continued care in the home setting), and to oversee the utilization of items and services in the time-limited home benefit. The utilization review committee, however, cannot act in place of a physician in ordering items and services other than those designated specifically for the purpose of this time-limited RNHCI home benefit. A claim from any other individual or provider attempting to seek Medicare payment for non-designated RHNCI home benefit items and services without a physician order will be disallowed.

We also recognize that implementing section 706 is particularly challenging in light of the fact that no sophisticated physical treatments or procedures are provided in RNHCIs, while conventional medical care becomes more technical every year, making the care delivered by HHA personnel increasingly complex. The major challenge was determining comparability between home health services for HHAs defined in part 409 subpart E, and RNHCI services which are nonmedical in nature.

Medicare pays for supportive care or dependent services under the home health benefit only when under the orders and direction of a licensed physician if there is a medical need for skilled health care by a registered nurse, physical therapist, speech-language therapist, occupational therapist, or medical social worker. Under the Medicare home health benefit, when there is no longer a need for the ''skilled'' health care services, the supportive dependent services no longer qualify for payment. Based on section 1861(m) of the Act, we believe that Medicare home health care benefits are skilled-care oriented. These benefits were not designed to provide coverage for care related to help with activities of daily living unless the patient requires skilled nursing care or physical or speech therapy. The RNHCI nurse may be skilled in ministering to a beneficiary's religious needs (not covered by Medicare), but does not have the training or nursing skill sets required of credentialed/licensed health care professionals (for example, a registered nurse). While the RNHCI nurse may provide supportive care, that care is focused primarily on religious healing and meeting basic beneficiary needs for assistance with activities of daily living (for example, bathing, toileting, dressing, ambulation), as part of creating an environment for religious healing. The care provided by a RNHCI nurse is not at the level of either a registered nurse or a licensed practical nurse. The physical care provided by a RNHCI nurse is at a level that could be considered as supportive, but is decidedly not skilled nursing care as that term is understood under the Medicare home health program.

In the search for comparability of services, we considered the requirements and functions of the home health aide contained in sections 1861(m) and 1891(a)(3)(A) of the Act and in the regulations at 42 CFR 484.36. We performed a parallel review of the activities and skills utilized by home health aides and RNHCI nurses to determine comparability at an operational level. We determined that both the RNHCI nurse and the home health aide perform the following basic tasks—

- Assisting with activities of daily living (ADLs) that include: ambulation, bed-to-chair transfer, and assisting with range of motion exercises; bathing, shampoo, nail care, and dressing; feeding and nutrition; and toileting;
- Performing light housekeeping, incident to visit; and
- Documenting the visit.

However, the home health aide is also responsible for—

- Care of catheters and drainage equipment;
- Checking oxygen and other respiratory equipment;
- Communicating with nurse or other skilled team members;*
- Assisting with exercises as ordered by PT, OT or speech language therapist;
- Observation and reporting of existing medical conditions;*
- Recognizing and responding to emergency situations (including CPR);
- Routine care of prosthetics and orthotics;
- Taking and reporting vital signs;*
- Using basic infection control procedures;* and
- Care of wound/stoma dressings.

The home health aide during a home visit will usually perform at least three of the four skills marked with an

asterisk (*) from the ten skills listed. The remaining areas of responsibility are carried out as indicated by the patient's needs and the patient's care plan.

In analyzing the outcomes of the home health aide/RNHCI nurse review, we found that both groups engaged in the comparable tasks of assisting with activities of daily living, performing light housekeeping (incident to visit), and documenting the visit. Therefore, we will pay for the performance of these tasks by a RNHCI nurse in the home under the home benefit established by section 706 of the MMA. However, in reviewing for comparability of these services, we also found that the Medicare requirements for a home health aide exceed the preparation and skills of the RNHCI nurse for furnishing physical care. The home health aide performs activities that support the patient's prescribed medical therapeutic regimen and contribute to the Outcome and Assessment Information Set (OASIS) data collection effort. Moreover, we assumed that a significant portion of each RNHCI nurse visit is focused on religious activity (noncovered by Medicare). However, in spite of the difference in skill levels and the incorporation of non-covered religious activity into a visit, Medicare payment for the RNHCI home benefit is based on a fixed payment per visit, rather than on a total number of hours or number of caregivers involved. Unlike the home health benefit, the RNHCI benefit does not involve multiple levels of covered caregivers. Under the home health PPS only the *low utilization payment adjustment* (LUPA) rate provides for payment for individual home health visits. Due to the uniqueness of the RNHCI and RNHCI nurses in the Medicare program, we have developed a payment rate that is a percentage of the PPS LUPA rate for home health aide visits provided under the home health PPS, which we believe adequately represents the percentage of comparable tasks performed by the RNHCI nurse. Only a visit by a RNHCI nurse to a home is payable by Medicare. The cost for the religious portion of the visit continues to be the responsibility of the individual patient or the specific RNHCI.

Another challenge was posed by the provision of DME items for RNHCI patients in the home, since all DME is covered for Medicare payment only when ordered by a physician. That physician order may provide the RNHCI patient with the desired DME item, but will also revoke the patient's election for RNHCI care. We addressed the issue of DME by reviewing those items that are routinely found in a RNHCI that are comparable to those used by a HHA that is not a RNHCI. This resulted in a list of DME items that one could normally buy or rent off the shelf from a community pharmacy or health care supply store. For purposes of this time-limited benefit, we are permitting the RNHCI nurse to order from this list of designated items under the oversight of the RNHCI utilization review committee. A listing of these items is provided in Table 15 below.

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TABLE 15:

DME with HCPCS Codes Available for the Home Benefit	
CANES	
E0100	Cane, includes canes of all materials, adjustable or fixed, with tip
E0105	Cane, quad or three prong, includes canes of
	all materials, adjustable or fixed, with tip
CRUTCHES	
E0112	Crutches, underarm, wood, adjustable or fixed, pair, with pads, tips, and handgrips
E0113	Crutch, underarm, wood, adjustable or fixed, pair, with pad, tip, and handgrip
E0114	Crutches, underarm, other than wood,adjustable or fixed, pair, with pads, tips, and handgrips
E0116	Crutch, underarm, other than wood, adjustable or fixed, with pad, tip and handgrip
WALKERS	
E0130	Walker, rigid (pickup), adjustable or fixed height
E0135	Walker, folding (pickup), adjustable or fixed height
E0141	Walker, rigid, wheeled, adjustable or fixed height
E0143	Walker, folding, wheeled, adjustable or fixed height
COMMODES	
E0163	Commode chair, stationary, with fixed arms
E0167	Pail or pan for use with commode chair
WHEELCHAIRS	
K0001	Standard wheelchair
HOSPITAL BEDS and ACCESSORIES	
E0250	Hospital bed, fixed height, with any type side rails, with mattress
E0255	Hospital bed, variable height, hi-lo, with any type side rails, with mattress
E0260	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress
E0275	Bed pan, standard, metal or plastic
E0276	Bed pan, fracture, metal or plastic
E0290	Hospital bed, fixed height, without side rails, with mattress

E0292	Hospital bed, variable height, hi-lo, without side rails, with mattress
E0325	Urinal; male, jug-type, any material
E0326	Urinal; female, jug-type, any material

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We will provide the specifics for implementing the DME items and payment under this time-limited benefit in later Medicare program instructions.

Under section 1861(aaa)(2)(B) of the Act, payments for the RNHCI home benefit may not be made that exceed $700,000 per calendar year, and not after December 31, 2006. Under the RNHCI home benefit, Medicare will pay only for nonmedical health services in the home, as well as for those DME items included in Table 15 of this preamble. Medicare will not pay for religious items or services provided by the RNHCI. We have developed a special billing system for those RNHCI providers offering the home benefit to monitor expenditures on home services and items for purposes of staying within the statutory calendar year expenditure limit.

5. RNHCI Regulatory Provisions—RNHCI Medicare Benefits, Conditions of Participation, and Payment

As noted previously, to implement section 706 of the MMA, we reviewed the requirements for both HHAs and RNHCIs to identify the most feasible approach. Accordingly, we have made the following changes to the RNHCI regulations:

a. Basis and Purpose of Religious Non-Medical Health Care Institutions Providing Home Services—§ 403.764

We added § 403.764 to set forth the basis and purpose of the RNHCI home benefit. Specifically, we added subsection (a) to include a reference to section 1861(aaa) of the Act to the general RNHCI authority noted in § 403.700 and a description of the provisions of section 1861(aaa). We also added subsection (b) to describe the home benefit, the statutory annual fiscal limitation, and the sunset provision.

b. Definitions and Terms—§ 403.702

We made no changes to the regulation.

c. Conditions for Coverage—§ 403.720

We made no changes to the regulation.

We wish to emphasize that the RNHCI home benefit is an option available to each RNHCI, and the facility is not required to offer this service to either gain or maintain RNHCI status.

The RNHCI home benefit is not to be confused with hospice care that may involve more frequent visits and can involve institutional services. If, for some reason, the RNHCI home-serviced patient requires more than what is provided under the RNHCI home benefit, RNHCI or other institutional services may be required.

d. Valid Election Requirements—§ 403.724

We made no changes to the regulation because no modification or clarification to this requirement is needed to implement the RNHCI home benefit. Section 1821(b) of the Act addresses the issues involved in beneficiary election of RNHCI services.

e. Conditions of Participation—§ 403.730 through § 403.746

We have not changed the following conditions of participation, as they do not require any modification or clarification for implementing the RNHCI home benefit:

- Patient Rights (§ 403.730)
- Quality Assessment and Performance Improvement (§ 403.732)
- Administration (§ 403.738)
- Staffing (§ 403.740)

We have not changed the following conditions of participation, as they are specific to institutions and are not applicable to the implementation of the RNHCI home benefit:

- Food Services (§ 403.734)
- Discharge Planning (§ 403.736)
- Physical Environment (§ 403.742)
- Life Safety From Fire (§ 403.744)

The following condition of participation requires the addition of a new standard to reflect the additional responsibility necessary for implementing the RNHCI home benefit:

- Utilization Review (§ 403.746)

As explained previously, the utilization review committee will review the need for care and oversee the utilization of items and services for the RNHCI home benefit. Accordingly, § 403.746 will be revised to reflect the additional responsibility necessary for implementing the RNHCI home benefit. Specifically, § 403.746 will be modified to add a new subsection (c) to read as follows:

(c) *Standard: Utilization review committee role in RNHCI home services.* In addition to the requirements in (b), the utilization review committee is responsible for the admission and continued care review (at least every 30 days) of each patient in the RNHCI home services program. The utilization review committee is responsible for oversight and monitoring of the home services program, including the purchase and utilization of designated durable medical equipment (DME) items for beneficiaries in the program.

We again note that under the RNHCI home benefit, one of the tasks of the RNHCI nurse is to order from a selected group of DME items that meet the documented needs presented by a patient, if that need is presented by the patient. The utilization review committee will provide oversight for the DME orders and utilization of the items. The utilization review committee cannot act as a physician in ordering DME items other than those items designated specifically for the purpose of this time limited RNHCI benefit. A claim from any other individual or provider attempting to seek Medicare payment for non-designated RNHCI home benefit DME items without a physician order will be disallowed.

In implementing section 706 of the MMA, we have also revised the regulations to add the following provisions:

a. Requirements for Coverage and Payment of RNHCI Home Services (§ 403.766)

The RNHCI home benefit is an option available to each RNHCI, but it is not a service that the facility must offer to gain or maintain RNHCI status. With the exception of limited DME items, we have determined that services that RNHCI nurses provide are generally covered for Medicare payment under the time limited RNHCI home benefit as these services (for example, assistance with ADLs, light housekeeping incident to the visit, and documentation of the visit), are comparable to the services of home health aides in HHAs that are not RNHCIs.

To reflect the requirements of this limited benefit, we are adding a new section 403.766. Specifically, in § 403.766(a), we are requiring the RNHCI provider to submit a notice of intent if it is interested in providing RNHCI home services. This will help us facilitate the implementation of the RNHCI home benefit by letting us focus our efforts on those providers interested in providing this new benefit. The RNHCI provider is also responsible for providing RNHCI home services to eligible beneficiaries. We are imposing this requirement because we believe the RNHCI provider itself is responsible for providing the RNHCI home services, directly or under arrangement, to the eligible beneficiary. This means that the beneficiary cannot contract directly with a supplier or RNHCI nurse, but that the RNHCI provider itself is responsible for provision of the RNHCI home benefit services. This requirement conforms to the ''under arrangement'' requirement that home health agencies generally have to comply with to receive payment under the home health prospective payment system (*see* § 409.100(a)(2)). Furthermore, because the RNHCI is not a supplier, we are explicitly requiring the RNHCI provider to make arrangements for suppliers to furnish the designated RNHCI home benefit DME items. Likewise, the RNHCI provider will have to arrange for the RNHCI nursing services. While the RNHCI regulations currently require the RNHCI provider to have a utilization review plan and committee in place, we believe it would be prudent in the RNHCI home benefit regulation to explicitly require the RNHCI home benefit provider to have a utilization review committee that assumes the additional responsibility for the oversight and monitoring of the items and RNHCI nursing services provided under the home benefit. Lastly, because the RNHCI home benefit does not supersede or otherwise replace the existing RNHCI benefit, the provider will continue to have to meet all the existing applicable RNHCI regulatory requirements in subpart G of part 403.

We will also define an ''eligible beneficiary'' for the RNHCI home benefit in § 403.766(b). First, the beneficiary must elect to receive RNHCI services. Clearly, the RNHCI home benefit can only be provided to a beneficiary who has elected RNHCI services. Second, we believe that the purpose of providing a home benefit by a RNHCI provider was not to expand the basic eligibility criteria for receiving home health services. In fact, section 1821(a) of the Act, as amended by the MMA, now states that payment for RNHCI home services be made only if the individual has an election in effect and has a condition such that the individual would otherwise qualify for Medicare home health services. Specifically, this means that the individual must be confined to the home, as defined in section 1814(a) of the Aft and have a condition that would make him or her eligible to receive Medicare home health services. Third, much like the requirement that the RNHCI provider is responsible for providing RNHCI home services directly or under arrangement to the beneficiary, the beneficiary can only receive RNHCI home services through the RNHCI. The purpose of this requirement is to provide Medicare payment for the RNHCI home benefit only to beneficiaries who receive these services through the RNHCI. This requirement is consistent with section 1821(a) of the Act, as amended, which provides Medicare payment for home services furnished an individual by a RNHCI. We note that under the home health benefit beneficiaries are responsible for the deductible and coinsurance for DME furnished as a home health services. We see no reason to modify that requirement for beneficiaries receiving RNHCI home services. As this is a new benefit for RNHCI beneficiaries, we wish to make it clear that they are responsible for deductible and coinsurance for the designated RNHCI home benefit DME items in the same manner as Medicare beneficiaries receiving DME under the home health benefit.

b. Excluded Services (§ 403.768)

Under the home health benefit, certain items and services are excluded under the benefit. The RNHCI home benefit will exclude the same items and services, which are:

- Drugs and biologicals;
- Transportation;
- Services that would not be covered as inpatient services;
- Housekeeping services;
- Services covered under the ESRD program;
- Prosthetic devices; and
- Medical social services provided to family members.

Accordingly, we are adding a new § 403.768 to reflect the services excluded under the RNHCI home benefit.

In addition, we note that the statute does not provide for the provision of the RNHCI home benefit in a home health agency that is not a RNHCI, and we will provide for this exclusion in the regulation. We wish to reiterate that items and services not provided by a RNHCI but instead provided by a supplier or RNHCI nurse not under arrangement with the RNHCI are not included under the RNHCI home benefit. The regulation will also note this exclusion.

c. Payment for RNHCI Home Services (§ 403.770)

As discussed above, providing home services in the RNHCI environment incorporates many of the same components of the provision of home health aide services under the Medicare home health benefit. Because this is a new benefit not contemplated under the original RNHCI legislation, an appropriate payment methodology needed to be developed. As explained previously, we believe that an appropriate proxy for the cost of providing RNHCI home services can be found in the low utilization payment amount for home health aide visits under the Medicare home health PPS. Generally, Medicare home health services are reimbursed a prospectively set payment amount for a 60-day episode of care, adjusted for case mix. This 60-day episode payment includes costs for non-routine medical supplies, as well as costs for the six major home health disciplines, including home health aide services. The home health episode payment rate does not include reimbursement for durable medical equipment, which is paid through a separate DME fee schedule. The home health PPS rates were required to be budget neutral to what would have been expended under the reasonable cost system. The 60-day episode rate is updated annually by some percentage of the home health market basket, as dictated by law, and is adjusted by the hospital wage index to account for geographic variations in labor costs.

Medicare home health services may also be paid on a visit basis if the home health episode has four or fewer visits. Medicare pays on the basis of a national per-visit amount by discipline, referred to as low utilization payment adjustment (LUPA), adjusted for case mix. As mentioned previously, the LUPA rate for home health aide services is a very close approximation of the cost of providing home services in the RNHCI environment. However, due to the difference in skill levels and the incorporation of RNHCI religious activities that are not covered by Medicare, payment for the RNHCI home benefit is set at 80 percent of the per visit rate for a home health aide visit under the Medicare home health benefit.

The policies and rationale governing LUPA payments under the Medicare home health benefit are described in the July 3, 2000 HH PPS final rule (65 FR 41127). Generally, low utilization episodes are paid at a standardized average per visit amount, adjusted for geographic differences in wages, which will be the basis of calculating payment under the RNHCI home benefit program. These amounts are updated annually by the home health market basket percentage as dictated by statute and are being used for the RNHCI home benefit. For CY 2005, the Medicare HHA PPS rates were updated by the home health market basket minus 0.8 percent. The HHA PPS LUPA amount for CY 2005 is $44.76 for a home health aide visit, as published in the **Federal Register** October 23, 2004 (69 FR 62124). Because we believe the intent is to provide comparable home health services to a beneficiary at home provided by a RNHCI, we believe it is similarly necessary to develop a payment methodology to reflect the provision of these comparable services. As previously mentioned, we have determined that the LUPA payment, as calculated under the home health PPS and adjusted for geographic differences in wages is an appropriate payment methodology for the RNHCI home benefit. We further note that as the LUPA will be updated by the applicable market basket percentage under the home health PPS, we will also adopt the updated LUPA payment for CY 2006 as the basis of payment for the RNHCI home benefit in CY 2006. An update of the HHA payment rates is published annually in the **Federal Register**, with CY 2006 updated figures available in Fall 2005. As mentioned above, the beneficiary receiving the RNHCI home benefit will be responsible for deductible and coinsurance for the designated RNHCI home benefit DME items. The regulation will indicate that payment for DME as a RNHCI home item is made less the deductible and coinsurance amount.

In view of the small size and low volume of most RNHCIs, we will use a 30-day cycle for the submission of RNHCI home benefit claims. Unlike standard HHAs that use a 60-day cycle, the RNHCI will use a 30-day cycle for both payment request and as a minimum for continued care home benefit review by the utilization review committee. Specific instructions on the processing of RNHCI home benefit payments will be issued in separate Medicare instructions.

Example of LUPA Payment Adapted for RNHCI Home Benefit Payment:

A RNHCI in Baltimore, Maryland is providing the RNHCI home benefit to a patient with a RNHCI election. The RNHCI has provided 12 visits within a 30-day cycle. The RNHCI would determine the payment for the home benefit visits as follows:

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TABLE 16:

Computation of Wage Index Adjusted Low Utilization Payment for the RNHCI Home Benefit

		Final wage standardized and budget neutral per-visit payment amount per 30 days for 2005
1. Home Health Aide Visit (2005)		$ 44.76
2. RNHCI Nurse Visit	(0.80 * $ 44.76)	35.81
3. Calculate the labor portion of the Standardized Budget Neutral Per-Visit Payment Amount for 1 RNHCI nurse visit	(0.76775 * $.35.81)	27.49
4. Apply wage index factor for Baltimore, MD	(0.9907 * $ 27.49)	27.23
5. Calculate the non-labor portion of the Standardized Budget Neutral Per-Visit Payment Amount for 1 RNHCI nurse visit	(0.23225 * $ 35.81)	8.32
6. Subtotal—Low Utilization Payment Adjustment (LUPA) wage for 1 RNHCI nurse visit	($ 27.49 +$ 8.32)	$ 35.55
7. Total - Calculate total Low Utilization Payment Adjustment (LUPA) for 12 RNHCI nurse visits provided during the 30-day episode	(12 * $ 35.55)	$ 426.60

Note: The same "labor"/"non-labor" portions applied in the home health PPS will be used
calculating the RNHCI LUPA payments.

Step 1. Take the home health aide visit base rate for the involved year from the home health PPS update published.

Step 2. To calculate the RNHCI nurse visit base rate, multiply the home health aide visit base rate ($ 44.76) by the allowed percentage for a RNHCI nurse visit (0.80 percent) =($ 35.81).

Step 3. To calculate the labor portion of the Standardized Budget Neutral Per-Visit Payment Amount for 1 RNHCI nurse visit, multiply the labor portion of 0 .76775 by the RNHCI nurse visit rate from Step 2 ($ 35.81) =($ 27.49).

Step 4. Apply the wage index for the involved Metropolitan Statistical Area (MSA)

from the home health PPS payment update published annually each November in the **Federal Register** (Baltimore, MD =0.9907) multiplied by the labor portion of the RNHCI nurse visit from Step 3 ($ 27.49) =($27.23).

Step 5. To calculate the non-labor portion of the Standardized Budget Neutral Per-Visit Payment Amount for 1 RNHCI nurse visit, multiply the non-labor portion of 0.23225 by the RNHCI nurse visit rate from Step 2 ($ 35.81) =($ 8.32).

Step 6. To calculate the LUPA rate for 1 RNHCI nurse visit, add the products from Step 4 ($27.49) and Step 5 ($ 8.32) =($ 35.55).

Step 7. To calculate the LUPA payment for RNHCI nurse visits to one beneficiary in a 30-day period, multiple the product of Step 6 ($ 35.55) by the number of visits (12) =($ 426.60).

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IV. Other Issues

A. Provisions Related to Therapy Services

1. Outpatient Therapy Services Performed ''Incident To'' Physicians' Services

Section 1862(a)(20) of the Act permits payment for therapy services furnished incident to a physician's professional services only if the practitioner meets the standards and conditions that would apply to the therapy services if they were furnished by a therapist, with the exception of any licensing requirement. We proposed to amend the regulations at § 410.26, § 410.59, § 410.60, and § 410.62 to reflect the statutory prohibition on payment for ''therapy'' services of individuals who do not meet the existing qualification and training standards for therapists (with the exception of licensure) as these standards are set out in § 484.4.

As discussed in the August 5, 2004 proposed rule, section 1862(a)(20) of the Act refers only to PT, OT, and SLP services and not to any other type of therapy or service. This section applies to covered services of the type described in sections 1861(p), 1861(g) and 1861(ll) of the Act; it does not, for example, apply to therapy provided by qualified clinical psychologists. This section also does not apply to services that are not covered either as therapy or as E/M services provided incident to a physician or NPP, such as recreational therapy, relaxation therapy, athletic training, exercise physiology, kinesiology, or massage therapy services.

In the following discussion, the phrase ''therapy services'' means only PT, OT, and SLP. Also, ''therapist'' means only a physical therapist, occupational therapist, and speech-language pathologist.

Section 1861(s)(2)(K) of the Act permits certain NPPs, specifically PAs, NPs, and CNSs, to function as physicians for the purposes of furnishing therapy services which they are legally authorized to perform by the State in which the services are performed. Therefore, in our responses to comments in the following discussion, the statements concerning therapy services that apply to physicians also apply to PAs, NPs, and CNSs.

We received many comments on this proposal from professionals and associations for audiologists, speech-language pathologists, physical therapists, occupational therapists, long term care facilities, kinesiotherapists, massage therapists, athletic trainers, nurses, and physicians such as physiatrists, neurologists, podiatrists, chiropractors, osteopaths, medical groups, and family practitioners.

The proposal describes covered Medicare services and is not intended to affect the policies of other insurers who may cover services that Medicare does not, for example, therapy services performed by massage therapists or athletic trainers.

Comment: Several associations believe that this proposal is based on an incorrect interpretation of the intent of section 1862(a)(20) of the Act. Some claim that the proposed clarification is prohibited by the statute. They note the lack of any elaboration upon the Congress' intent in the Conference Report accompanying section 4541(b) of the BBA, but suggest the provision was based on a 1994 OIG report, ''Physical Therapy in Physicians' Offices'' (OEI–02–90–00590, March 1994). In the view of some commenters, the intended effect of section 1862(a)(20) of the Act was to apply to incident to therapy services the standards and conditions related to treatment plans, the need for goals, and the requirement that therapy is to be restorative. This position is based on the fact that these standards were the focus of the 1994 OIG report. The commenters point out that the report did not compare therapist services to services furnished by nontherapists in a physician's office, but it only compared the services billed by therapists to those billed by physicians.

Commenters argued that the plain meaning of section 1862(a)(20) of the Act indicates that incident to services are not necessarily furnished by therapists. They point to the parenthetical exclusion of licensure requirements in the statutory language as evidence that the Congress did not intend to apply the personnel requirements applicable to therapists in private practice to incident to therapy services. Some commenters believe this exclusion was intended to preserve the right of physicians to supervise auxiliary personnel that were not licensed as therapists. They suggest that we are creating a de facto licensure requirement.

Comments from the two members of the Congress who introduced the act that resulted in section 1862(a)(20) of the Act support the proposed rule, stating that the proposed clarification meets the intent of the law when it was passed by the Congress in 1997. These commenters confirm that the legislation was based in part on the 1994 OIG report and the intent was to establish ''a consistent standard for the delivery for PT services to ensure quality patient care.'' Two additional comments were received from the Congress in support of the proposal.

Response: Our interpretation is based on the plain language of the law: no payment may be made for incident to therapy services ''that do not meet the standards and conditions (other than any licensing requirement specified by the Secretary) under the second sentence of section 1861(p) * * * ''

The second sentence of section 1861(p) of the Act reads as follows:

''The term 'outpatient physical therapy services' also includes PT services furnished an individual by a physical therapist (in his office or in such individual's home) who meets licensing and other standards prescribed by the Secretary in regulations, otherwise than under an arrangement with and under the supervision of a provider of services, clinic, rehabilitation agency, or public health agency, if the furnishing of such services meets such conditions relating to health and safety as the Secretary may find necessary.''

It is evident then, that the standards and conditions referenced in section 1862(a)(20) of the Act encompass qualifications of the individual providing the therapy. Consequently, we disagree with those commenters who suggest that it was not the intent of section 1862(a)(20) of the Act to apply the personnel qualifications of the second sentence of section 1861(p) of the Act to therapy provided incident to a physician's service. We believe our interpretation of the law is further supported by the comment received from the Congress members who sponsored the original bill that became section 1862(a)(20) of the Act.

According to the proposed requirements, a person who is trained in therapy, but has not completed the further requirements of therapy licensure, may provide services incident to a physician's services. These individuals are not therapists, since they are not licensed, but they are qualified personnel who may, under direct supervision, provide therapy services incident to a physician.

A physician may utilize supervised unlicensed staff and may bill for a covered therapy service incident to the physician's service if it is provided according to Medicare policies, including coverage and incident to policies.

Comment: Commenters also note that qualifications at § 484.4 are in the home health agency section of the regulations, while the second sentence of section 1861(p) of the Act (referenced by section 1862(a)(20) of the Act) does not apply to therapy provided in home health agencies.

Response: The statute specifies therapy services provided incident to a physician must meet the standards and conditions that would apply to a therapist, except licensure. For the history of the qualifications for the private practice setting, please see the discussion in this rule as described below in section IV.A.2, ''Qualification Standards and Supervision Requirements in Therapy Private Practice Settings.'' We proposed to apply to all settings the qualifications in § 484.4 because they are standards that currently apply to therapists in provider settings. It is our intent to make therapist qualifications consistent in all settings (unless otherwise required by statute). Therefore, unless a person meets the standards in § 484.4, except licensure, their services may not be billed as therapy services incident to a physician's service, regardless of any other training, other licensure or certification or other experience they may have. For example, the services of chiropractors or athletic trainers who do not meet the requirements in § 484.4 except licensure, cannot be billed as therapy services incident to a physician's service.

Comment: Several associations indicated that we are changing our interpretation of the statute. They assumed any instruction relevant to the law was made in 1998 through Transmittal 1606. That transmittal provided guidance for therapy services, but did not address the qualification of the people who furnish therapy incident to physician services. It was also suggested that we delay implementation to allow further study and comment from interested parties. The AMA urged us to withdraw proposed changes and reissue a later proposal after consulting with all affected physician and other health professional organizations.

Also, the commenters note that the Administrative Procedure Act (APA) requires that we characterize this as a change rather than a clarification.

Response: In the past, we did not discuss the plain language of the law ecause we did not believe it needed extensive clarification. However, it has become clear to us that contractors have varied in their policies.

Some contractors created local policies that paid only for services provided by licensed therapists in all settings including incident to a physician's service. Others had no policies that assured the qualifications of personnel furnishing services billed as therapy services incident to a physician.

Study of the utilization of therapy services, internal discussions with contractors and medical review of claims for the purpose of error rate analysis all suggested that the services being performed in the offices of physicians did not consistently meet the standards and conditions we applied to therapy services in private practice or in provider settings. Problems associated with an imprecise definition of therapy services were discussed at length in Section 4.1 of the ''Study and Report on Outpatient Therapy Utilization'' (the DynCorp utilization study) found at *http://www.cms.hhs.gov/medlearn/therapy.* Review of medical records following this report reinforced the personnel qualification problem.

In Pub. 100–04, the Medicare Claims Processing Manual at chapter 5, section 20, there is a list of codes that represent services that are always therapy services (available online at *http://www.cms.hhs.gov/manuals/104_claims/clm104c05.pdf).* Whenever these codes are billed, they must have a modifier that identifies the type of therapy (PT, OT, or SLP) and the services provided must meet the standards and conditions that apply to outpatient therapy services. In the medical review of therapy claims, there were frequent observations of ''always therapy'' services performed by persons other than therapists, which were billed inappropriately as therapy.

Since the qualifications of therapists and therapy services continued to be problematic, we chose to raise the subject of therapist qualifications last year. Last year's comments made it clear that there is widespread use of nontherapists, particularly athletic trainers, in the offices of physicians and those services are being billed as therapy services. The volume of similar comments this year made it evident to us that the clarification was needed.

We characterize this statement as a clarification because it merely restates the law. Moreover, we announced our clarification in the proposed rule, and it has been subject to comment in last year's proposed rule and again this year. So, assuming that it did change policy, its promulgation meets the requirements of the APA.

In addition, we note that we continue to pay only for covered services whether they are therapy or other services. Coverage rules in the Program Integrity Manual, chapter 13.5.1, require, for example, that the service be safe, effective, in accordance with accepted standards of medical practice, and furnished by qualified personnel.

We recognize there has been inconsistent application of this statutory requirement. Therefore, in order to allow sufficient time for physicians to adjust their practices, and to avoid disrupting ongoing therapy in affected practices, we will delay implementation

until manual instructions are published. We anticipate publication of manual instructions on or after March 1, 2005.

Comment: Many commenters offered the opinion that restricting payment for therapy services to those performed by therapists would reduce access and quality of care and increase costs. They noted that it is more convenient for therapy to be available in a physician's office than at another site. Also, there was concern that therapists may not work in rural areas, especially because there is a shortage of qualified therapists.

Response: The statute requires that those who provide therapy services meet therapy standards. It provides an exception for licensure in an incident to setting, but it does not provide an exception for rural areas. Since recent changes allow physical and occupational therapists that are enrolled in Medicare to work for physicians, there is no legal impediment to physicians being able to provide therapy services in their offices without the use of nontherapists. The Department of Labor Bulletin 2572, titled ''Occupational Projections and Training Data 2004–05 Edition'', suggests no shortage of therapists.

Nor do we find evidence to suggest the quality of care will be decreased by the use of personnel trained in therapy services as opposed to those trained in other disciplines. The cost of therapy services to Medicare will not be changed by the use of appropriately trained personnel.

Comment: Many comments from physical therapists and PT associations agreed in principle with consistently defining the qualifications for therapists in all settings. They point out that, although the statute allows unlicensed people to provide therapy services incident to the services of a physician, the purpose of licensure is to assure that services are safely and effectively furnished by professionals who have demonstrated the necessary knowledge and skills. The statute permits the use of therapists who have not met licensing requirements and those whose licenses were revoked due to malpractice or fraud. The supervision requirement that the physician be present somewhere in the suite, but not in line of sight, is insufficient to assure the safety and quality of service provided by unlicensed staff.

Response: Although the law permits unlicensed individuals to provide services incident to the services of a physician, we believe physicians will be motivated to screen employees to weed out sanctioned or incompetent people who have training in therapy since physicians would be liable for the actions of an incompetent employee. We require direct supervision of the employee by the physician as a minimum standard, but a physician will provide whatever guidance and supervision is required to assure the safety, effectiveness and quality of the service.

Comment: Many comments were received from individuals such as athletic trainers, kinesiotherapists, massage therapists and chiropractors describing their training as equal or superior to therapists' and suggesting that they provide care similar to therapists.

Response: The statute allows Medicare to pay only for PT, OT and SLP services. Comments from therapists and nontherapists agreed that their training and licensure is unique to their professions, and they are separately trained and licensed for those unique professions. It is clear that many nontherapist health care practitioners are well-trained professionals dedicated to the provision of quality treatment for their patients. However, their training is not in PT, OT, or SLP, but in the other disciplines for which they are licensed or accredited.

Comment: A number of physicians and associations for physicians wrote to tell us that they believe it is their right and within their authority to decide who can provide effective therapy services in their offices.

Response: The statute requires Medicare to pay only for services that meet the standards and conditions, except licensure, that apply to therapists. It is the right and responsibility of a physician to recommend services for patients that in the physician's judgment are needed and effective. Medicare, however, need not pay for all services that a physician recommends. We are required to pay for services that are covered in the statute and to deny payment for services that are not covered, even if the physician considers those services necessary and effective.

Comment: Some physicians wrote to tell us they are currently billing Medicare for therapy services when athletic trainers perform services in their offices. Several commenters asked what services may be billed to Medicare when provided by auxiliary staff who are qualified as athletic trainers, or who have certification in fields other than therapy.

Response: While some carriers may have paid claims for incident to therapy services furnished by individuals without therapy training, we have never had a policy that permits athletic trainers or any other staff who do not have training in PT to provide services that are billed as PT services. Carrier payment for a service is not conclusive evidence that the service was appropriately rendered. Billing with a code that does not accurately represent the service provided is inappropriate. If identified by carrier medical review, these claims must be denied, and further development of the claim may be indicated to determine if there was intent to bill improperly.

Medicare defines PT, OT and SLP as services that require the skills of a physical therapist, occupational therapist or speech-language pathologist. Therapy codes are priced based on the salaries and expenses of therapists and we expect that therapy claims are made for services of therapists (or, for incident to services by someone with their training, except for licensure).

When a service is not a covered service, it is inappropriate to bill Medicare for that service as a service incident to a physician, or as an E/M service. For example, if a service is appropriately described as acupuncture or athletic training or massage therapy, Medicare will not pay for that service because it is not covered.

A physician may not bill Medicare for a service that is on the list of ''always therapy'' services (see Pub. 100–04, the Medicare Benefit Policy Manual, chapter 5, section 20) if the service was done by staff that is not qualified to provide a skilled therapy service, because that is not a covered therapy service. The ''always therapy'' codes always require a modifier to describe whether the service was PT, OT or SLP.

There are covered services that other staff, such as athletic trainers, may perform with other training, however, these are not therapy services. Other codes on the therapy list are ''sometimes therapy'' services and require modifiers only when they are therapy services rather than physician services. For example, a physician may apply a surface neurostimulator (CPT 64550) as an isolated service, outside of a therapy plan of care and appropriately bill the code without a therapy modifier. That service is not a therapy service. If that physician supervises auxiliary personnel in the provision of that same nontherapy service, the auxiliary personnel does not have to be qualified as a therapist because the service rendered is not therapy. In any case, when Medicare is billed for a service, the person providing the service must be qualified to provide the service, as determined by the contractor in accordance with coverage requirements

in Pub. 100–08, the Medicare Program Integrity Manual, chapter 13.5.1. However, if a therapist provides the service under any circumstance, or if either the physician or qualified personnel provides the service as part of a therapy plan of care, it is a therapy service and it requires a modifier. In cases where there is doubt, the contractor will determine whether the service is therapy or is not therapy.

Further information about services that may be completed by non-therapists will be available in implementing instructions.

Comment: The American Chiropractic Association commented that doctors of chiropractory are authorized to perform PT services in all but two States, Michigan and Washington. They request that we note that fact in our commentary and in the regulation. They note that Doctors of Chiropractic are included in the definition of ''physician'' and they propose language in addition to that in § 484.4 to define the qualifications of chiropractors, in order to recognize the State-authorized practice privileges of Doctors of Chiropractic.

Response: Chiropractors may bill services to Medicare as physicians, but only for the purposes of providing manipulation of the spine for the correction of a subluxation, which is a chiropractor service, and not a therapy service. For these manipulation services, chiropractors may directly *supervise* employees who provide incident to services. However, as Medicare physicians, chiropractors are not authorized to *order* therapy services or to perform any other services. To qualify to provide therapy services incident to a physician, chiropractors must meet all of the criteria set forth at § 484.4 except licensure.

Comment: Several associations and some individuals commented that we are creating a monopoly for therapists to provide therapy services and unnecessarily restricting other professions from providing therapy services.

Response: We are bound by the statutory authority given to us in section 1832 of the Act to pay only for services for which there are benefits enumerated in the statute. PT, OT and SLP have benefits in section 1861 of the Act. Therefore, Medicare pays only for those services.

Comment: Several commenters noted that some NPPs, specifically PAs, NPs, and CNSs, may perform therapy services billable under Medicare as therapy services if their State scope of practice allows. The commenters question whether those NPPs may also perform therapy services incident to a physician or NPP.

Response: Medicare does not impose therapy training requirements on physicians whose State scope of practice allows them to perform therapy services. Section 1861(s)(2)(K) of the Act permits PAs, NPs, and CNSs, to furnish services which would be physicians' services, that is, to function as physicians for purposes of furnishing services, including therapy services, which they are legally authorized to perform by the State in which the services are performed. Therefore, this final rule has been modified to reflect that in States that authorize physicians, PAs, NPs, and CNSs to provide one or more of the therapy services (PT, OT, or SLP services), those NPPs may provide the services incident to the services of a physician or NPP under the same conditions as physicians, that is, without meeting the training requirements applicable to therapists.

Results of Evaluation of Comments

To the extent that this policy is different from current manual text, we proposed this rule and received comments. We are finalizing the proposal in this final rule with the changes noted above in accordance with the APA. We will implement this regulation through manual guidance on or after March 1, 2005.

2. Qualification Standards and Supervision Requirements in Therapy Private Practice Settings

Sections 1861(g) and (p) of the Act include services furnished to individuals by physical and occupational therapists meeting licensing and other standards prescribed by the Secretary if the services meet the necessary conditions for health and safety. These services include those furnished in the therapist's office or the individual's home. By regulation, we have defined therapists under this provision as physical or occupational therapists in private practice (PTPPs and OTPPs).

Under Medicare Part B, outpatient therapy services, including physical and occupational therapy services, are generally covered when reasonable and necessary and when provided by physical and occupational therapists meeting the qualifications set forth at § 484.4. Services provided by qualified therapy assistants, including physical therapist assistants (PTAs) and occupational therapy assistants (OTAs), may also be covered by Medicare when furnished under the level of supervision by the therapist that is required for the setting in which the services are provided (institutions and private practice therapist offices). For PTPPs and OTPPs, the regulations now specify only that the PT or OT meet State licensure or certification standards; the regulations and do not currently refer to the professional qualification requirements at § 484.4.

Since 1999, when therapy services are provided by PTAs and OTAs in the private practice of a PT or OT, the services must be personally supervised by the PTPP or OTPP. In response to a requirement to report to the Congress on State standards for supervision of PTAs, we contracted with the Urban Institute. The Urban Institute found that no State has the strict, full-time personal supervision requirement, for any setting, that Medicare places on PTAs in PTPPs. (The report examined only PTAs, who are more heavily regulated by the States than OTAs).

To provide a consistent therapy assistant supervision policy, we proposed to revise the regulations at § 410.59 and § 410.60 to require direct supervision of PTAs and OTAs when PTs or OTs provide therapy services in private practice. We also specifically solicited comments regarding the proposed PTA supervision policy, and whether or not it would have implications for the quality of services provided, or for Medicare spending, either through increased capacity to provide these services, or, in the event that the Congress again extends the moratorium on the implementation of the limits on Medicare reimbursement for therapy services imposed by the BBA of 1997.

In addition, as discussed in the August 5, 2004 proposed rule, the current OTPP or PTPP regulations at § 410.59(c) and § 410.60(c) do not reference qualification requirements for therapy assistants or other staff working for PTs and OTs in private practices. In order to create consistent requirements for therapists and for therapy assistants, we proposed to restore the qualifications by adding the cross-reference to the qualifications at § 484.4 for privately practicing therapists and their therapy assistants at § 410.59 and § 410.60.

Comment: Commenters representing therapy organizations, as well as individual providers, were supportive of our proposal to revise the regulations at § 410.59 and § 410.60 to require direct, rather than personal, supervision of PTAs and OTAs when therapy services are provided by PTs or OTs in private practice.

(We use the 3 supervision levels defined at § 410.32, personal, direct, and

general, to describe the supervision requirements for various Medicare services and settings.)

Many commenters also stated that this is consistent with the Medicare requirements in other provider settings, such as hospitals, HHAs and rehabilitation agencies and is also consistent with the Medicare requirements for therapists in private practice that were in place prior to 1999. Commenters also believe that this will assist in ensuring access to therapy services and in protecting patient privacy.

Response: Requiring direct supervision of therapy assistants in PT and OT private practice settings is consistent with the supervision requirements that PTs and OTs in independent practice were required to meet, prior to 1999, at § 410.59(c) and § 410.60(c). This direct supervision requirement in PT and OT private practices requiring the therapist to be on site or ''in the office suite'' differs from our therapy assistant supervision requirements in institutional settings (for example, outpatient hospital departments, HHAs, and rehabilitation agencies). In those settings, PTs and OTs may provide general supervision of therapy assistants without being on-site.

We agree that changing the level of supervision of therapy assistants from personal to direct will help to improve access to medically necessary services.

Comment: A few commenters stated they believe permitting general supervision, rather than direct, is more consistent with State therapy supervision requirements. While State requirements vary, this variation may be due to the fact that PTAs are not licensed in some States. Other commenters stated that therapy assistants are qualified to provide services without having therapists in-the-room to provide personal supervision.

Response: A review of State practice acts revealed that Medicare's personal in-the-room supervision requirement for therapy assistants in PT and OT private practices was more stringent than any State supervision requirement for any setting. The Urban Institute report also found that most States permit a supervision level similar to our general supervision requirement for institutional settings. However, we believe that services delivered by therapy assistants in private practices require a higher level of therapist supervision than those provided in institutional settings where stringent standards for Medicare participation are enforced through State survey and certification programs, rather than the simplified carrier enrollment process for the PT or OT private practice offices.

Comment: One commenter stated that only licensed therapists should be allowed to provide and bill for therapy and another commenter demanded that therapy services only be reimbursed when provided by a therapist, not any other professional, including nurses, PAs, or chiropractors, and not by therapy assistants. They suggested that without this requirement there would be program abuses.

Response: We concur with the therapy associations and the overwhelming majority of commenters that therapy assistants are qualified by their training and education to provide services without the personal in-the-room supervision in the private practice setting. This does not mean, however, that therapy assistants may bill for the services they provide. Under the law, only PTs and OTs in private practice may bill Medicare for the therapy services provided by PTAs and OTAs. These therapists enroll in the Medicare program and receive a provider identification number (PIN) in order to file claims for the therapy services provided as a PTPP or OTPP. Institutional therapy providers bill Medicare on behalf of the PTs, OTs, and speech language pathologists who provide therapy services in these settings.

Other professionals, including nurses, athletic trainers, and chiropractors do not meet the statutory requirements for therapists in section 1861(p) of the Act and as implemented at § 484.4. We proposed to amend the regulations at § 410.59 and § 410.60 to specify that only individuals meeting the qualification standards and training consistent with § 484.4 may bill and receive Medicare payment for therapy services. In addition, a State license or certification in PT or OT will continue to be required for therapist providing services as PTPPs or OTPPs.

When PAs, NPs, or CNSs are authorized by their State practice acts to provide physical or occupational therapy services, and these NPPs are acting within their capacity to provide physician services under section 1861(s)(2)(K) of the Act, their services are considered therapy services.

Comment: One commenter stated that allowing lesser trained individuals such as therapist assistants to provide services if a therapist supervises, but prohibiting physicians from delegating performance of these services to doctors of chiropractic inappropriately gives therapists more authority than physicians.

Response: Medicare law recognizes chiropractors as physicians, but only for the limited purpose of providing manipulation of the spine for the correction of a subluxation. In order to qualify as a PT or OT for Medicare purposes, chiropractors would need to meet all of the criteria set forth at § 484.4.

Comment: In response to our request for information on the impact of this proposed change on the quality of services and Medicare spending, several individuals stated that the proposed change would not affect the way therapists practice, since they are fully accountable for services provided under their direction and, therefore, the change would not diminish the quality of services. Furthermore, commenters believe the change would also allow the appropriate and efficient utilization of therapist assistants because the in-the-room supervision unnecessarily drives up the cost of health care without providing additional consumer protection.

The American Physical Therapy Association (APTA) anticipates there will be little, if any, increase in spending as a result of this policy and believes that any increases would be due to improving access to medically necessary outpatient therapy services provided by qualified practitioners. For spending implications, the APTA believes it is highly unlikely that physical therapists would significantly alter their staffing patterns and thereby increase spending as a result of this change in policy. The majority of States have laws that establish limits on the number of PTAs that a PT can supervise (referred to as ''supervision ratios''). For example, a large number of States have a supervision ratio of one PT to two PTAs. There are also a limited number of PTAs whom PTs could supervise, and APTA does not anticipate substantial growth in the number of PTAs in the foreseeable future. To the contrary, the number of PTA education programs is declining.

Furthermore, services of PTs in private practice comprise a relatively small percentage of services billed under the Medicare program. Therefore, the overall financial impact of any change in the supervision requirement in this setting would be minimal.

Response: We appreciate the information provided by the commenters. Other opportunities already exist for therapists to provide services under Medicare in rehabilitation agencies and CORFs where the therapy assistant supervision level is general. Therapists opting to utilize therapy assistants might be more

likely to own a rehabilitation facility where the physical or occupational therapy assistant supervision level is general, rather than a private practice office where the therapist is required to be on-site to supervise services of the therapy assistant. The Urban Institute Report confirmed the limited number of therapy assistants available to be hired and found that workforce and distribution percentages of PTs and PTAs parallel each other, with nearly 25 percent of PTAs employed by PTPPs. We believe that the State supervision requirements and the limited number of PTAs are likely to limit the financial implications of this change. We plan to monitor this area to determine whether volume changes occur and, if so, in what settings they occur.

Comment: Commenters supported our proposal to revise § 410.59 and § 410.60 to cross-reference the qualifications at § 484.4 for privately practicing therapists and their therapy assistants.

Response: We appreciate the numerous letters of support for this proposal, including the national and State-level therapy organizations, other professional organizations, and many therapists and therapy assistants.

Result of Evaluation of Comments

We will finalize the proposed revisions to § 410.59 and § 410.60 to require direct supervision of PTAs and OTAs when therapy services are provided by PTs or OTs in private practice and also to cross-reference the qualifications at § 484.4 for privately practicing therapists and their therapy assistants.

3. Other Technical Revisions

We proposed technical corrections to § 410.62 to refer consistently to SLP (currently the terms ''speech pathology'' and ''speech-language pathology'' are used interchangeably) and proposed revisions to § 410.62(a)(2)(iii) to appropriately reference § 410.61 (the current reference is to § 410.63).

We also proposed removing subpart D, Conditions for Coverage: Outpatient Physical Therapy Services Furnished by Physical Therapists, from part 486. Our November 1998 rule (63 FR 58868) discussed replacing this subpart with a simplified carrier enrollment process for physical or occupational therapists in private practice; however, the conforming regulatory change to remove subpart D was never made.

In addition, we proposed a technical change at § 484.4 to correct the title ''physical therapy assistant'' to ''physical therapist assistant'' and proposed amending § 410.59(e) and § 410.60(e) to include a reference to the 2-year moratorium on the therapy caps established by section 624 of the MMA.

Comment: Commenters representing therapy specialty organizations supported these changes.

Response: We will finalize these changes as proposed.

Result of Evaluation of Comments

We are finalizing the changes as proposed.

B. Low Osmolar Contrast Media

High osmolar and low osmolar contrast media (LOCM) are used to enhance the images produced by various types of diagnostic radiological procedures. When the Medicare physician fee schedule was established, findings of studies of patients receiving both types of contrast media had been published, and the ACR had adopted criteria for the use of LOCM. At that time, we determined that the older, less expensive high osmolar contrast media (HOCM) could be used safely in a large percentage of the Medicare population. However, we also decided that separate payment for LOCM may be made for patients with certain medical characteristics. We adopted the ACR criteria, with some modification, as the basis for a policy that separate payments are made for the use of LOCM in radiological procedures for patients meeting certain criteria. These criteria were established at § 414.38. Under these conditions, we pay for LOCM, utilizing HCPCS codes A4644 through A4646.

In the August 5, 2004 rule, we proposed to revise the regulations at § 414.38 to eliminate the restrictive criteria for the payment of LOCM. This proposal would make Medicare payment for LOCM consistent across settings since, under the OPPS, there is no longer a payment difference between LOCM and other contrast materials.

We also proposed that, effective January 1, 2005, payment for LOCM would be made on the basis of the ASP plus six percent in accordance with the standard methodology for drug pricing established by the MMA. However, because the technical portions of radiology services are currently valued in the nonphysician work pool and the CPEP inputs for these services are not used in calculating payment, we also indicated we would continue to reduce payment for LOCM by eight percent to avoid any duplicate payment for contrast media.

Comment: Commenters representing radiology, interventional radiology, and imaging contrast manufacturers were supportive of this proposed change; however, our payment methodology of ASP plus six percent minus eight percent was questioned. Two commenters also believe that the implementation date for the application of ASP methodology should be changed from January 1, 2005. One requested an effective date of April 1, 2005 and the other requested an effective date of January 1, 2006.

Response: We appreciate the commenters' support for this change. We stated in the proposed rule that effective January 1, 2005, payment for LOCM would be made on the basis of the ASP plus six percent. However, there is an October 30, 2004 deadline for submission of the ASP data used for the January 1, 2005 payment, and this date occurred prior to our finalizing the proposed payment methodology for LOCM. Therefore, the ASP payment methodology for LOCM will be made effective April 1, 2005. Manufacturers of LOCM will be required to submit their fourth quarter 2004 (4Q04) ASP information to us on or before January 30, 2005. Subsequent data must be submitted within 30 days after the end of each calendar quarter. The 4Q04 data will be used to determine the April 1, 2005 ASP plus six percent payment limits. Further information on the specific format of the data submission and the address to which the information can be sent is found on the CMS ASP Web site, specifically at *http://www.cms.hhs.gov/providers/drugs/asp.asp.*

Our policy to reduce payment for LOCM by 8 percent stems from the fact that the technical component RVUs for these procedures took into account the use of (and expenses for) HOCM in the (see the November 25, 1991 final rule (56 FR 59502)). However, since that time, the price differential between HOCM and LOCM has declined. In addition, upon further review, we are not able to determine accurately the degree of duplicate payment that might occur when both the imaging procedure and LOCM are billed. Therefore, we are not applying the eight percent reduction to the LOCM payment as proposed. The payment for LOCM will be consistent with the payment rate for the majority of drugs administered by physicians.

Comment: One contrast agent industry association suggested that we issue additional codes for the reporting of contrast media.

Response: For 2005, we are continuing to use the current three HCPCS codes in the reporting of low osmolar contrast agents. However, we are exploring the possibility of additional codes to accurately capture the cost differences among all contrast agents as well as the differing clinical

uses, concentration, and dose administrations. We welcome input from the medical community and the manufacturers of contrast media on this issue.

Comment: A commenter suggested that we use a model to capture volume and concentration variances of LOCM. In this model, ASP would be calculated as ASP = Total Sales/Total Volume.

Response: This suggested methodology does not take into account the weighted average for each national drug code (NDC) within a HCPCS code that must be used to derive an appropriate ASP code price.

Result of Evaluation of Comments

We are revising the regulations at § 414.38 to eliminate the criteria for the payment of LOCM. In addition, effective April 1, 2005, payment for LOCM will be made on the basis of the ASP plus six percent.

C. Payments for Physicians and Practitioners Managing Patients on Dialysis

1. ESRD-Related Services Provided to Patients in Observation Settings

In response to comments received on billing procedures for physicians and practitioners managing patients on dialysis when the dialysis patient is hospitalized during the month, we stated in the November 7, 2003 **Federal Register** (68 FR 63220) that ESRD-related visits furnished to patients in observation status would not be counted as visits under the MCP but would be paid separately. Prior to this, long-standing Medicare policy had included ESRD-related visits furnished in the observation setting within the MCP. However, upon further review of this issue, in the proposed rule published August 5, 2004, we proposed a revision to this policy and stated that ESRD-related visits provided to patients by the MCP physician in an observation setting would be counted as visits for purposes of billing the MCP codes.

Comment: Several commenters expressed support for allowing ESRD-related visits provided to patients by the MCP physician in the observation setting to be counted for purposes of billing the MCP codes. However, Kidney Care Partners (KCP) and the Renal Physicians Association (RPA) requested clarification as to how a physician or practitioner who is not part of the MCP practice team should bill for visits furnished in the hospital observation setting. The RPA suggested that a hemodialysis procedure with single physician evaluation as described by CPT code 90935 be used.

Response: Physicians or practitioners who are not part of the MCP practice team but who furnish a visit to an ESRD beneficiary in the observation setting can bill the appropriate observation codes that accurately describe the service (CPT codes 99217 through 99220). A hemodialysis procedure with single physician visit as described by CPT code 90935 will only be used when the beneficiary is an inpatient or for outpatient dialysis services for a non-ESRD patient.

2. Payment for Outpatient ESRD-Related Services for Partial Month Scenarios

Since changing our payments for physicians and practitioners managing patients on dialysis, we have received a number of comments from the nephrology community requesting guidance on billing for outpatient ESRD-related services provided to transient patients and in partial month scenarios (for example, when the patient is hospitalized during the month or receives a kidney transplant). To address this issue, we proposed to change the description of the G codes for ESRD-related home dialysis services, less than full month, as identified by G0324 through G0327. The new descriptor would include other partial month scenarios, in addition to patients dialyzing at home. The proposed descriptors for G0324 through G0327 are as follows:

- G0324, End stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients under two years of age;
- G0325, End stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients between two and eleven years of age;
- G0326, End stage renal disease (ESRD) related services for dialysis less than a full month of service, per day, for patients between twelve and nineteen years of age.
- G0327, End stage renal disease (ESRD) related services for dialysis less than a full month of service, per day, for patients twenty years of age and over.

In the August 5, 2004 proposed rule, we stated that these G codes would provide a consistent way to bill for outpatient ESRD-related services provided under the following circumstances:

- Transient patients—Patients traveling away from home (less than full month);
- Home Dialysis Patients (less than full month);
- Partial month where there were one or more face-to-face visits without the comprehensive visit and either the patient was hospitalized before a complete assessment was furnished, dialysis stopped due to death, or the patient had received a kidney transplant.

However, we noted that this proposed change to the descriptions of G0324 through G0327 was intended to accommodate unusual circumstances when the outpatient ESRD-related services would not be paid for under the MCP and that use of the codes would be limited to the circumstances listed above. Physicians who have an on-going formal agreement with the MCP physician to provide cursory visits during the month (for example ''rounding physicians'') could not use the per diem codes.

Clarification on Billing for Transient Patients

In the August 5, 2004 proposed rule, we stated that, for transient patients who are away from their home dialysis site and at another site for fewer than 30 consecutive days, the revised per diem G codes (G0324 through G0327) would be billed by the physician or practitioner responsible for the transient patient's ESRD-related care. Only the physician or practitioner responsible for the traveling ESRD patient's care would be permitted to bill for ESRD-related services using the per diem G codes (G0324 through G0327).

If the transient patient is under the care of a physician or practitioner other than his or her regular MCP physician for a complete month, the physician or practitioner responsible for the transient patient's ESRD-related care would not be able to bill using the per diem codes. We also solicited comments on when a patient will be considered transient.

Comment: Several commenters, including the ASN, KCP, and the RPA, supported our proposed change to the description of HCPCS codes G0324–G0327 (per diem codes). The KCP believed that this change would provide a consistent billing method when the patient is transient, furnished home dialysis (less than full month), and for other partial month scenarios when the patient is hospitalized, has a transplant or when the patient expires. Additionally, several commenters praised us for our willingness to work with the renal community to address the multitude of issues surrounding the way physicians and practitioners are paid for managing patients on dialysis.

However, the RPA and KCP suggested that, in addition to the situations described in the proposed rule, the per diem codes as described by G0324 through G0327 should be used to bill whenever one or more visits occurred

during the month regardless of whether the complete monthly assessment was furnished.

Response: As explained in the proposed rule, we believe the per diem codes will only be used for unusual circumstances where the ongoing management of an ESRD patient would not be paid through the MCP. As discussed earlier, we proposed to allow the per diem codes only in specific circumstances. However, after further review of this issue, we believe that it would also be appropriate to use the per diem codes when the beneficiary's MCP practitioner changes permanently during the month. For example, the ESRD beneficiary moves from one State to another and a new MCP physician or practitioner has the ongoing responsibility for the E/M of the patient's ESRD-related care who is not part of the same group practice as an employee of the previous MCP physician. We addressed this issue in a recent instruction published on September 17, 2004 (CR 3414 ''Payment for Outpatient ESRD-Related Services'', Transmittal 300). For more information on this instruction please visit our Web site at *http://www.cms.hhs.gov/manuals/* and select 2004 transmittals under the program transmittals link.

However, we will not permit the use of per diem codes (HCPCS codes G0324 through G0327) for all instances when the MCP physician or practitioner furnishes at least one visit during the month without regard to the status of a complete monthly assessment of the patient. We are concerned that permitting the per diem codes to be used in this manner may undermine the MCP. For example, the ESRD MCP includes various physician and practitioner services such as the establishment of a dialyzing cycle, outpatient E/M of the dialysis visit(s), telephone calls, patient management as well as clinically appropriate physician or practitioner visit(s) during the month. At least one of the visits must include a clinical examination of the vascular access site furnished face-to-face by a physician, CNS, NP or PA. When a practitioner bills for the MCP, the medical record must document that all of these services are furnished. By using the per diem codes in the manner suggested by the commenter, it would not be necessary for the practitioner to provide a complete monthly assessment of the ESRD beneficiary to receive payment for the ongoing management of patients on dialysis.

Comment: With regard to the ESRD-related services for home dialysis patients, less than full month, one healthcare corporation believes that the proposed coding changes continue to penalize nephrologists for prescribing home therapy because a per diem (pro-rated) payment is made when a hospitalization occurs. The commenter believes that this policy results in an inequity as compared to a physician providing 2–3 visits per month for center-based dialysis patients. Additionally, the commenter argues that the pro-rated methodology used for home dialysis patients (partial month) is inconsistent with how we pay the MCP physician for patients undergoing dialysis treatments in a dialysis facility.

The commenter believes that we should increase the payment for ESRD-related services for home dialysis patients to a level that is at least as high as the ESRD-related services (for full month) with 4 or more visits per month. The commenter contends that raising the payment amount for home-based dialysis patients would result in revenue opportunities similar to those available in the center-based scenario and would provide a greater incentive for home dialysis treatment.

Response: We do not agree with the commenter's statement that an inconsistency exists in the way we pay the MCP physician for managing a home dialysis patient (less than full month) and center dialysis patient (less than full month).

Our proposed change to the description of HCPCS codes G0324 through G0327 would apply to dialysis patients who receive dialysis in a dialysis center or other facility during the month as well as to home dialysis patients. For example, if a center dialysis patient is hospitalized during the month, has a transplant, or expires before a complete assessment is furnished (including a face-to-face examination of the vascular access site), the MCP physician would use the per diem rate to bill for ESRD-related care. When either a home dialysis patient or a patient who receives dialysis in a dialysis facility is hospitalized, the MCP physician or practitioner may bill for inpatient hemodialysis visits as appropriate (for example CPT codes 90935 and 90937).

Additionally, we believe the current payment level for physicians managing patients on home dialysis for a full month already provides an incentive for an increased use of home dialysis. For instance, payment for the monthly management of home dialysis patients is made at the same rate as the MCP with 2 to 3 visits. However, a monthly visit is not required as a condition of payment for physicians and practitioners managing home dialysis patients. Essentially, a physician or practitioner managing ESRD patients who receive dialysis in a dialysis facility would be required to furnish 2 to 3 face-to-face visits in order to receive the same level of payment as he or she would have received for managing a home dialysis patient. We do not believe it would be appropriate to pay physicians managing home dialysis patients at the highest MCP amount when no visits are required as a condition of payment.

Definition of a ''Transient Patient''

Comment: The RPA and KCP believe that it would be more appropriate to refer to these patients as ''visiting patients''. The RPA suggested that a ''visiting patient'' be defined as a ''patient receiving dialysis or renal-related care whose care is temporarily supervised (for less than one month's time) by a physician who is not a member of the practice that usually charges under the MCP or G codes''.

Response: We believe the term ''transient patients'' better describes a beneficiary who is away from his or her home dialysis site for less than a full month.

General Comments on Our Changes in Payments for Physicians and Practitioners Managing Patients on Dialysis

Comment: One commenter requested clarification as to how ESRD-related visits furnished to beneficiaries residing in a skilled nursing facility (SNF) adjacent to a hospital should be handled. The commenter explained that his SNF patients with ESRD usually receive dialysis treatments in an independent dialysis facility connected to a hospital's SNF. However, in cases when the patient is ''too ill'' to be transported to the independent dialysis facility, the dialysis treatment occurs in the inpatient dialysis treatment area (but the patient is not admitted to the hospital as an inpatient). The commenter noted that ESRD-related visits may be furnished while the patient is dialyzing or at the SNF when the patient is not dialyzing.

Response: Although we have not issued specific instructions on this issue, we believe that ESRD-related visits furnished to SNF residents are similar to other ongoing management services under the MCP. As such, ESRD-related visits furnished to patients residing in a SNF will be counted for purposes of billing the MCP codes. However, if the beneficiary is admitted to the hospital as an inpatient, the appropriate inpatient visit code will be used, for example, CPT code 90935.

Comment: With regard to our revisions to the MCP (as published in the CY 2004 final rule), the American Association of Kidney Patients (AAKP) questioned if we have any current data on or future plans to study whether access to nephrologists or the quality of medical care for ESRD patients has been improved or impaired. Additionally, AAKP questioned whether we have any plans to develop additional proposals (beyond the telehealth proposal) to address access needs in rural and other underserved areas.

Response: In evaluating the MCP, we will be looking for trends in hospitalization rates and resource utilization for ESRD patients. Moreover, we understand the challenges nephrologists face in visiting all patients on dialysis. To that end, we believe that our policy to allow clinical nurse specialists, nurse practitioners and physician assistants to furnish visits under the MCP, along with our addition of specific ESRD-related services to the list of Medicare telehealth services, will help ameliorate access issues.

Comment: The RPA and the ASN continued to express concerns with the changes made in the CY 2004 final rule to the way physicians are paid for managing patients on dialysis. The RPA strongly believes that many of the underlying principles of the new HCPCS codes for managing ESRD patients need to be changed. The RPA cited the impact on rural providers, the lack of gradation in payment amounts between furnishing 2 and furnishing 3 visits per month, and the premise that more visits will equate to better quality of care as major shortcomings of the new ESRD MCP.

The RPA and ASN emphasized their belief that more physician and practitioner visits per month does not correlate to efforts to improve the quality of care for ESRD patients. RPA contends that a stratified MCP system based on the number of monthly physician and practitioner visits is unnecessarily complicated and believes that the vast majority of nephrologists provided appropriate ESRD-related care under the previous MCP. To that end, the RPA urged us to implement a simpler system based on a minimum number of patient visits and a new documentation requirement for the services provided under the MCP.

Response: We appreciate the commenters' suggestions and will consider these comments as we continue to refine how we pay for physicians and practitioners managing patients on dialysis.

Results of Evaluation of Comments

ESRD-related visits provided to patients by the MCP physician or practitioner in an observation setting will be counted as visits for purposes of billing the MCP codes.

Moreover, we will change the description of the G codes for ESRD-related home dialysis services, less than full month, as identified by G0324 through G0327. The new descriptor will include other partial month scenarios, in addition to patients dialyzing at home. The descriptors for G0324 through G0327 will be as follows:

- G0324: End stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients under two years of age.
- G0325: End stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients between two and eleven years of age.
- G0326: End stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients between twelve and nineteen years of age.
- G0327: End stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients twenty years of age and over.

The revised per diem ESRD-related services G codes will be used for outpatient ESRD-related services provided in the following scenarios:

- Transient patients—Patients traveling away from home (less than full month);
- Home dialysis patients (less than full month);
- Partial month where one or more face-to-face visits without the comprehensive visit and either the patient was hospitalized before a complete assessment was furnished, dialysis stopped due to death, or the patient had a transplant.
- Patients who have a permanent change in their MCP physician during the month.

D. Technical Revision—§ 411.404

In § 411.404, Medicare noncoverage of all obesity-related services is used as an example. Since we are currently revising this coverage policy, we proposed to omit this example.

Commenters were supportive of this proposed change and we are finalizing it as proposed.

E. Diagnostic Psychological Tests

All diagnostic tests covered under section 1861(s)(3) of the Act and payable under the physician fee schedule must be furnished under the appropriate level of supervision by a physician as defined in section 1861(r) of the Act. Section 410.32(b)(2)(iii) states an exception to these physician supervision requirements for clinical psychologists and independently practicing psychologists (who are not clinical psychologists) which allows them to personally perform diagnostic psychological testing services without physician supervision. However, diagnostic psychological tests performed by anyone other than a clinical psychologist or an independently practicing psychologist must be provided under the general supervision of a physician as defined in section 1861(r) of the Act. Accordingly, clinical psychologists and independently practicing psychologists have not been permitted to supervise others in the administration of diagnostic psychological tests.

As discussed in the August 5, 2004 proposed rule, we were asked to re-evaluate our regulations regarding clinical psychologists' supervision of diagnostic psychological tests, and additional information concerning provision of these services was also supplied. Based upon our review of this issue, we determined that clinical psychologists possess knowledge sufficient to direct test selection and interpret test data. Therefore, we proposed to change the requirements at § 410.32(b)(2)(iii) to permit clinical psychologists to supervise the performance of diagnostic psychological and neuropsychological testing services.

Comment: Two specialty societies representing psychologists and many individual commenters were in support of the change. One major association representing psychiatrists and a few individual commenters opposed the proposal. According to the association, expanding the supervision requirements will not lessen the burden on physicians and healthcare facilities within rural areas. In addition, this association asked that we provide data showing that the change to the supervision requirements will reduce the burden on physicians and health care facilities, and that access will be improved in rural areas.

Response: We appreciate the positive comments in support of this proposal.

In response to the request for evidence that this change will reduce burden and improve access, we would first note that our primary reason for proposing this change was that we believe clinical psychologists possess the core knowledge to sufficiently supervise the administration of these tests. By enabling them to do so, this change will allow greater flexibility in their practices.

With regard to improved access in rural areas, we noted previously in this rule that we recognize mental health HPSAs for incentive payments for psychiatrists. Accordingly, we believe that the expansion of the supervision requirements will help improve access in these areas.

Result of Evaluation of Comments

As proposed, we are revising § 410.32(b)(2)(iii) to permit clinical psychologists to supervise the performance of diagnostic psychological and neuropsychological testing services.

F. Care Plan Oversight

Care Plan Oversight (CPO) refers to the supervision of patients receiving Medicare-covered home health or hospice services requiring complex multidisciplinary care modalities, including regular development and review of plans of care. In the August 5, 2004 rule, we proposed to revise § 414.39 to clarify that NPPs can perform home health CPO; however, they cannot certify a patient for home health services and sign the plan of care. We also proposed the conditions under which NPP services may be billed for CPO and explained that the proposed conditions are meant to ensure that the NPP has seen and examined the patient and that the appropriate and established relationship exists between the physician who certifies the patient for home health services and the NPP who will provide the home health CPO.

Comment: Several commenters support the proposed revision and conditions of coverage. They support the integrated practice arrangements required by proposed § 414.39(c)(2)(iii). They believe the proposed conditions ensure appropriate, ongoing supervision of both the patient's condition and the NPP.

Response: We appreciate the commenters' support for this proposal.

Comment: We received a comment from an association representing home care physicians requesting that we include PAs in the clarification because PAs increasingly play the same role as NPs in home health care and bill under the same house call codes.

Response: We agree with the commenter that we include PAs in the clarification. The definition of NPPs in proposed § 414.39(a) includes NPs, CNSs, and PAs. However, we also note that PAs cannot bill directly for their own services.

Comment: We received a comment requesting that we clearly state the definition of the appropriate relationship between the physician and the NPP. The commenter requested that we cross-reference applicable State standards because the meaning of collaboration varies across States and some States require employment relationships. Also, the commenter recommended that we require a written agreement regarding the responsibilities for managing care when the NP or PA is not from the same organization as the physician who has certified the skilled home care services.

Response: We agree that State laws or regulations governing collaborative relationships, where applicable, would be useful in this regard. In the absence of State laws or regulations, NPs and CNSs will be required to document their scope of practice and indicate the relationships they have with physicians to handle issues outside their scope of practice. If the NPP is a PA, the physician signing the plan of care also must be the physician who provides general supervision of PA services for the practice.

Comment: We received a comment requesting that this clarification be made retroactive to at least FY 2000 to allow denied claims to be resubmitted. The commenter stated that many claims for CPO services by NPs were denied over the past several years, despite CMS and legislative intent to have these claims reimbursed.

Response: We clarified in the November 1, 2000 final rule (65 FR 65407) that CPO services of NPPs, practicing within the scope of State law applicable to their services, could be paid under Medicare. However, our policy has also been that the physician who bills for CPO must be the same physician who signs the plan of care.

Appeal rights are available for these claims for CPO services provided by NPPs in HHAs if the appeal is requested within 120 days of the date of the claim denial. If appeal rights have expired, the physician or supplier may request a reopening for any reason within 12 months of the date of the notice of initial determination. After the 12-month period, but within 4 years from the date of the initial determination, a reopening may be requested for good cause. The decision on whether to reopen a claim at the request of the physician or supplier is at the discretion of the Medicare contractor.

Comment: We received comments noting that this clarification does not allow NPs, CNSs, or PAs to certify a patient for home health care services or to sign the plan of care. The commenters noted that certification by NPPs is not currently permitted under the statute. One of the commenters recommended that we revise the rules on certification and recertification to allow NPs, CNSs, or PAs to perform them.

Response: The commenters are correct that the statute (sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act) requires a physician to certify a patient for home health care services or to sign the plan of care. Therefore, the issue of whether to allow NPs, CNSs, or PAs to certify a patient for home health care services or to sign the plan of care is not within the purview of this rule.

Result of Evaluations of Comments

We are adopting the proposed changes to § 414.39 that clarify that NPPs can provide care plan oversight for beneficiaries who receive home health services.

G. Assignment of Medicare Claims—Payment to the Supplier

The current regulation requires the beneficiary (or the person authorized to request payment on the beneficiary's behalf) to assign a claim to the supplier for an assignment to be effective. However, over time, the Act was amended in various sections to require that Medicare payment for certain services would only be made on an assigned basis regardless of whether or not the beneficiary actually assigns the claim to the supplier. In these instances, the current requirement in § 424.55(a), which specifies that the beneficiary assign the claim to the supplier, is now unnecessary. Therefore, we proposed to create an exception to the general rule in § 424.55(a). New § 424.55(c) would eliminate the requirement that beneficiaries assign claims to suppliers in situations when payment under the Act can only be made on an assignment-related basis or when payment is for services furnished by a participating physician or supplier.

Comment: The ACLA supports the proposal and agrees that this new exception to the requirement for beneficiaries to assign benefits in situations where benefits can, by statute, only be paid on an assigned basis will reduce the paperwork burden on beneficiaries and suppliers.

Response: We agree that the proposed regulation will reduce the paperwork burden on beneficiaries and suppliers and we are finalizing the revisions as proposed.

Result of Evaluation of Comments

We are finalizing § 424.55(c) as proposed.

H. Additional Issues Raised by Commenters

Comment: Two specialty societies representing plastic surgeons and

podiatrists, as well as the RUC, recommended that the global period for CPT 15342, Application of bilaminate skin substitute/neodermis; 25 sq cm, be changed from a 10-day global period to a 0-day global period. The commenters stated that the plastic surgeons generally perform this procedure on more severely injured patients, such as burn patients, who are often seen in the inpatient setting. The podiatrists, on the other hand, typically treat patients with diabetic foot ulcers in the outpatient setting. Therefore, the commenters contend that though the work required to perform the procedure is the same for both specialties, the post-surgical work and time are not and the change in the global period would allow both scenarios to be paid appropriately.

Response: We understand that this code can represent differing scenarios. However, while podiatrists perform approximately 45 percent of the procedures and general surgeons 17 percent, plastic surgeons perform only 7 percent. In addition, only 9 percent are performed in the inpatient hospital setting. Our general approach and the one adopted by the RUC for valuing all services is to base our review on the typical patient. In this case, the podiatric scenario would clearly dominate and applying a 10-day global period to capture the post-procedure office visit appears appropriate. However, we would be willing to discuss this issue further with the specialties involved and with the RUC.

Comment: The American Society of Anesthesiologists (ASA) provided comments asking that we consider revising the current teaching regulations to place teaching anesthesiologists' reimbursements on par with the teaching of resident physicians in surgery and other high-risk specialties. Also, that we redefine the HCPCS claims service modifier ''AA'' to include both the personal administration of the anesthesia by the physician and teaching up to two resident physicians concurrently. In its comments, the ASA stated that it believes we possess the authority under the terms of section 1871 of the Medicare statute to make the requested change in its teaching reimbursement rules, effective January 1, 2005, as follows: the agency can treat the rule as a logical outgrowth of a prior proposal; it can issue a final rule with comment period as part of the 2005 physician payment final rule; or, it can promptly issue a free-standing rule proposing the change and allow for public comment and subsequent effectiveness along with the 2005 physician payment rule. The American Association of Nurse Anesthetists (AANA) asked that, if we review proposed revisions to the teaching anesthesiologist rules, that we carefully consider how these revisions might impact teaching Certified Registered Nurse Anesthetists (CRNAs). The AANA commented that our rules should not favor one type of provider over another.

Response: Surgical services are paid differently than anesthesia services. For example, surgical codes usually have global periods and payment includes the payment for the surgical procedure and postoperative visits during the global period. Anesthesia services include the preanesthesia examination and evaluation, the anesthesia service associated with the surgical service, and immediate postanesthesia care. Currently, the teaching physician's presence during the key or critical period criteria applies to both the services of the teaching surgeon and the teaching anesthesiologist. The key or critical services are different for the service of each specialty.

We plan to explore these issues further prior to deciding whether to include this change in the proposed rule for 2006.

Comment: We received comments from a manufacturer, many providers and individuals requesting that new HCPCS codes be created for a specific laser surgery treatment for benign prostatic hyperplasia. Commenters stated that current CPT codes used for billing this service under the physician fee schedule are not specific to the unique technology involved with this laser surgery treatment and result in underpayment when this technology is used. They noted that under the hospital OPPS, this treatment was assigned to a new technology code.

We also received requests from other individuals for new G codes and payment for other specific services, and for certain HCPCS codes that currently are paid only under OPPS.

Response: We do not believe that it is necessary to create new HCPCS codes for these services. Commenters that believe the existing CPT codes do not reflect their technology or services, may contact the AMA's CPT Editorial Panel to review these matters, particularly since the CPT Editorial Panel has a new coding classification specifically for new and emerging technologies.

There will be situations where codes are used under OPPS but not recognized under the physician fee schedule (PFS) because of the different payment methodologies.

Comment: A specialty society urged us to discontinue use of the HCPCS codes for positron emission tomography (PET) procedures and to instruct physicians to use the available CPT codes. They also urged us to adopt RUC recommendations for new PET codes rather than carrier price these services. The commenter stated they would like to meet to discuss these new codes and PET/computed tomography (CT) technology.

Response: We will continue to use HCPCS codes and carrier price these services at this time. We will be examining the overall issue of Medicare coding, payment, and coverage of PET services and would be happy to meet with the specialty society to discuss this issue.

General Issues

We also received comments on issues and concerns that were beyond the scope of the proposed rule. These include: The need for quality standards for diagnostic imaging; concerns about outreach and access; requests for revisions to current policy; and, concerns about the accuracy of code descriptors. While we will try to ensure these comments are provided to appropriate CMS components, commenters should also feel free to contact the appropriate CMS components about their concerns. To the extent that these comments involved valuation of services under the physician fee schedule, we are also soliciting comments on services for which the physician work may be misvalued. See section VI for additional information on this process.

V. Refinement of Relative Value Units for Calendar Year 2005 and Response to Public Comments on Interim Relative Value Units for 2004

[If you choose to comment on issues in this section, please include the caption ''Interim Work Relative Value Units'' at the beginning of your comments.]

A. Summary of Issues Discussed Related to the Adjustment of Relative Value Units

Section V.B. and V.C. of this final rule describes the methodology used to review the comments received on the RVUs for physician work and the process used to establish RVUs for new and revised CPT codes. Changes to codes on the physician fee schedule reflected in Addendum B are effective for services furnished beginning January 1, 2005.

B. Process for Establishing Work Relative Value Units for the 2004 Physician Fee Schedule

Our November 7, 2003 final rule (69 FR 1084) contained the work RVUs for Medicare payment for existing

procedure codes under the physician fee schedule and interim RVUs for new and revised codes beginning January 1, 2004. We considered the RVUs for the interim codes to be subject to public comment under the annual refinement process. (Note that the November rule was subsequently revised on January 7, 2004 to reflect revisions to procedure codes required by the MMA.) In this section, we summarize the refinements to the interim work RVUs published in the November 7, 2003 rule and our establishment of the work RVUs for new and revised codes for the 2005 physician fee schedule.

C. Work Relative Value Unit Refinements of Interim Relative Value Units

1. Methodology (Includes Table Titled ''Work Relative Value Unit Refinements of the 2003 Interim and Related Relative Value Units'')

Although the RVUs in the January 2004 final rule were used to calculate 2004 payment amounts, we considered the RVUs for the new or revised codes to be interim. We accepted comments for a period of 60 days. We received substantive comments on approximately 12 CPT codes with interim work RVUs.

To evaluate these comments we used a process similar to the process used since 1997. (See the October 31, 1997 final rule (62 FR 59084) for the discussion of refinement of CPT codes with interim work RVUs.) We convened a multispecialty panel of physicians to assist us in the review of the comments. The comments that we did not submit to panel review are discussed at the end of this section, as well as those that were reviewed by the panel. We invited representatives from the organizations from which we received substantive comments to attend a panel for discussion of the code on which they had commented. The panel was moderated by our medical staff, and consisted of the following voting members:

- One or two clinicians representing the commenting organization.
- One primary care clinician nominated by the American College of Physicians and American Society of Internal Medicine.
- Four carrier medical directors.
- Four clinicians with practices in related specialties who were expected to have knowledge of the service under review.

The panel discussed the work involved in the procedure under review in comparison to the work associated with other services under the physician fee schedule. We assembled a set of 300 reference services and asked the panel members to compare the clinical aspects of the work of the service a commenter believed was incorrectly valued to one or more of the reference services. In compiling the set, we attempted to include: (1) Services that are commonly performed whose work RVUs are not controversial; (2) services that span the entire spectrum from the easiest to the most difficult; and (3) at least three services performed by each of the major specialties so that each specialty would be represented. The intent of the panel process was to capture each participant's independent judgment based on the discussion and his or her clinical experience. Following the discussion, each participant rated the work for the procedure. Ratings were individual and confidential, and there was no attempt to achieve consensus among the panel members.

We then analyzed the ratings based on a presumption that the interim RVUs were correct. To overcome this presumption, the inaccuracy of the interim RVUs had to be apparent to the broad range of physicians participating in each panel.

Ratings of work were analyzed for consistency among the groups represented on each panel. In addition, we used statistical tests to determine whether there was enough agreement among the groups of the panel and whether the agreed-upon RVUs were significantly different from the interim RVUs published in Addendum C of the final rule. We did not modify the RVUs unless there was a clear indication for a change. If there was agreement across groups for change, but the groups did not agree on what the new RVUs should be, we eliminated the outlier group and looked for agreement among the remaining groups as the basis for new RVUs. We used the same methodology in analyzing the ratings that we first used in the refinement process for the 1993 physician fee schedule. The statistical tests were described in detail in the November 25, 1992 final rule (57 FR 55938).

Our decision to convene multispecialty panels of physicians and to apply the statistical tests described above was based on our need to balance the interests of those who commented on the work RVUs against the redistributive effects that would occur in other specialties.

We also received comments on RVUs that were interim for 2004, but for which we did not submit the RVUs to the panel for review for a variety of reasons. These comments and our decisions on those RVUs commented upon are discussed in further detail below.

Table 17 below lists those interim codes reviewed under the refinement panel process described in this section. This table includes the following information:

- CPT Code. This is the CPT code for a service.
- Description. This is an abbreviated version of the narrative description of the code.
- 2004 Work RVU. The work RVUs that appeared in the January 2004 rule are shown for each reviewed code.
- Requested Work RVU. This column identifies the work RVUs requested by commenters.
- 2005 Work RVU. This column contains the final RVUs for physician work.

TABLE 17:

Codes Reviewed Under the Refinement Panel Process

CPT code*	Mod	Descriptor	2004 work RVU	Requested work RVU	2005 work RVU
43752		Nasal/orogastric w/stent	0.68	0.82	0.81
63103		Remove vertebral body add-on	3.90	5.00	4.82

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2. Interim 2004 Codes

CPT code 43752 *Naso- or oro-gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report).*

The RUC recommended a work RVU of 0.82 for this service based on a comparison of this procedure to CPT code 44500, *Introduction of long gastrointestinal tube.* While we agreed that CPT code 43752 is similar in work intensity to CPT code 44500, we believed the intra-service time is more appropriately valued at the 25th percentile (15 minutes of intra-service time vs. 20 minutes of intra-service time). This reduced the total time associated with CPT code 43752 from 30 minutes to 25 minutes. We applied the ratio of the RUC recommended value of 0.82 work RVU over 30 minutes to the revised intra-service time of 25 minutes and assigned 0.68 interim work RVUs for CPT code 43752.

Comment: Commenters disagreed with our decision not to accept the RUC recommended WRVU of 0.82 and with our rejection of the survey time, particularly since this service involves both tube placement and imaging. Based on these comments, we referred this code to the multispecialty validation panel for review.

Response: As a result of the statistical analysis of the 2004 multispecialty validation panel ratings, we have assigned 0.81 work RVUs to CPT code 43752.

CPT code 63103 *Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (for example, for tumor or retropulsed bone fragments); thoracic or lumbar, each additional segment (List separately in addition to code for primary procedure).*

The RUC recommended a work RVU of 5.00 for this service based on a comparison of this procedure to CPT code 63088, the add-on code for the vertebral corpectomy, thoracic lumbar approach. We stated that it was unclear from the clinical vignettes supplied by the specialty society whether the additional corpectomy would more commonly involve the lumbar or the thoracic region of the spine. There is a significant difference in work intensity associated with the resection of an additional corpus in the thoracic region as opposed to the lumbar region. For this reason we applied the ratio of the reference service (CPT code 63088) to its primary service (CPT code 63087) to CPT code 63101 (primary service associated with CPT 63103) to assign 3.90 interim work RVUs for CPT code 63103.

Comment: Commenters requested that we withdraw the arbitrary reduction of the work RVU for CPT code 63103 stating that the unique aspects of the lateral extracavitary approach make the location in the lumbar and thoracic spine less relevant than the actual exposure of an additional level itself. The commenters stated that in contrast to anterior thoracic or lumbar approaches for vertebral corpectomy, the lateral extracavitary approach requires an unrelated and significantly greater muscle dissection of spinal/paraspinal tissues, as well as an additional rib, transverse process, and pedicle removal with isolation and division of another pair of segmental vessels. Based on these comments, we referred this code to the multispecialty validation panel for review.

Response: As a result of the statistical analysis of the 2004 multispecialty validation panel ratings, we have assigned 4.82 work RVUs to CPT code 63103.

CPT codes 38207 *Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage,* 38208 *Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, without washing,* 38209 *Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, with washing* 38210 *Transplant preparation of hematopoietic progenitor cells; specific cell depletion within harvest, T-cell depletion,* 38211 *Transplant preparation of hematopoietic progenitor cells; tumor cell depletion,* 38212 *Transplant preparation of hematopoietic progenitor cells; red blood cell removal,* 38213 *Transplant preparation of hematopoietic progenitor cells; platelet depletion,* 38214 *Transplant preparation of hematopoietic progenitor cells; plasma (volume) depletion,* 38215 *Transplant preparation of hematopoietic progenitor cells; cell concentration in plasma, mononuclear, or buffy coat layer.*—These codes were new for CY 2003 but we did not receive the final RUC recommendations in time for inclusion in the final rule. In the December 31, 2002 rule we discussed the interim RUC recommendations and our concerns for removing these codes from the laboratory fee schedule, and paying them instead on the physician fee schedule (67 FR 80007). We received the final RUC recommendations in May 2003 and in the November 7, 2003 final rule we stated we were maintaining a status indicator ''I'' for these services making them not valid for payment under the physician fee schedule. (Note: In the December 31, 2002 rule, as part of the discussion about these CPT codes, we discussed the creation of HCPCS codes G0265, *Cryopreservation, freezing and storage of cells for therapeutic use, each cell line;* G0266 *Thawing and expansion of frozen cells for therapeutic use, each aliquot;* and G0267, *Bone marrow or peripheral stem cell harvest,*

modification or treatment to eliminate cell type(s) (for example, T-cells, metastic carcinoma). We stated that these HCPCS codes are paid under the laboratory fee schedule.)

Comment: We received comments regarding these codes in response to the 2002 and 2003 final rules. Commenters expressed concern, which was shared by the RUC about the CMS decision pertaining to these CPT codes. They stated that CMS was invited to conduct site visits to observe and have a better understanding of these services. They believe such visits would provide additional information on these services and allow for a more informed decision about their placement on the physician fee schedule.

Response: CPT codes 38207, 38208, 38209, 38210, 38211, 38212, 38213, 38214 and 38215 reflect services that are typically provided by laboratory personnel who require general oversight and supervision by a laboratory physician, analogous to a physician providing oversight in a blood banking facility. Based on site visits, we continue to believe that these services are not typically provided by a physician. We recognize that variability pertaining to the clinical and laboratory management of patients does exist and that in some bone marrow transplant centers these laboratory services are closely supervised and managed by physicians. These centers, however, do not reflect the typical practice pattern for the majority of bone marrow transplant centers. Therefore, we will continue to allow use of HCPCS codes G0265 Cryopreservation, freezing and storage of cells for therapeutic use, each cell line and G0266 Thawing and expansion of frozen cells for therapeutic use, each aliquot to report these services, and G0267 Bone marrow or peripheral stem cell harvest, modification or treatment to eliminate cell type(s) (for example, T-cells, metastatic carcinoma). These services are currently on the laboratory fee schedule. We welcome additional comments to help us better determine whether to place CPT codes 38207 through 38215 on either the physician or laboratory fee schedule.

Note: We identified the services provided within transplant centers as clinical services typically provided by a physician in conjunction with the following codes: CPT codes 38205—Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogenic, CPT 38206—Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous, CPT codes 38240—Bone Marrow or bone derived peripheral stem cell transplantation; allogenic, CPT code 38241—Bone Marrow or bone derived peripheral stem cell transplantation; autologous, and CPT code 38242—Bone Marrow or bone derived peripheral stem cell transplantation; allogeneic lymphocyte donor infusions. We believe the physician work RVUs assigned by the RUC to these codes (CPT code 38205–1.50, CPT code 38206–1.50, CPT code 38240–2.24 RVUs, CPT code 38241–2.24 RVUs, and CPT code 38242–1.71 RVUs) appropriately reflect the physician work intensity for each of these services and reaffirm our prior decision announced in 2002. CPT code 38204—Management of recipient hematopoietic progenitor cell donor search and cell acquisition was valued at 2.00 RVUs by the RUC in 2002. We believe there may be physician work when providing this service. However, information obtained during our site visits revealed that the bulk of the service was provided by the transplant coordinator, who worked closely with the physician. It is unclear at this point what the appropriate value will be for the physician who provides this service. We welcome comments on this issue.

CPT code 76514 *Ophthalmic ultrasound, echography, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness).*—We accepted the RUC recommendation of 0.17 work RVUs.

Comments: The American Academy of Ophthalmology commented that the assigned work RVU does not accurately reflect the value intended by the RUC or CPT; the value should be doubled. The Academy stated that the problem arose when the RUC recommended to CPT that the descriptor should be changed from unilateral to unilateral or bilateral. The commenter suggested that either the descriptor be changed to reflect only the unilateral, which will take a while to accomplish, or that we increase valuation to correctly reflect valuation by RUC.

Response: Because we have no data that indicates whether the unilateral or bilateral procedure is more typical, we are not changing the RVUs at this time. We would suggest that the Academy contact the CPT Editorial Panel if a change to the descriptor would be helpful to the specialty.

Establishment of Interim Work Relative Value Units for New and Revised Physician's Current Procedural Terminology (CPT) Codes and New Healthcare Common Procedure Coding System Codes (HCPCS) for 2005 (Includes Table Titled ''American Medical Association Specialty Relative Value Update Committee and Health Care Professionals Advisory Committee Recommendations and CMS's Decisions for New and Revised 2005 CPT Codes'')

One aspect of establishing RVUs for 2005 was to assign interim work RVUs for all new and revised CPT codes. As described in our November 25, 1992 notice on the 1993 physician fee schedule (57 FR 55983) and in section III.B. of the November 22, 1996 final rule (61 FR 59505 through 59506), we established a process, based on recommendations received from the AMA's RUC, for establishing interim work RVUs for new and revised codes.

This year we received work RVU recommendations for 149 new and revised CPT codes from the RUC. Our staff and medical officers reviewed the RUC recommendations by comparing them to our reference set or to other comparable services for which work RVUs had previously been established. We also considered the relationships among the new and revised codes for which we received RUC recommendations and agreed with the majority of the relative relationships reflected in the RUC values. In some instances, although we agreed with the relationships, we nonetheless revised the work RVUs to achieve work neutrality within families of codes. That is, the work RVUs have been adjusted so that the sum of the new or revised work RVUs (weighted by projected frequency of use) for a family will be the same as the sum of the current work RVUs (weighted by projected frequency of use) for the family of codes. We reviewed all the RUC recommendations and accepted approximately 99 percent of the RUC recommended values. For approximately 1 percent of the recommendations, we agreed with the relativity established by the RUC, but needed to adjust work RVUs to retain budget neutrality.

We received four recommendations from the HCPAC. We agreed with two of these recommendations and disagreed with two of them.

Table 18, titled ''AMA RUC and HCPAC Recommendations and CMS Decisions for New and Revised 2005 CPT Codes,'' lists the new or revised CPT codes, and their associated work RVUs, that will be interim in 2005. This

table includes the following information:

- A ''#'' identifies a new code for 2005.
- CPT code. This is the CPT code for a service.
- Modifier. A ''26'' in this column indicates that the work RVUs are for the professional component of the code.
- Description. This is an abbreviated version of the narrative description of the code.
- RUC recommendations. This column identifies the work RVUs recommended by the RUC.
- HCPAC recommendations. This column identifies the work RVUs recommended by the HCPAC.
- CMS decision. This column indicates whether we agreed or we disagreed with the RUC recommendation. Codes for which we did not accept the RUC recommendation are discussed in greater detail following this table. An ''(a)'' indicates that no RUC recommendation was provided.
- 2005 Work RVUs. This column establishes the interim 2005 work RVUs for physician work.

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TABLE 18: AMA RUC and HCPAC Recommendations and CMS Decisions for New and Revised 2005 CPT Codes

*CPT CODE	Mod	Description	RUC recommendation	HCPAC recommendation	CMS Decision	2004 work RVU
#11004		Debride genitalia & perineum	10.31	----------	Agree	10.31
#11005		Debride abdom wall	13.75	----------	Agree	13.75
#11006		Debride genit/per/abdom wall	12.61	----------	Agree	12.61
#11008		Remove mesh from abd wall	5.00	----------	Agree	5.00
#19296		Place po breast cath for rad	3.63	----------	Agree	3.63
#19297		Place breast cath for rad	1.72	----------	Agree	1.72
#19298		Place breast rad tube/caths	6.00	----------	Agree	6.00
#27412		Autochondrocyte implant knee	23.23	----------	Agree	23.23
#27415		Osteochondral knee allograft	18.49	----------	Agree	18.49
#29866		Autgrft implnt, knee w/scope	13.88	----------	Agree	13.88
#29867		Allgrft implnt, knee w/scope	17.00	----------	Agree	17.00
#29868		Meniscal trnspl, knee w/scpe	23.59	----------	Agree	23.59
#31545		Remove vc lesion w/scope	6.30	----------	Agree	6.30
#31546		Remove vc lesion scope/graft	9.73	----------	Agree	9.73
#31620		Endobronchial us add-on	1.40	----------	Agree	1.40
31630		Bronchoscopy dilate/fx repr	3.81	----------	Agree	3.81
31631		Bronchoscopy, dilate w/stent	4.36	----------	Agree	4.36
#31636		Bronchoscopy, bronch stents	4.30	----------	Agree	4.30
#31637		Bronchoscopy, stent add-on	1.58	----------	Agree	1.58
#31638		Bronchoscopy, revise stent	4.88	----------	Agree	4.88
#32019		Insert pleural catheter	4.17	----------	Agree	4.17
#32855		Prepare donor lung, single	(a)	----------	(a)	Carrier
#32856		Prepare donor lung, double	(a)	----------	(a)	Carrier
#33933		Prepare donor heart/lung	(a)	----------	(a)	Carrier
#33944		Prepare donor heart	(a)	----------	(a)	Carrier
#34803		Endovas aaa repr w/3-p part	24.00	----------	Agree	24.00
#36475		Endovenous Rf, 1st Vein	6.72	----------	Agree	6.72
#36476		Endovenous rf, vein add-on	3.38	----------	Agree	3.38
#36478		Endovenous Laser, 1st Vein	6.72	----------	Agree	6.72

#36479	Endovenous laser vein addon	3.38	----------	Agree	3.38
#36818	Av fuse, uppr arm, cephalic	11.52	----------	Agree	11.52
36819	Av fuse, uppr arm, basilic	13.98	----------	Agree	13.98
37205	Transcath iv stent, percut	8.27	----------	Agree	8.27
37206	Transcath iv stent/perc addl	4.12	----------	Agree	4.12
#37215	Transcath stent, cca w/eps	18.71	----------	Agree	18.71
#37216	Transcath stent, cca w/o eps	17.98	----------	Agree	17.98
#43257	Uppr gi scope w/thrml txmnt	5.50	----------	Agree	5.50
#43644	Lap gastric bypass/roux-en-y	27.83	----------	Agree	27.83
#43645	Lap gastr bypass incl smll i	29.96	----------	Agree	29.96
#43845	Gastroplasty duodenal switch	Carrier	----------	Agree	Carrier
#44137	Remove intestinal allograft	Carrier	----------	Agree	Carrier
#44715	Prepare donor intestine	(a)	----------	(a)	Carrier
#44720	Prep donor intestine/venous	5.00	----------	Agree	5.00
#44721	Prep donor intestine/artery	7.00	----------	Agree	7.00
#45391	Colonoscopy w/endoscope us	5.09	----------	Agree	5.09
#45392	Colonoscopy w/endoscopic fnb	6.54	----------	Agree	6.54
#46947	Hemorrhoidopexy by stapling	5.20	----------	Agree	5.20
47140	Partial removal, donor liver	54.92	----------	Agree	54.92
47141	Partial removal, donor liver	67.40	----------	Agree	67.40
47142	Partial removal, donor liver	74.89	----------	Agree	74.89
#47143	Prep donor liver, whole	(a)	----------	(a)	Carrier
#47144	Prep donor liver, 3-segment	(a)	----------	(a)	Carrier
#47145	Prep donor liver, lobe split	(a)	----------	(a)	Carrier
#47146	Prep donor liver/venous	6.00	----------	Agree	6.00
#47147	Prep donor liver/arterial	7.00	----------	Agree	7.00
#48551	Prep donor pancreas	(a)	----------	(a)	Carrier
#48552	Prep donor pancreas/venous	4.30	----------	Agree	4.30
#50323	Prep cadaver renal allograft	(a)	----------	(a)	Carrier
#50325	Prep donor renal graft	(a)	----------	(a)	Carrier
#50327	Prep renal graft/venous	4.00	----------	Agree	4.00
#50328	Prep renal graft/arterial	3.50	----------	Agree	3.50
#50329	Prep renal graft/ureteral	3.34	----------	Agree	3.34
50360	Transplantation of kidney	31.48	----------	Agree	31.48
50365	Transplantation of kidney	36.75	----------	Agree	36.75
#50391	Instll rx agnt into rnal tub	1.96	----------	Agree	1.96
50547	Laparo removal donor kidney	25.46	----------	Agree	25.46
#57267	Insert mesh/pelvic flr addon	4.88	----------	Agree	4.88
57282	Colpopexy, extraperitoneal	8.85	----------	Disagree	6.86
#57283	Colpopexy, intraperitoneal	14.00	----------	Disagree	10.84
#58356	Endometrial cryoablation	Carrier	----------	Agree	Carrier
#58565	Hysteroscopy, sterilization	7.02	----------	Agree	7.02
#58956	Bso, omentectomy w/tah	20.78	----------	Agree	20.78
#63050	Cervical laminoplasty	20.75	----------	Agree	20.75
#63051	C-laminoplasty w/graft/plate	24.25	----------	Agree	24.25
#63295	Repair of laminectomy defect	5.25	----------	Agree	5.25
66710	Ciliary transscleral therapy	4.77	----------	Agree	4.77

#66711	Ciliary endoscopic ablation	6.60	----------	Agree	6.60
75960	Transcath iv stent rs&i	0.82	----------	Agree	0.82
76075	Dxa bone density, axial	0.30	----------	Agree	0.30
76076	Dxa bone density/peripheral	0.22	----------	Agree	0.22
#76077	Dxa bone density/v-fracture	0.17	----------	Agree	0.17
#76510	Ophth us, b & quant a	1.55	----------	Agree	1.55
76511	Ophth us, quant a only	0.94	----------	Agree	0.94
76512	Ophth us, b w/non-quant a	0.94	----------	Agree	0.94
76513	Echo exam of eye, water bath	0.66	----------	Agree	0.66
76514	Echo exam of eye, thickness	0.17	----------	Agree	0.17
#76820	Umbilical artery echo	0.50	----------	Agree	0.50
#76821	Middle cerebral artery echo	0.70	----------	Agree	0.70
76827	Echo exam of fetal heart	0.58	----------	Agree	0.58
76828	Echo exam of fetal heart	0.56	----------	Agree	0.56
77750	Infuse radioactive materials	4.90	----------	Agree	4.90
#78811	Tumor imaging (pet), limited	1.54	----------	Agree	1.54
#78812	Tumor image (pet)/skul-thigh	1.93	----------	Agree	1.93
#78813	Tumor image (pet) full body	2.00	----------	Agree	2.00
#78814	Tumor image pet/ct, limited	2.20	----------	Agree	2.20
#78815	Tumorimage pet/ct skul-thigh	2.44	----------	Agree	2.44
#78816	Tumor image pet/ct full body	2.50	----------	Agree	2.50
#79005	Nuclear rx, oral admin	1.80	----------	Agree	1.80
#79101	Nuclear rx, iv admin	1.96	----------	Agree	1.96
79200	Nuclear rx, intracav admin	1.99	----------	Agree	1.99
79300	Nuclr rx, interstit colloid	1.60	----------	Agree	1.60
79440	Nuclear rx, intra-articular	1.99	----------	Agree	1.99
#79445	Nuclear rx, intra-arterial	2.40	----------	Agree	2.40
79999	Nuclear medicine therapy	Carrier	----------	Agree	Carrier
84165	Protein e-phoresis, serum	0.37	----------	Agree	0.37
#84166	Protein e-phoresis/urine/csf	0.37	----------	Agree	0.37
86334	Immunofix e-phoresis, serum	0.37	----------	Agree	0.37
#86335	Immunfix e-phorsis/urine/csf	0.37	----------	Agree	0.37
#88184	Flowcytometry/ tc, 1 marker	0.00	----------	Agree	0.00
#88185	Flowcytometry/tc, add-on	0.00	----------	Agree	0.00
#88187	Flowcytometry/read, 2-8	1.36	----------	Agree	1.36
#88188	Flowcytometry/read, 9-15	1.69	----------	Agree	1.69
#88189	Flowcytometry/read, 16 & >	2.23	----------	Agree	2.23
#88360	Tumor immunohistochem/manual	1.10	----------	Agree	1.10
88361	Tumor immunohistochem/comput	1.18	----------	Agree	1.18
88365	Insitu hybridization (fish)	1.20	----------	Agree	1.20
#88367	Insitu hybridization, auto	1.30	----------	Agree	1.30
#88368	Insitu hybridization, manual	1.40	----------	Agree	1.40
#90465	Immune admin 1 inj, < 8 yrs	0.17	----------	Agree	0.17
#90466	Immune admin addl inj, < 8 y	0.15	----------	Agree	0.15
#90467	Immune admin o or n, < 8 yrs	0.17	----------	Agree	0.17
#90468	Immune admin o/n, addl < 8 y	0.15	----------	Agree	0.15
90471	Immunization admin	0.17	----------	Agree	0.17

90472	Immunization admin, each add	0.15	----------	Agree	0.15
#91034	Gastroesophageal reflux test	0.97	----------	Agree	0.97
#91035	G-esoph reflx tst w/electrod	1.59	----------	Agree	1.59
#91037	Esoph imped function test	0.97	----------	Agree	0.97
#91038	Esoph imped Funct Test > 1h	1.10	----------	Agree	1.10
#91040	Esoph balloon distension tst	0.97	----------	Agree	0.97
#91120	Rectal sensation test	0.97	----------	Agree	0.97
93741	Analyze ht pace device sngl	0.80	----------	Agree	0.80
93742	Analyze ht pace device sngl	0.91	----------	Agree	0.91
#93745	Set-up cardiovert-defibrill	(a)	----------	(a)	Carrier
#93890	Tcd, vasoreactivity study	1.00	----------	Agree	1.00
#93892	Tcd, emboli detect w/o inj	1.15	----------	Agree	1.15
#93893	Tcd, emboli detect w/inj	1.15	----------	Agree	1.15
#94452	Hast w/report	0.31	----------	Agree	0.31
#94453	Hast w/oxygen titrate	0.40	----------	Agree	0.40
#95928	C motor evoked, uppr limbs	1.50	----------	Agree	1.50
#95929	C motor evoked, lwr limbs	1.50	----------	Agree	1.50
95971	Analyze neurostim, simple	0.78	----------	Agree	0.78
95972	Analyze neurostim, complex	1.50	----------	Agree	1.50
95973	Analyze neurostim, complex	0.92	----------	Agree	0.92
#95978	Analyze neurostim brain/1h	3.50	----------	Agree	3.50
#95979	Analyz neurostim brain addon	1.64	----------	Agree	1.64
#97597	Active wound care/20 cm or <	----------	0.58	Agree	0.58
#97598	Active wound care > 20 cm	----------	0.80	Agree	0.80
#97605	Neg press wound tx, < 50 cm	----------	0.55	Disagree	0.00
#97606	Neg press wound tx, > 50 cm	----------	0.60	Disagree	0.00

(a) No Final RUC recommendation provided

\# New CPT codes

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Table 19, which is titled ''AMA RUC ANESTHESIA RECOMMENDATIONS AND CMS DECISIONS FOR NEW AND REVISED 2005 CPT CODES'', lists the new or revised CPT codes for anesthesia and their base units that will be interim in 2005. This table includes the following information:

- CPT code. This is the CPT code for a service.
- Description. This is an abbreviated version of the narrative description of the code.
- RUC Recommendations. This column identifies the base units recommended by the RUC.
- CMS decision. This column indicates whether we agreed or we disagreed with the RUC recommendation. Codes for which we did not accept the RUC recommendation are discussed in grreater detail following this table.
- 2005 Base Units. This column establishes the 2005 base units for these services.

TABLE 19:
AMA RUC ANESTHSIA RECOMMENDATIONS AND CMS DECISIONS FOR NEW AND REVISED CPT CODES

*CPT CODE	Description	RUC recommendation	CMS Decision	2005 Base Units
#00561	Anesth, heart surg <age 1	25.00	Agree	25.00

*All CPT codes copyright 2005 American Medical Association.

New CPT code.

Discussion of Codes for Which There Were No RUC Recommendations or for Which the RUC Recommendations Were Not Accepted

The following is a summary of our rationale for not accepting particular RUC work RVU or base unit recommendations. It is arranged by type of service in CPT order. Additionally, we discuss those CRP codes for which we received no RUC recommendations for physician work RVUs. This summary refers only to work RVUs or base units.

New and Revised Codes for 2005

CPT mode 97605 *Negative pressure wound therapy (for example, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters* and CPT code 97606 *Negative pressure wound therapy* (for example, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters.—The RUC HCPAC review board recommended 0.55 work RVUs for CPT code 97605 and 0.60 work RVUs for CPT code 97606, which we did not accept. We disagree with their recommendation that these services contain physician work and will not assign work RVUs. Further, when the negative pressure wound therapy service does not encompass selective debridement, we consider this service to represent a dressing change and will not make separate payment. When the negative pressure wound therapy service includes the need for selective debridement, we consider the services represented by CPT codes 97605 and 97606 to be bundled into CPT codes 97597 or 97598, the new debridement codes, which will be appropriately billed. We are assigning a status indicator of ''B'' to these two new CPT codes (97605 and 97606), meaning that we will not make separate payment for these services.

CPT code 57282, *Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus) and CPT code 57283 Colpopexy, vaginal; intra-peritoneal approach (uterosacral, levator myorrhaphy).*—The CPT Editorial Panel revised an existing code (57282) and created a new code (57283) to describe vaginal extra and intraperitoneal colpopexies. The RUC recommended maintaining the current work PVUs of 8.85 for 57282 and recommended 14.00 work PVUs for 57283. Previously, both the extra-peritoneal approach and intra-peritoneal approach were billed under CPT code 57282. Effective January 1, 2005, CPT code 57282 will be used to report colpopexy, vaginal; extra-peritoneal approach, while CPT code 57283 will be used to report colpopexy vaginal; intraperitoneal approach. Although we agree with the relativity established by the RUC, we believe that the work RVUs for CPT code 57282 should have been adjusted to reflect that the intra-peritoneal approach is now being reported using CPT code 57283. In order to retain work neutrality between these two services, we adjusted the work RVUs using the utilization crosswalks provided by the specialty survey to account for the work that was previously associated with performing these procedures when only one code existed. This results in work RVUs of 6.86 for CPT code 57282 and 10.84 work RVUs for CPT code 57283.

We have not received the final recommendations from the RUC on these services and carriers will price these services in 2005.

CPT Code 32855 *Backbench standard preparation of cadaver donor lung allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare pulmonary venous/atrial cuff, pulmonary artery, and bronchus; unilateral;* CPT Code 32856 *Backbench standard preparation of cadaver donor lung allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare pulmonary venous/atrial cuff, pulmonary artery, and bronchus; bilateral;* CPT Code 33933 *Backbench standard preparation of cadaver donor heart/lung allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare aorta, superior vena cava, inferior vena cava, and trachea for implantation;* CPT Code 33944 *Backbench standard preparation of cadaver donor heart allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare aorta, superior vena cava, inferior vena cava, pulmonary artery, and left atrium for implantation;* CPT Code 44715 *Backbench standard preparation of cadaver or living donor intestine allograft prior to transplantation, including mobilization and fashioning of the superior mesenteric artery and vein;* CPT Code 47143 *Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; without trisegment or lobe spilt;* CPT Code 47144 *Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; with trisegment split of whole liver graft into two partial liver grafts (that is, left lateral segment (segments II and III) and right trisegment (segments I and IV through VIII));* CPT Code 47145 *Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; with lobe split of whole liver graft into two partial liver grafts (that is, left lobe (segments II, III, and IV) and right lobe (segments I and V through VIII));* CPT Code 48551 *Backbench standard preparation of cadaver donor pancreas allograft prior to transplantation, including dissection of allograft from surrounding soft tissues, splenectomy, duodenotomy, ligation of bile duct, ligation of mesenteric vessels, and Y-graft arterial anastomoses from iliac artery to superior mesenteric artery and to splenic artery,* CPT Code 50323 *Backbench standard preparation of cadaver donor renal allograft prior to transplantation, including dissection and removal of perinephric fat, diaphragmatic and retroperitoneal attachments, excision of adrenal gland, and preparation of ureter(s), renal vein(s), and renal artery(s), ligating branches, as necessary;* CPT Code 50325 *Backbench standard preparation of living donor renal allograft (open or laparoscopic) prior to transplantation, including dissection and removal of perinephric fat and preparation of ureter(s), renal vein(s), and renal artery(s), ligating branches, as necessary;* and CPT Code 93745 *Initial set-up and programming by a physician of wearable cardioverter-defibrillator includes initial programming of system, establishing baseline electronic ECG, transmission of data to data repository, patient instruction in wearing system and patient reporting of problem or events.*

Establishment of Interim Practice Expense RVUs for New and Revised Physician's Current Procedural Terminology (CPT) Codes and New Healthcare Common Procedure Coding System (HCPCS) Codes for 2005

We have developed a process for establishing interim practice expense RVUs for new and revised codes that is similar to that used for work RVUs. Under this process, the RUC recommends the practice expense direct inputs (the staff time, supplies and equipment) associated with each new code. We then review the recommendations in a manner similar to our evaluation of the recommended work RVUs.

The RUC recommendations on the practice expense inputs for the new and revised 2005 codes were submitted to us as interim recommendations.

We have accepted, in the interim, the practice expense recommendations submitted by the RUC for the codes listed in the table titled ''AMA RUC and HCPAC RVU Recommendations and CMS Decisions for New and Revised 2005 CPT Codes.'' However, we will be reviewing the supplies, including the DNA probes, for the new and revised in situ hybridization codes (CPT 88365, 88367 and 88368) to ensure that the practice expense database accurately reflects the supplies associated with these services.

Other Issues

Comment: The RUC requested that we modify the definition of the ''preservice'' portion for the 0-, 10- and 90-day global periods to state, ''The preservice period includes the physicians' services following the visit at which the decision for surgery is finalized until the time of the operative procedure.'' The current definition of the preservice time for the 0 and 10-day global periods includes the preservice work occurring on the day of surgery, while the 90-day global period includes the preservice work occurring the day before surgery.

Response: We are reluctant to revise the definition of preservice until there is further review of the issue. Though the suggested change in preservice definition for physician work would correspond to the change made in the definition for practice expense purposes, that revision was made at the beginning of the practice expense refinement. It is not clear to us how the relativity would be maintained between existing codes valued under the current definition and new codes valued using an expanded definition of preservice work. In addition, among different procedures, there is most likely much variation in the time period between the decision to perform surgery and the time of the operative procedure. The absence of a specific timeframe could result in an inconsistent application of the definition. However, we would look forward to further discussion with the RUC concerning this issue.

Comment: Solid compensator-based intensity modulated radiation therapy (IMRT) is one of the IMRT technologies currently paid using the radiation therapy CPT code 77418, *Intensity modulated treatment delivery.* For 2005, CPT created a Category III tracking code 0073T, *Compensator-based beam modulation treatment delivery of inverse planned treatment using three or more high resolution (milled or cast) compensatory convergent beam modulated fields, per treatment session.* CPT instructions for CPT code 77418 now specifically exclude this technology.

Physicians performing compensator-based IMRT expressed concern that we generally carrier price tracking codes and that carriers often will not pay for them, considering services reported with a tracking code to be experimental. One commenter requested that, in order to allow payment for solid compensator-based IMRT under the physician fee schedule, we assign RVUs to the new CPT tracking code 0073T.

Response: As noted by the commenters, we generally do not nationally price tracking codes, which are most often used to report new or experimental services. Rather, we designate them as carrier priced until there is sufficient volume and information to develop appropriate RVUs. However, solid compensator based IMRT is an established technology that is currently paid both under the physician fee schedule and in the hospital outpatient department. We are concerned that having this service be reported using a carrier-priced tracking code could have an adverse effect on access to this technology. Therefore, we are assigning interim RVUs to this tracking code. For payment under the physician fee schedule, we will crosswalk the practice expense and malpractice RVUs assigned to CPT code 77418 to the Category III tracking code 0073T. (Note that this is a technical component only service and there are no associated physician work RVUs.)

Comment: For 2005, CPT has eliminated CPT code 79900, *Provision of Therapeutic Radiopharmaceuticals.* We received comments from several organizations and individuals concerning elimination of this CPT code. Commenters requested we either grant a grace period for the CPT code or reinstate the HCPCS code Q3001, *Radioelements for brachytherapy, any type, each,* so that payment can be made under the physician fee schedule.

Response: We are reinstating HCPCS code Q3001 under the physician fee schedule. This service will be carrier priced.

Note that there have been new HCPCS drug administration codes for physicians' services established for CY 2005. Please see section III.E.2 for specific information related to these new HCPCS codes.

VI. Five-Year Refinement of Relative Value Units

[If you choose to comment on issues in this section, please include the caption ''Five Year Refinement of Work Relative Value Units for Calendar Year 2004'' at the beginning of your comments.]

A. Background

The work RVUs were originally developed by a research team at the Harvard School of Public Health in a cooperative agreement with us. Harvard established the work RVUs for almost all fee schedule codes. The RVUs for anesthesia services were based on relative values from the American Society of Anesthesiology. The original RVUs for radiology codes were based on the American College of Radiology relative value scale. The work RVUs reflect the physician's effort in providing a service by accounting for: the physician's time; the technical difficulty of the procedure; the average severity of illness among patients receiving the procedure; and the degree of physical and mental effort required of the physician to perform the procedure.

Section 1848(c)(2)(B)(i) of the Act requires that we review all RVUs no less than every 5 years. We initiated the first 5-year review in 1994 and refinements went into effect beginning in 1997. The second 5-year review began in 1999 and refinements went into effect beginning in 2002. It is now time to begin the third 5-year review of the physician work RVUs with the resulting changes being effective beginning in 2007.

As part of the final rule published December 8, 1994 (59 FR 63453), we solicited public comment on all work RVUs for approximately 7,000 CPT and HCPCS codes. The scope of the 5-year review was limited to work values, since at that time, the statute required practice expense and malpractice RVUs be calculated based on 1991 allowed charges and practice expense and malpractice expense shares for the specialties performing the services. Also, the December 8, 1994 final rule

outlined the proposed process for refinement of the work RVUs and provided a suggested format for submission of comments.

We indicated that we were particularly interested in receiving comments on physicians' services for which medical practice had changed since the Harvard surveys were performed, but for which there were no code changes and, therefore, no reconsideration of whether the work RVUs were still accurate. As a result of the December 8, 1994 final rule, we received more than 500 comments on approximately 1,100 codes. Subsequent to review of the comments by our medical staff, comments on approximately 700 codes were forwarded to the AMA's Specialty Society RUC for review. An additional 300 codes identified by our staff as potentially misvalued were also forwarded to the RUC. A process similar to that used for the annual physician fee schedule update was used for evaluating the proposed changes to the work RVUs and a notice discussing these proposed changes was published in the May 3, 1996 **Federal Register** (61 FR 19992). As outlined in this notice, we proposed to increase the work RVUs for 28 percent of the codes; we proposed to maintain the work RVUs for 61 percent of the codes and we proposed to decrease the work RVUs for 11 percent of the codes. (Our proposed work RVUs agreed with the RUC recommendations for 93 percent of the codes.) In response to the May 3, 1996 proposed notice, we received more than 2,900 comments on approximately 133 codes plus all anesthesia services. In order to address these comments, we convened multi-specialty panels of physicians. A detailed discussion of this process, as well as the results of the 5-year review were included in the final rule with comment period published November 22, 1996 (61 FR 59490).

We initiated the second 5-year review by soliciting comments on potentially misvalued work RVUs for all services in the CY 2000 physician fee schedule in the November 2, 1999, final rule (64 FR 59427). We indicated that the scope of the second 5-year review would be restricted to work RVUs, since resource-based malpractice RVUs had only just been implemented in CY 2000, and we were in the middle of transitioning to a fully resource-based system for practice expense RVUs.

In our July 17, 2000 proposed rule (66 FR 31028), we explained the process used to conduct the second 5-year review of work, beginning with the solicitation of comments on services that were potentially misvalued, in our November 2, 1999 final rule with comment period.

We received comments from approximately 30 specialty groups, organizations, and individuals involving over 900 procedure codes. After review by our medical staff, we shared all of the comments we received concerning potentially misvalued services with the RUC.

The RUC submitted work RVU recommendations for all of the codes we forwarded with the exception of the anesthesia codes and conscious sedation codes. We analyzed all of the RUC recommendations and evaluated both the recommended work RVUs and the rationale for the recommendations. If we had concerns about the application of a particular methodology, but thought the recommended work RVUs were reasonable, we verified that the recommended work RVUs were appropriate by using alternative methodologies. We announced our proposed decisions on the revised work RVUs in the proposed notice published June 8, 2001 (66 FR 31028).

Overall, we proposed to accept 92 percent of RUC recommended work RVUs (RVUs or 792 services). Of the RUC recommendations we disagreed with, we proposed to increase the work RVUs for 37 services and decrease the work RVUs for 22 services. We did not accept the RUC recommendations of an increase for 6 services that were previously reviewed by a multi-specialty physician panel in 2000. The Health Care Professional Advisory Committee (HCPAC), an advisory committee to the RUC representing non-physician health professionals, also reviewed a total of 12 services as part of the 5-year review. For 5 of the services reviewed, the HCPAC did not offer a recommendation. Of the remaining 7 services, we proposed to accept the HCPAC recommendations.

Comments received on the June 8, 2001 proposed notice generally supported our proposed changes. In addition, we received more than 125 comments on approximately 39 specific codes plus all the anesthesia services. The majority of these comments addressed the gastrointestinal endoscopy codes and anesthesia services. As with the first 5-year review, we convened a multi-specialty panel of physicians to assist us in the review of the comments. For additional information about this process, the comments received, and the results of the second 5-year review, see the final rule with comment period published November 2, 2001 (66 FR 55285).

B. Scope of the 5-Year Refinement

As with the second 5-year review, we are soliciting comments only on the work RVUs that may be inappropriately valued. The malpractice RVUs were implemented in CY 2000 and revisions to these RVUs are addressed as part of this final rule.

We are not including the practice expense RVUs as part of this refinement. The PEAC, an advisory committee of the RUC, has been providing us with recommendations for refining the direct practice expense inputs (clinical staff, supplies, and equipment) used in calculating the practice expense RVUs for established codes. As discussed in the August 5, 2004 proposed rule, the PEAC held its last meeting March 2004 and future practice expense issues, including the refinement of the remaining codes not addressed by the PEAC, would be handled by the RUC. As we determine the process that will be used to refine the remaining codes, we will also be considering how to address future review of practice expense RVUs. We would also welcome comments on how this might be addressed. However, to the extent that there are changes in physician time or in the number or level of post procedure visits as a result of the 5-year review of work, there would be a potential impact on the practice expense inputs, and we would revise the inputs accordingly.

C. Refinement of Work Relative Value Units

During the first and second 5-year reviews, we relied on public commenters to identify services that were potentially misvalued.

For the third 5-year review, we are again requesting comments on potentially misvalued work RVUs for all services in the CY 2005 physician fee schedule. However, we recognize that this process generally elicits comments focusing on undervalued codes. Therefore, in addition to the codes submitted by commenters, we will also identify codes (especially high-volume codes across specialties) that:

- Are valued as being performed in the inpatient setting, but that are now predominantly performed on an outpatient basis; and
- Were not reviewed by the RUC, (that is, Harvard RVUs are still being used, or there is no information).

Public comments must include the appropriate CPT code (for example, CPT code 90918) and the suggested RVUs (for example, 11.00 RVUs), and evidence that the current work RVU is misvalued. Failure to provide this information may result in our inability

to evaluate the comments adequately. We will consider all comments on all work RVUs in the development of a proposed rule that we intend to publish in 2006. In that rule, we will propose the revisions to work RVUs that we believe are needed. We will then review and analyze the comments received in response to our proposed revisions and publish our decisions in the 2006 final rule.

In addition to internal review and analysis, we propose to share comments we receive on all work RVUs with the RUC, which currently makes recommendations to us on the assignment of RVUs to new and revised CPT codes. This process was used during the last 5-year review, and we believe that it was beneficial. The RUC's perspective will be helpful because of its experience in recommending RVUs for new and revised CPT codes since we implemented the physician fee schedule. Furthermore, the RUC, by virtue of its multispecialty membership and consultation with approximately 65 specialty societies, involves the medical community in the refinement process.

D. Nature and Format of Comments on Work Relative Value Units

While all written public comments are welcomed, based on our past experience we have found it particularly beneficial if the comments include certain information: the CPT code or codes recommended for review, a clinical description of the service(s), the current work RVUs and the suggested work RVUs. Because our initial assumption will be that each code is currently appropriately valued, the commenter may also include some rationale to support the need for review. For example, one approach would be to compare the physician work of each nominated code to the work involved in an analogous service that has higher or lower work RVUs. In other situations, the commenter could demonstrate that there is a rank order anomaly within a family of codes. Another reason for reviewing the physician work involved in a service could be that the physician time or intensity required by the procedure has changed since it was last reviewed, perhaps because of a change in technology or in patient characteristics.

The RUC has also developed more detailed ''Compelling Evidence Standards'' which are used by the RUC as part of their process to determine if a recommendation to change the work RVUs is warranted for a given code. We are including these standards below solely for informational purposes so that commenters are aware what kind of information will be needed to make a successful argument to the RUC for changing work RVUs.

RUC Compelling Evidence Standards

The RUC operates with the initial presumption that the current values assigned to the codes under review are correct. This presumption can be challenged by a society or other organization presenting a compelling argument that the existing values are no longer rational or appropriate for the codes in question. The argument for a change must be substantial and meet the RUC's compelling evidence standards. This argument must be provided in the comment letter to us, and then later to the RUC in writing on the Summary of Recommendation form. The following guidelines may be used to develop a ''compelling argument'' that the published relative value for a service is inappropriately valued:

- Documentation in the peer-reviewed medical literature or other reliable data that there have been changes in physician work due to one or more of the following:

+ Technique
+ Knowledge and technology
+ Patient population
+ Site-of-service
+ Length of hospital stay
+ Physician time

- An anomalous relationship between the code being valued and other codes. For example, if code A describes a service that requires more work than codes B, C, and D, but is nevertheless valued lower. The specialty would need to assemble evidence on service time, technical skill, patient severity, complexity, length of stay and other factors for the code being considered and the codes to which it is compared. These reference services may be both inter- and intra-specialty.
- Evidence that technology has changed physician work that is, diffusion of technology.
- Analysis of other data on time and effort measures, such as operating room logs or national and other representative databases.
- Evidence that incorrect assumptions were made in the previous valuation of the service, as documented, such as:

+ A misleading vignette, survey or flawed crosswalk assumptions in a previous evaluation;

+ A flawed mechanism or methodology used in the previous valuation, for example, evidence that no pediatricians were consulted in assigning pediatric values; and

+ A previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data.

We emphasize, however, as we reiterated for the last 5-year review, that we retain the responsibility for analyzing the comments on the suggested work RVU revisions, developing the proposed rule, evaluating the comments on the proposed rule, and deciding whether to revise RVUs. We are not delegating this responsibility to the RUC or any other organization.

VII. Update to the Codes for Physician Self-Referral Prohibition

[If you choose to comment on issues in this section, please include the caption ''Physician Self-Referral Designated Health Services'' at the beginning of your comments.]

A. Background

Section 1877 of the Act prohibits a physician from referring a Medicare beneficiary for certain designated health services (DHS) to a health care entity with which the physician (or a member of the physician's immediate family) has a financial relationship, unless an exception applies. The following services are DHS, as specified in section 1877 of the Act and in regulations at § 411.351:

- Clinical laboratory services.
- Physical therapy, occupational therapy, and speech-language pathology services.
- Radiology and certain other imaging services.
- Radiation therapy services and supplies.
- Durable medical equipment and supplies.
- Parenteral and enteral nutrients, equipment, and supplies.
- Prosthetics, orthotics, and prosthetic devices and supplies.
- Home health services.
- Outpatient prescription drugs.
- Inpatient and outpatient hospital services.

In § 411.351, the entire scope of the first four of these DHS categories is defined in a list of CPT/HCPCS codes (the Code List), which is updated annually to account for changes in the most recent CPT and HCPCS publications. The updated Code List appears as an addendum to the physician fee schedule final rule and is available on our Web site at *http://cms.hhs.gov/medlearn/refphys.asp.* We also include in the Code List those items and services that may qualify for either of the following two exceptions to the physician self-referral prohibition:

- EPO and other dialysis-related drugs furnished in or by an ESRD facility (§ 411.351(g)).
- Preventive screening tests, immunizations or vaccines (§ 411.351(h)).

The Code List was updated in the physician fee schedule final rule published in the **Federal Register** on November 7, 2003 (68 FR 63196). It was subsequently corrected in a notice that was published in the **Federal Register** on March 26, 2004 (69 FR 15729). We also published the Phase II physician self-referral interim final rule with comment period on March 26, 2004 in the **Federal Register** (69 FR 16054), which made several additional changes to the Code List, effective July 26, 2004.

The updated all-inclusive Code List effective January 1, 2005 is presented in Addendum L of this final rule.

B. Response to Comments

We received two public comments relating to the Code List published in the November 7, 2003 physician fee schedule final rule. One commenter supported the exclusion of interventional radiology services from the definition of radiology and certain other imaging services, as reflected on the Code List. The other commenter raised a concern over the exclusion of nuclear medicine services as a DHS.

Additionally, the proposed physician fee schedule rule that was published on August 5, 2004 in the **Federal Register** (69 FR 47488) generated one comment relating to the Code List. That comment and our response also are provided below. We note that we will address in a separate **Federal Register** document those public comments relating to the Code List that were received in response to the Phase II physician self-referral final rule published on March 26, 2004.

Comment: One commenter requested that we include nuclear medicine services as DHS. The commenter is concerned that physicians may engage in lucrative financial relationships associated with nuclear medicine studies such as PET scans.

Response: We are mindful of the issue raised by the commenter, and we continue to consider the application of section 1877 of the Act to nuclear medicine procedures. However, we note that the purpose of this update is merely to conform the Code List to the most recent publications of HCPCS and CPT codes. Substantive changes to DHS definitions, such as that advocated by the commenter, are beyond the scope of this rulemaking.

Comment: One commenter asked us to clarify that the Code List does not define all DHS and that we indicate where providers can obtain more information on the remaining categories. Additionally, the commenter suggested that we define all DHS in the Code List and that the definitions be included in the quarterly updated Microsoft Excel spreadsheet of RVU values, global periods and supervision levels for Medicare covered services posted on our Web site.

Response: We believe that most readers are aware that the Code List does not define every DHS category. Nevertheless, we will add a footnote to the Code List indicating that § 411.351 defines those DHS categories not reflected on the Code List.

The comment advocating that we define all DHS by CPT or HCPCS code on the Code List would require a substantive change to existing DHS definitions and is therefore beyond the scope of this rulemaking. We will explore the possibility of identifying certain DHS in the National Physician Fee Schedule Relative Value File (*http://www.cms.hhs.gov/providers/pufdownload/rvudown.asp*).

C. Revisions Effective for 2005

Tables 20 and 21, in this section, identify the additions and deletions, respectively, to the comprehensive Code List included in the Phase II physician self-referral interim final rule published March 26, 2004. Tables 20 and 21 also identify the additions and deletions to the lists of codes used to identify the items and services that may qualify for the exceptions in § 411.355(g) (regarding EPO and other dialysis-related outpatient prescription drugs furnished in or by an ESRD facility) and in § 411.355(h) (regarding preventive screening tests, immunizations and vaccines).

We will consider comments for the codes listed in Tables 20 and 21 below, if we receive them by the date specified in the **DATES** section of this final rule. We will not consider any comment that advocates a substantive change to any of the DHS defined in § 411.351.

BILLING CODE 4120–01–P

TABLE 20: ADDITIONS TO THE PHYSICIAN SELF-REFERRAL

HCPCS/CPT[1] CODES	
CLINICAL LABORATORY SERVICES	
0064T	Spectroscop eval expired gas
0085T	Breath test heart reject
0087T	Sperm eval hyaluronan
36415	Routine venipuncture
PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH-LANGUAGE PATHOLOGY SERVICES	
97597	Active wound care/20cm or <
97598	Active wound care > 20cm
97605	Neg press wound tx, < 50 cm
97606	Neg press wound tx, > 50 cm
G0329	Electromagntic tx for ulcers
RADIOLOGY AND CERTAIN OTHER IMAGING SERVICES	
76077	Dxa bone density/v-fracture
76510	Ophth us, b & quant a
76820	Umbilical artery echo
76821	Middle cerebral artery echo

93890 Tcd, vasoreactivity study

93892 Tcd, emboli detect w/o inj

0067T Ct colonography;dx

Q0092 Set up port xray equipment

RADIATION THERAPY SERVICES AND SUPPLIES

19296 Place po breast cath for rad

19297 Place breast cath for rad

19298 Place breast rad tube/caths

57155 Insert uteri tandems/ovoids

58346 Insert Heyman uteri capsule

0073T Delivery, comp imrt

0082T Stereotactic rad delivery

0083T Stereotactic rad tx mngmt

DRUGS USED BY PATIENTS UNDERGOING DIALYSIS

[no additions]

PREVENTIVE SCREENING TESTS, IMMUNIZATIONS AND VACCINES

80061 Lipid panel [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V.81.2]

82465 Assay, bld/serum cholesterol [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V.81.2]

82947 Assay, glucose, blood quant [only when billed with ICD-9-CM code V77.1]

82950 Glucose test [only when billed with ICD-9-CM code V77.1]

82951 Glucose tolerance test (GTT) [only when billed with ICD-9-CM code V77.1]

83718 Assay of lipoprotein [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V.81.2]

84478 Assay of triglycerides [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V.81.2]

90656 Flu vaccine no preserv 3 & >

[1]CPT codes and descriptions only are copyright 2004 American Medical Association. All rights are reserved and applicable FARS/DFARS clauses apply.

TABLE 21: DELETIONS TO THE PHYSICIAN SELF-REFERRAL HCPCS/CPT[1] CODES

CLINICAL LABORATORY SERVICES

G0001 Drawing blood for specimen

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH-LANGUAGE PATHOLOGY SERVICES

97601 Wound(s) care, selective

RADIOLOGY AND CERTAIN OTHER IMAGING SERVICES

[no deletions]

RADIATION THERAPY SERVICES AND SUPPLIES

50559 Renal endoscopy/radiotracer

DRUGS USED BY PATIENTS UNDERGOING DIALYSIS

[no deletions]

PREVENTIVE SCREENING TESTS, IMMUNIZATIONS AND VACCINES

[no deletions]

[1]CPT codes and descriptions only are copyright 2004 American Medical Association. All rights are reserved and applicable FARS/DFARS clauses apply.

BILLING CODE 4120–01–C

The additions specified in Table 20 generally reflect new CPT and HCPCS codes that become effective January 1, 2005 or that became effective since our last update. It also reflects the addition of codes that will be recognized by Medicare for payment purposes effective January 1, 2005.

Additionally, we are adding HCPCS code Q0092 to the category of radiology and certain other imaging services since it may be billed in conjunction with the provision of portable x-ray services and had been inadvertently omitted.

We are also adding two existing brachytherapy codes (CPT 57155 and 58346) to the category of radiation therapy services and supplies. As noted in the March 26, 2004 Phase II physician self-referral interim final rule (69 FR at 16104–16105), brachytherapy is a DHS. We inadvertently omitted these codes when compiling the Code List.

Table 20 also reflects the addition of a flu vaccine code (CPT 90656), CV screening blood tests (CPT 80061, 82465, 83718 and 84478) and diabetes screening tests (CPT 82947, 82950 and 82951) to the list that identifies preventive screening tests, immunizations and vaccines that may qualify for the exception described in § 411.355(h) for such items and services. The physician self-referral prohibition will not apply to these services if the conditions set forth in § 411.355(h) are satisfied. We note that CPT codes 80061, 82465, 83718, 84478, 82947, 82950, and 82951 are eligible for the exception at § 411.355(h) only when billed with the appropriate screening diagnosis codes specified on the Code List for each test.

Table 21 reflects the deletions necessary to conform the Code List to the most recent publications of CPT and HCPCS codes.

VIII. Physician Fee Schedule Update for Calendar Year 2005

A. Physician Fee Schedule Update

The physician fee schedule update is determined using a formula specified by statute. Under section 1848(d)(4) of the Act, the update is equal to the product of 1 plus the percentage increase in the MEI (divided by 100) and 1 plus the update adjustment factor (UAF). For CY 2005, the MEI is equal to 3.1 percent (1.031). The UAF is −7.0 percent (0.930). Section 1848(d)(4)(F) of the Act requires an additional 0.8 percent (1.008) increase to the update for 2005. The product of the MEI (1.031), the UAF (0.930), and the statutory adjustment factor (1.008) equals the CY 2005 update of −3.3 percent (0.967). However, section 601 of the MMA amended section 1848(d) of the Act to specify that the update to the single CF for 2005 cannot be less than 1.5 percent. Because the statutory formula will yield an update of −3.3 percent, consistent with section 601 of the MMA, we are establishing a 2005 physician fee schedule update of 1.5 percent.

Our calculations of all of the above figures are explained below.

B. The Percentage Change in the Medicare Economic Index Medicare Economic Index (MEI)

The MEI measures the weighted-average annual price change for various inputs needed to produce physicians' services. The MEI is a fixed-weight input price index, with an adjustment for the change in economy-wide multifactor productivity. This index, which has 2000 base year weights, is comprised of two broad categories: physician's own time and physician's practice expense.

The physician's own time component represents the net income portion of business receipts and primarily reflects the input of the physician's own time into the production of physicians' services in physicians' offices. This category consists of two subcomponents: wages and salaries, and fringe benefits.

The physician's practice expense category represents nonphysician inputs used in the production of services in physicians' offices. This category consists of wages and salaries and fringe benefits for nonphysician staff and other nonlabor inputs. The physician's practice expense component also includes the following categories of nonlabor inputs: office expense, medical materials and supplies, professional liability insurance, medical equipment, professional car, and other expenses. The components are adjusted to reflect productivity growth in physicians' offices by the 10-year moving average of multifactor productivity in the private nonfarm business sector. The Table 22 below presents a listing of the MEI cost categories with associated weights and percent changes for price proxies for the 2005 update. For calendar year 2005, the increase in the MEI is 3.1 percent, which includes a 0.9 percent change in the 10-year moving average of multifactor productivity. This result is the result of a 3.0 percent increase in Physician's Own Time and a 5.2 percent increase in Physician's Practice Expense. Within the Physician's Practice Expense, the largest increase occurred in Professional Liability Insurance, which increased 23.9 percent.

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TABLE 22:

INCREASE IN THE MEDICARE ECONOMIC INDEX UPDATE FOR CALENDAR YEAR 2005[1]		
Cost Categories and Price Measures	CY 2000 Weights[2]	CY 2005 Percent Changes
Medicare Economic Index Total, productivity adjusted	n/a	3.1
Productivity: 10-year moving average of multifactor productivity, private nonfarm business sector*	n/a	0.9
Medicare Economic Index Total, without productivity adjustment	100.000	4.0
1. Physician's Own Time[3]	52.466	3.0
a. Wages and Salaries: Average Hourly Earnings, private nonfarm	42.730	2.1
b. Fringe Benefits: Employment Cost Index, benefits, private nonfarm	9.735	6.8
2. Physician's Practice Expense[3]	47.534	5.2
a. Nonphysician Employee Compensation	18.653	3.8
1. Wages and Salaries: Employment Cost Index, wages and salaries, weighted by occupation	13.808	3.0

INCREASE IN THE MEDICARE ECONOMIC INDEX UPDATE FOR CALENDAR YEAR 2005[1]		
2. Fringe Benefits: Employment Cost Index, fringe benefits, white collar	4.845	6.1
b. Office Expense: Consumer Price Index for Urban Areas (CPI-U), housing	12.209	2.3
c. Drugs and Medical Materials and Supplies	4.319	4.0
1. Medical Materials and Supplies: Producer Price Index (PPI), surgical appliances and supplies/CPI-U, medical equipment and supplies (equally weighted)	2.011	2.0
2. Pharmaceuticals: Producer Price Index (PPI ethical prescription drugs)	2.308	5.6
d. Professional Liability Insurance: Professional liability insurance premiums[4]	3.865	23.9
e. Medical Equipment: PPI, medical instruments and equipment	2.055	1.9
f. Other Expenses	6.433	1.4

INCREASE IN THE MEDICARE ECONOMIC INDEX UPDATE FOR CALENDAR YEAR 2005[1]
* As of September 22, 2004, Bureau of Labor Statistics had not released the estimates of nonfarm multifactor productivity growth for 2002. Therefore, we used the most recently available information (thru CY 2001) to develop the productivity adjustment for the CY 2005 update. This produces a productivity adjustment that is equivalent to the one used in the CY 2004 update.
1 The rates of historical change are estimated for the 12-month period ending June 30, 2004, which is the period used for computing the CY 2005 update. The price proxy values are based upon the latest available Bureau of Labor Statistics data as of September 22, 2004.
2 The weights shown for the MEI components are the 2000 base-year weights, which may not sum to subtotals or totals because of rounding. The MEI is a fixed-weight, Laspeyres-type input price index whose category weights indicate the distribution of expenditures among the inputs to physicians' services for CY 2000. To determine the MEI level for a given year, the price proxy level for each component is multiplied by its 2000 weight. The sum of these products (weights multiplied by the price index levels) over all cost categories yields the composite MEI level for a given year. The annual percent change in the MEI levels is an estimate of price change over time for a fixed market basket of inputs to physicians' services.
3 The measures of productivity, average hourly earnings, Employment Cost Indexes, as well as the various Producer and Consumer Price Indexes can be found on the Bureau of Labor Statistics website- *http://stats.bls.gov*.

INCREASE IN THE MEDICARE ECONOMIC INDEX UPDATE FOR CALENDAR YEAR 2005[1]	
4	Derived from data collected from several major insurers (the latest available historical percent change data are for the period ending second quarter of 2004).
n/a	Productivity is factored into the MEI categories as an adjustment to the price variables; therefore, no explicit weight exists for productivity in the MEI.

C. The Update Adjustment Factor

Section 1848(d) of the Act provides that the physician fee schedule update is equal to the product of the MEI and a UAF. The UAF is applied to make actual and target expenditures (referred to in the statute as ''allowed expenditures'') equal. Allowed expenditures are equal to actual expenditures in a base period updated each year by the sustainable growth rate (SGR). The SGR sets the annual rate of growth in allowed expenditures and is determined by a formula specified in section 1848(f) of the Act.

1. Calculation Under Current Law

Under section 1848(d)(4)(B) of the Act, the UAF for a year beginning with 2001 is equal to the sum of the following—

• Prior Year Adjustment Component. An amount determined by—

+ Computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services for the prior year (the year prior to the year for which the update is being determined) and the amount of the actual expenditures for those services for that year;

+ Dividing that difference by the amount of the actual expenditures for those services for that year; and

+ Multiplying that quotient by 0.75.

• Cumulative Adjustment Component. An amount determined by—

+ Computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services from April 1, 1996, through the end of the prior year and the amount of the actual expenditures for those services during that period;

+ Dividing that difference by actual expenditures for those services for the prior year as increased by the sustainable growth rate for the year for which the update adjustment factor is to be determined; and

+ Multiplying that quotient by 0.33.

Section 1848(d)(4)(E) of the Act requires the Secretary to recalculate allowed expenditures consistent with section 1848(f)(3) of the Act. Section 1848(f)(3) specifies that the SGR (and, in turn, allowed expenditures) for the upcoming CY (2005 in this case), the current CY (2004) and the preceding CY (2003) are to be determined on the basis of the best data available as of September 1 of the current year. Allowed expenditures are initially estimated and subsequently revised twice. The second revision occurs after the CY has ended (that is, we are making the final revision to 2003 allowed expenditures in this final rule). Once the SGR and allowed expenditures for a year have been revised twice, they are final.

Table 23 shows annual and cumulative allowed expenditures for physicians' services from April 1, 1996 through the end of the current CY, including the transition period to a CY system that occurred in 1999. Also shown is the SGR corresponding with each period. The calculation of the SGR is discussed in detail below.

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TABLE 23:

Period	Annual Allowed Expenditures ($ in billions)	Annual Actual Expenditures ($ in billions)	Cumulative Allowed Expenditures ($ in billions)	Cumulative Actual Expenditures ($ in billions)	FY/CY SGR
4/1/96-3/31/97	$48.9	$48.9	$48.9	$48.9	N/A
4/1/97-3/31/98	50.5	49.4	99.4	98.4	FY 1998=3.2%
4/1/98-3/31/99	52.6	50.5	152.0	148.9	FY 1999=4.2%
1/1/99-3/31/99	13.3	13.1	([1])	148.9	FY 1999=4.2%
4/1/99-12/31/99	42.1	39.5	([2])	188.4	FY 2000=6.9%
1/1/99-12/31/99	55.3	52.6	194.1	188.4	FY 1999/2000[(3)]
1/1/00-12/31/00	59.4	58.1	253.4	246.5	CY 2000=7.3%
1/1/01-12/31/01	62.0	66.3	315.5	312.9	CY 2001=4.5%
1/1/02-12/31/02	67.2	71.0	382.6	383.8	CY 2002=8.3%
1/1/03-12/31/03	72.1	76.8	454.6	460.6	CY 2003=7.3%
1/1/04-12/31/04	77.1	84.9	531.8	545.5	CY 2004=7.0%

1/1/05-12/31/05	80.4	N/A	612.2	N/A	CY 2005=4.3%

(1) Allowed expenditures for the first quarter of 1999 are based on the FY 1999 SGR.

(2) Allowed expenditures for the last three quarters of 1999 are based on the FY 2000 SGR.

(3) Allowed expenditures in the first year (April 1, 1996--March 31, 1997) are equal to actual expenditures. All subsequent figures are equal to quarterly allowed expenditure figures increased by the applicable SGR. Cumulative allowed expenditures are equal to the sum of annual allowed expenditures. We provide more detailed quarterly allowed and actual expenditure data on our website under the Medicare Office of the Actuary's (OACT) publications at the following address: http://www.cms.hhs.gov/statistics/actuary/. We expect to update the website with the most current information later this month.

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Consistent with section 1848(d)(4)(E) of the Act, Table 23 includes our final revision of allowed expenditures for 2003, a recalculation of allowed expenditures for 2004, and our initial estimate of allowed expenditures for 2005. To determine the update adjustment factor for 2005, the statute requires that we use allowed and actual expenditures from April 1, 1996 through December 31, 2004 and the 2005 SGR. Consistent with section 1848(d)(4)(E) of the Act, we will be making further revisions to the 2004 and 2005 SGRs

and 2004 and 2005 allowed expenditures. Because we have incomplete actual expenditure data for 2004, we are using an estimate for this period. Any difference between current estimates and final figures will be taken into account in determining the update adjustment factor for future years.

We are using figures from Table 23 in the statutory formula illustrated below:

UAF = Update Adjustment Factor
$Target_{04}$ = Allowed Expenditures for 2004 or $77.1 billion
$Actual_{04}$ = Estimated Actual Expenditures for 2004 = $84.9 billion
$Target_{4/96–12/04}$ = Allowed Expenditures from 4/1/1996–12/31/2004 = $531.8 billion
$Actual_{4/96–12/04}$ = Estimated Actual Expenditures from 4/1/1996–12/31/2003 = $545.5 billion
SGR_{05} = 4.3 percent (1.043)

Section 1848(d)(4)(D) of the Act indicates that the UAF determined under section 1848(d)(4)(B) of the Act for a year may not be less than −0.070 or greater than 0.03. Since −0.120 is less than −0.070, the UAF for 2005 will be −0.070.

Section 1848(d)(4)(A)(ii) of the Act indicates that 1 should be added to the UAF determined under section 1848(d)(4)(B) of the Act. Thus, adding 1 to −0.070 makes the update adjustment factor equal to 0.930.

IX. Allowed Expenditures for Physicians' Services and the Sustainable Growth Rate

A. Medicare Sustainable Growth Rate

The SGR is an annual growth rate that applies to physicians' services paid by Medicare. The use of the SGR is intended to control growth in aggregate Medicare expenditures for physicians' services. Payments for services are not withheld if the percentage increase in actual expenditures exceeds the SGR. Rather, the physician fee schedule update, as specified in section 1848(d)(4) of the Act, is adjusted based on a comparison of allowed expenditures (determined using the SGR) and actual expenditures. If actual expenditures exceed allowed expenditures, the update is reduced. If actual expenditures are less than allowed expenditures, the update is increased.

Section 1848(f)(2) of the Act specifies that the SGR for a year (beginning with 2001) is equal to the product of the following four factors:

(1) The estimated change in fees for physicians' services.

(2) The estimated change in the average number of Medicare fee-for-service beneficiaries.

(3) The estimated projected growth in real GDP per capita.

(4) The estimated change in expenditures due to changes in law or regulations.

In general, section 1848(f)(3) of the Act requires us to publish SGRs for 3 different time periods, no later than November 1 of each year, using the best data available as of September 1 of each year. Under section 1848(f)(3)(C)(i) of the Act, the SGR is estimated and subsequently revised twice (beginning with the FY and CY 2000 SGRs) based on later data. (There were also provisions in the Act to adjust the FY 1998 and FY 1999 SGRs. See the February 28, 2003 **Federal Register** (68 FR 9567) for a discussion of these SGRs). Under section 1848(f)(3)(C)(ii) of the Act, there are no further revisions to the SGR once it has been estimated and subsequently revised in each of the 2 years following the preliminary estimate. In this final rule, we are making our preliminary estimate of the 2005 SGR, a revision to the 2004 SGR, and our final revision to the 2003 SGR.

B. Physicians' Services

Section 1848(f)(4)(A) of the Act defines the scope of physicians' services covered by the SGR. The statute indicates that ''the term ''physicians' services'' includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician's office, but does not include services furnished to a Medicare+Choice plan enrollee.'' We published a definition of physicians' services for use in the SGR in the **Federal Register** (66 FR 55316) on November 1, 2001. We defined physicians' services to include many of the medical and other health services listed in section 1861(s) of the Act. For purposes of determining allowed expenditures, actual expenditures, and SGRs through December 31, 2002, we have specified that physicians' services include the following medical and other health services if bills for the items and services are processed and paid by Medicare carriers (and those paid through intermediaries where specified):

- Physicians' services.
- Services and supplies furnished incident to physicians' services.
- Outpatient PT services and outpatient OT services.
- Antigens prepared by, or under the direct supervision of, a physician.
- Services of PAs, certified registered nurse anesthetists, CNMs, clinical psychologists, clinical social workers, NPs, and CNSs.
- Screening tests for prostate cancer, colorectal cancer, and glaucoma.
- Screening mammography, screening pap smears, and screening pelvic exams.
- Diabetes outpatient self-management training services.
- Medical nutrition therapy services.
- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests (including outpatient diagnostic laboratory tests paid through intermediaries).
- X-ray, radium, and radioactive isotope therapy.
- Surgical dressings, splints, casts, and other devices used for the reduction of fractures and dislocations.
- Bone mass measurements.

Sections 611 through 613 of the MMA, respectively, modified section 1861(s) of the Act to add Medicare coverage for an initial preventive exam,

CV screening blood tests, and diabetes screening tests. We believe that these services are commonly performed or furnished by a physician or in a physician's office and are including them in the definition of physicians' services for purposes of the SGR.

Comment: We received a number of comments requesting that we use our administrative authority to remove drugs from the SGR. According to one of these comments, drugs are not physicians' services and should never have been included in the SGR. One of these comments indicated that the SGR ''is a seriously flawed formula that will continue to require frequent Congressional intervention to avoid payment cuts * * *'' According to this comment, ''the Administration should reduce the price tag and help pave the way for an appropriate long-term solution by removing drugs from the SGR pool.'' We also received a number of comments suggesting that we use our administrative authority to adjust the SGR for changes in spending associated with national coverage determinations (NCDs).

Response: We remain concerned about forecasts of reductions in physician fees and will carefully consider the issues raised by the comments when we make changes to the physician fee schedule for 2006. We believe that the physician payment system should be structured to control costs and achieve predictable and stable changes to Medicare's rates while being equitable to physicians. We note that administrative changes affecting the SGR would have significant long-term cost implications but will not have an impact on the update for 2006 or the subsequent few years. Therefore, without a statutory change, there will still be a reduction in physicians' fee schedule rates for 2006 and subsequent years. Towards those goals, we have already taken several actions that will improve Medicare's physician payment system:

- Using multifactor productivity in place of labor productivity in the MEI beginning in 2003. This change increased the physician fee schedule update by 0.7 percentage points for 2003 and was estimated to increase Medicare spending by $14.5 billion over 10 years.
- Increasing the weight of malpractice costs in the MEI from 3.2 to 3.9 percent, a 21 percent increase beginning in 2004.
- Incorporating an increase in malpractice premiums of 16.9 percent into the 2004 MEI and 23.9 percent into the 2005 MEI. The increased weight for malpractice in the MEI makes the index a more accurate representation of inflation in physician office costs.

C. Preliminary Estimate of the SGR for 2005

Our preliminary estimate of the 2005 SGR is 4.3 percent. We first estimated the 2005 SGR in March and made the estimate available to the Medicare Payment Advisory Commission and on our Web site. Table 24 shows that March 2004 and our current estimates of the factors included in the 2005 SGR.

TABLE 24:

Statutory Factors	March Estimate	Current Estimate
Fees	2.6 percent (1.026)	1.3 percent (1.013)
Enrollment	-0.2 percent (0.998)	-0.3 percent (0.997)
Real Per Capita GDP	2.2 percent (1.022)	2.2 percent (1.022)
Law and Regulation	0.0 percent (1.000)	1.0 percent (1.010)
Total	4.6 percent (1.046)	4.3 percent (1.043)

Note: Consistent with section 1848(f)(2) of the Act, the statutory factors are multiplied, not added, to produce the total (that is, $1.013 \times 0.997 \times 1.022 \times 1.010 = 1.37$). A more detailed explanation of each figure is provided below in section H.1.

D. Revised Sustainable Growth Rate for 2004

Our current estimate of the 2004 SGR is 7.0 percent. Table 25 shows our preliminary estimate of the 2004 SGR that was published in the **Federal Register** on November 7, 2003 (68 FR 63249) and our current estimate.

TABLE 25:

Statutory Factors	November 7, 2003 Estimate	Current Estimate
Fees	2.7 percent (1.027)	1.4 percent (1.014)
Enrollment	1.7 percent (1.017)	1.7 percent (1.017)
Real Per Capita GDP	2.8 percent (1.028)	2.2 percent (1.022)
Law and Regulation	0.0 percent (1.000)	1.5 percent (1.015)
Total	7.4 percent (1.074)	7.0 percent (1.070)

A more detailed explanation of each figure is provided below in section H.2.

E. Final Sustainable Growth Rate for 2003

The SGR for 2003 is 7.3 percent. Table 26 shows our preliminary estimate of the SGR published in the **Federal Register** on December 31, 2002 (67 FR 80027), our revised estimate published in the **Federal Register** on November 7, 2003 (67 FR 63249) and the final figures

determined using the latest available data.

TABLE 26:

Statutory Factors	12/31/02 Estimate	11/7/03 Estimate	Final
Fees	2.9 percent (1.029)	2.8 percent (1.028)	2.8 percent (1.028)
Enrollment	1.2 percent (1.012)	2.4 percent (1.024)	2.3 percent (1.023)
Real Per Capita GDP	3.3 percent (1.033)	1.4 percent (1.014)	2.0 percent (1.020)
Law and Reg	0.0 percent (1.000)	0.0 percent (1.000)	0.0 percent (1.000)
Total	7.6 percent (1.076)	6.7 percent (1.067)	7.3 percent (1.073)

A more detailed explanation of each figure is provided below in section H.2.

F. Calculation of 2005, 2004, and 2003 Sustainable Growth Rates

1. Detail on the 2005 SGR

All of the figures used to determine the 2005 SGR are estimates that will be revised based on subsequent data. Any differences between these estimates and the actual measurement of these figures will be included in future revisions of the SGR and allowed expenditures and incorporated into subsequent physician fee schedule updates.

Factor 1—Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for CY 2005

This factor is calculated as a weighted average of the 2005 fee increases for the different types of services included in the definition of physicians' services for the SGR. Medical and other health services paid using the physician fee schedule are estimated to account for approximately 83.9 percent of total allowed charges included in the SGR in 2005 and are updated using the MEI. The MEI for 2005 is 3.1 percent. Diagnostic laboratory tests are estimated to represent approximately 7.1 percent of Medicare allowed charges included in the SGR for 2005. Medicare payments for these tests are updated by the Consumer Price Index for Urban Areas (CPI–U). However, section 629 of the MMA specifies that diagnostic laboratory services will receive an update of 0.0 percent from 2004 through 2008.

Drugs are estimated to represent 9.0 percent of Medicare allowed charges included in the SGR in 2005. As indicated earlier in this final rule, sections 303 and 304 of the MMA require Medicare to pay for most drugs at 106 percent of ASP beginning January 1, 2005. We estimated a weighted average change in fees for drugs included in the SGR using the ASP plus 6 percent pricing methodology of −14.7 percent for 2005. Table 27 shows the weighted average of the MEI, laboratory and drug price changes for 2005.

TABLE 27:

	Weight	Update
Physician	0.839	3.1
Laboratory	0.071	0.0
Drugs	0.090	-14.7
Weighted Average	1.000	1.3

We estimate that the weighted-average increase in fees for physicians' services in 2005 under the SGR (before applying any legislative adjustments) will be 1.3 percent.

Factor 2—The Percentage Change in the Average Number of Part B Enrollees From 2004 to 2005

This factor is our estimate of the percent change in the average number of fee-for-service enrollees from 2004 to 2005. Services provided to Medicare+Choice (M+C) plan enrollees are outside the scope of the SGR and are excluded from this estimate. OACT estimates that the average number of Medicare Part B fee-for-service enrollees will decrease by 0.3 percent from 2004 to 2005. Table 28 illustrates how this figure was determined.

TABLE 28:

	2004	2005
Overall	39.041 million	39.547 million
Medicare+Choice	4.671 million	5.275 million
Net	34.370 million	34.272 million
Percent Increase		-0.3 percent

An important factor affecting fee-for-service enrollment is beneficiary enrollment in M+C plans. Because it is difficult to estimate the size of the M+C enrollee population before the start of a calendar year, at this time we do not know how actual enrollment in M+C plans will compare to current estimates. For this reason, the estimate may change substantially as actual Medicare fee-for-service enrollment for 2005 becomes known.

Factor 3—Estimated Real Gross Domestic Product Per Capita Growth in 2005

We estimate that the growth in real per capita GDP from 2004 to 2005 will be 2.2 percent. Our past experience indicates that there have also been large changes in estimates of real per capita GDP growth made before the year begins and the actual change in GDP computed after the year is complete. Thus, it is likely that this figure will change as actual information on economic performance becomes available to us in 2005.

Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Law or Regulations in CY 2005 Compared With CY 2004

There are a number of statutory provisions that will affect the 2005 SGR. As indicated above, sections 303 and 304 of the MMA changed Medicare payment for drugs. These provisions also changed Medicare payments for the administration of drugs. Section 303(a)(1) amended section 1848(c)(2) of the Act to require the Secretary to make a number of changes that increased Medicare payment for drug administration beginning January 1, 2004. These changes permanently increased Medicare payments for drug administration by a weighted average of 110 percent. Section 303(a)(4) of the MMA required an additional transitional adjustment (temporary increase) to Medicare's payment for drug administration of 32 percent for 2004 and 3 percent for 2005. The change in the transitional adjustment of 32 percent for 2004 to 3 percent for 2005 would reduce Medicare payments for drug administration between 2004 and 2005. However, some of this reduction will be lessened because we are also adopting changes to the codes and payment amounts for drug administration based on recommendations from the AMA's CPT Editorial Panel and Relative Value Update Committee (RUC), under the authority of section 1848(c)(2)(J) of the Act. We are further increasing physician fee schedule payments by paying separately for injections provided on the same day as another physician fee schedule service. We are further increasing physician fee schedule payments by paying separately for injections provided on the same day as another physician fee schedule service. We estimate that changes to our policy on injections and the changes to our drug administration payments taken together will increase physician spending by 0.2 percent.

We are also adjusting the SGR to account for OACT's assumptions about predicted physician behavior in response to the payment reductions. OACT assumes that reduced fees are likely to be met by a combination of an increase in volume and a shift in the mix or intensity of services furnished to Medicare beneficiaries so as to offset 30 percent of the payment reduction that would otherwise occur. Because OACT assumes that physicians will offset some of the loss in payments that will occur from changes in Medicare payments for drugs (as described earlier) and drug administration and the change in payment can be attributed to a change in law, we are increasing the SGR by 0.4 percent for this factor. (Discussion may change based on recent decisions.)

There are several other statutory provisions that are estimated to increase Medicare spending for physicians' services under the SGR. Section 413(a) of the MMA establishes a 5 percent increase in the physician fee schedule payment for services provided in physician scarcity areas. Section 413(b) improves the procedures for paying the 10 percent physician fee schedule bonus payment for services provided in health professional shortage areas. We estimate that the provisions of section 413 will increase Medicare physician fee schedule payments by 0.1 percent.

Sections 611 through 613 of the MMA, respectively, provide Medicare coverage for an initial preventive physical examination, CV and diabetes screening tests. We estimate that new Medicare coverage for these preventive services will increase spending for physicians' services under the SGR by 0.3 percent. Taken together, we estimate that all of the statutory provisions for 2005 will increase Medicare spending for physicians' services by 0.5 percent.

Comment: We received comments concerned that we will underestimate the costs associated with the initial preventive physical examination. These comments suggested that we should account for ''both spending due to use of the new or expanded benefit, as well as additional services triggered by implementation of the new benefit.'' We received other comments concerned that we will underestimate the cost of CV and diabetes screening tests because we will use the national coverage determination (NCD) process to decide if any additional tests may be eligible for coverage. The commenters have this concern because we do not adjust the SGR for NCDs.

Response: Our estimates of the costs of the initial preventive physical exam and the CV and diabetes screening tests account for utilization of other Medicare services (preventive and nonpreventive) that may result from coverage of the new preventive services. We also note that our current estimates of the initial preventive examination and CV and diabetes screening tests are based only on our projections without any data on actual use of the benefits. The statute requires us to revise our current estimate of the 2005 SGR no later than November 1, 2005 and to make a final revision to our estimate no later than November 1, 2006. At the time we make the final revision to the 2005 SGR, we will have complete data on use of the new preventive services that will enable us to more accurately reflect these costs in the SGR.

With respect to the comments about use of the NCD process to establish additional CV and diabetes screening tests that will be eligible for Medicare coverage, the regulation lists the common types of tests that are currently

used to screen patients for these conditions. Our adjustment to the SGR will cover all of the costs associated with these new Medicare covered screening tests. However, if we use the NCD process to cover additional tests, we will consider this issue further.

2. Detail on the 2004 SGR

A more detailed discussion of our revised estimates of the four elements of the 2004 SGR follows.

Factor 1—Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for 2004

This factor was calculated as a weighted average of the 2004 fee increases that apply for the different types of services included in the definition of physicians' services for the SGR.

We estimate that services paid using the physician fee schedule account for approximately 83.7 percent of total allowed charges included in the SGR in 2004. These services were updated using the 2004 MEI of 2.9 percent. We estimate that diagnostic laboratory tests represent approximately 7.1 percent of total allowed charges included in the SGR in 2004. Medicare payments for these tests are updated by the CPI–U. However, section 629 of the MMA specifies that diagnostic laboratory services will receive an update of 0.0 percent from 2004 through 2008. We estimate that drugs represent 9.2 percent of Medicare allowed charges included in the SGR in 2004. Historically, Medicare paid for drugs under section 1842(o) of the Act at 95 percent of average wholesale price (AWP). However, with some exceptions, sections 303 and 304 of the MMA generally require Medicare to pay for drugs at 85 percent of the AWP determined as of April 1, 2003 or a specified percentage of AWP based on studies by the Government Accountability Office and the Office of the Inspector General in 2004. (We implemented section 303 and 304 of the MMA in an interim final rule published in the **Federal Register** on January 7, 2004 (see 69 FR 1086). Taking sections 303 and 304 of the MMA into account, we estimate a weighted average change in fees for drugs included in the SGR of −11.7 percent for 2004. Table 29 shows the weighted average of the MEI, laboratory and drug price changes for 2004.

TABLE 29:

	Weight	Update
Physician	0.837	2.9
Laboratory	0.071	0.0
Drugs	0.092	-11.7
Weighted Average	1.000	1.4

After taking into account the elements described in Table 29, we estimate that the weighted-average increase in fees for physicians' services in 2004 under the SGR (before applying any legislative adjustments) will be 1.4 percent. Our November 7, 2003 estimate of this factor was 2.7 percent. The reduction from 2.7 percent to our current estimate of 1.4 percent is primarily due to application of the drug pricing changes required by sections 303 and 304 of the MMA.

Factor 2—The Percentage Change in the Average Number of Part B Enrollees From 2003 to 2004

OACT estimates that the average number of Medicare Part B fee-for-service enrollees (excluding beneficiaries enrolled in M+C plans) increased by 1.7 percent in 2004. Table 30 illustrates how we determined this figure.

TABLE 30:

	2003	2004
Overall	38.465 million	39.041 million
Medicare+Choice	4.655 million	4.671 million
Net	33.810 million	34.370 million
Percent Increase		1.7 percent

OACT's estimate of the 1.7 percent change in the number of fee-for-service enrollees, net of M+C enrollment for 2004 compared to 2003, is the same as our original estimate published in the November 7, 2003 final rule (68 FR 63250). While our current projection based on data from 8 months of 2004 is the same as our original estimate when we had no data, it is still possible that our final estimate of this figure will be different once we have complete information on 2004 fee-for-service enrollment.

Factor 3—Estimated Real Gross Domestic Product Per Capita Growth in 2004

We estimate that the growth in real per capita GDP will be 2.2 percent for 2004. Our past experience indicates that there have also been large differences between our estimates of real per capita GDP growth made prior to the year's end and the actual change in this factor. Thus, it is likely that this figure will change further as complete actual information on 2004 economic performance becomes available to us in 2005.

Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Law or Regulations in 2004 Compared With 2003

There are four statutory provisions that are increasing 2004 Medicare spending relative to 2003. Section 412 of the MMA established a floor of 1.0 on adjustments to the physician work relative value unit for the geographic practice cost index (GPCI) for the years 2004 through 2006. Section 602 of the MMA increases the GPCIs for work, practice expense, and malpractice in Alaska to 1.67. Because these provisions increase the work GPCIs that are below 1.0 to 1.0 and, for services in Alaska, we estimate that sections 412 and 602 of the MMA are increasing 2004 Medicare spending included in the SGR by 0.6 percent. Sections 303 and 304 of the MMA increased Medicare's payments for drug administration in 2004. It further exempted the increases in payment from the budget neutrality provisions of section 1848(c)(2) of the Act. We estimate the section 303 and 304 provisions will increase spending for physicians' services by 0.8 percent in 2004. Taken together, we estimate that statutory provisions are increasing 2004 spending for physicians' services by 1.5 percent (after accounting for rounding).

3. Detail on the 2003 SGR

A more detailed discussion of our revised estimates of the four elements of the 2003 SGR follows.

Factor 1—Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for 2003

This factor was calculated as a weighted average of the 2003 fee increases that apply for the different types of services included in the definition of physicians' services for the SGR.

Services paid using the physician fee schedule accounted for approximately 83.0 percent of total Medicare allowed charges included in the SGR for 2003 and are updated using the MEI. The MEI for 2003 was 3.0 percent. Diagnostic laboratory tests represent approximately 7.2 percent of total Medicare allowed charges included in the SGR and are updated by the CPI–U. The CPI–U applied to payments for laboratory services for 2003 was 1.1 percent. Drugs represented approximately 9.8 percent of total Medicare allowed charges included in the SGR for 2003. According to section 1842(o) of the Act, Medicare pays for drugs based on 95 percent of AWP. Using wholesale pricing information and Medicare utilization for drugs included in the SGR, we estimate a weighted average fee increase for drugs of 1.9 percent for 2003. Table 31 shows the weighted average of the MEI, laboratory, and drug price increases for 2003.

TABLE 31:

	Weight	Update
Physician	0.830	3.0
Laboratory	0.072	1.1
Drugs	0.098	1.9
Weighted Average	1.000	2.8

After taking into account the elements described in Table 31, we estimate that the weighted-average increase in fees for physicians' services in 2003 under the SGR (before applying any legislative adjustments) was 2.8 percent.

Factor 2—The Percentage Change in the Average Number of Part B Enrollees From 2002 to 2003

We estimate the increase in the number of fee-for-service enrollees (excluding beneficiaries enrolled in M+C plans) from 2002 to 2003 was 2.3 percent. Our calculation of this factor is based on complete data from 2003. Table 32 illustrates the calculation of this factor.

TABLE 32:

	2002	2003
Overall	38.049 million	38.465 million
Medicare+Choice	5.005 million	4.655 million
Net	33.044 million	33.810 million
Percent Increase		2.3 percent

Factor 3—Estimated Real Gross Domestic Product Per Capita Growth in 2003

We estimate that the growth in real per capita GDP was 2.0 percent in 2003. This figure is a final one based on complete data for 2003.

Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Law or Regulations in 2003 Compared With 2002

There are no statutory or regulatory changes that affect Medicare expenditures for services included in the SGR in 2003.

X. Anesthesia and Physician Fee Schedule Conversion Factors (CF) for Calendar Year 2005

The 2005 physician fee schedule CF will be $37.8975. The 2005 national average anesthesia conversion factor is $17.7594.

Physician Fee Schedule Conversion Factor

Under section 1848(d)(1)(A) of the Act, the physician fee schedule CF is equal to the CF for the previous year multiplied by the update determined under section 1848(d)(4) of the Act. Using this formula would result in a 3.3 percent reduction to the physician fee schedule CF for 2005. However, section 601 of the MMA amended section 1848(d) of the Act to specify that the update to the single CF for 2004 and 2005 will not be less than 1.5 percent. Because the statutory formula will yield a 3.3 percent reduction to the 2005 physician fee schedule CF and the amendments to the statute indicate that the update for 2005 cannot be less than 1.5 percent, we are increasing the physician fee schedule conversion factor by 1.5 percent.

We illustrate the calculation for the 2005 physician fee schedule CF in Table 33 below.

TABLE 33:

2004 Conversion Factor	$37.3374
2005 Update	1.5 percent (1.015)
2005 Conversion Factor	$37.8975

• *Anesthesia Fee Schedule Conversion Factor*

Anesthesia services do not have RVUs like other physician fee schedule services. Therefore, we account for any necessary RVU adjustments through an adjustment to the anesthesia fee schedule CF. The only adjustment we are applying to the anesthesia fee schedule CF for 2005 is the physician fee schedule update. We used the following figures to determine the anesthesia fee schedule CF (see Table 34).

TABLE 34:

2004 Anesthesia Conversion Factor	$17.4969
2005 Update	1.5 percent (1.0150)
2005 Anesthesia Conversion Factor	$17.7594

XI. Telehealth Originating Site Facility Fee Payment Amount Update

Section 1834(m) of the Act establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001 through December 31, 2002, at $20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased by the percentage increase in the MEI as defined in section 1842(i)(3) of the Act. The MEI increase for 2005 is 3.1 percent.

Therefore, for CY 2005, the payment amount for HCPCS code ''Q3014, telehealth originating site facility fee'' is 80 percent of the lesser of the actual charge or $21.86. The Medicare telehealth originating site facility fee and MEI increase by the applicable time period is shown in Table 35.

TABLE 35:

Facility Fee	MEI Increase	Period
$20.00	N/A	10/01/2001 - 12/31/2002
$20.60	3.0%	01/01/2003 - 12/31/2003
$21.20	2.9%	01/01/2004 - 12/31/2004
$21.86	3.1%	01/01/2005 - 12/31/2005

XII. Provisions of the Final Rule

The provisions of this final rule restate the provisions of the August 2004 proposed rule, except as noted elsewhere in the preamble.

XIII. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule. The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substances of the proposed rule or a description of the subjects and issues involved. This procedure can be waived, however, if an agency finds

good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued.

We believe that providing a notice and comment procedure with regard to the RNHCI home benefit would be contrary to the public interest. The RNHCI home benefit provisions were added by the Congress to get a RNHCI benefit to those beneficiaries who are confined to the home. We believe that the Congress intended to provide the benefit to the homebound RNHCI beneficiaries as means of providing a similar home option as is offered to the general Medicare population. However, this expanded benefit is, by statute, a time limited benefit. Any delay in implementation could prevent beneficiaries from utilizing this expanded benefit at all or could seriously impinge on the amount of time they can use the benefit. Therefore, we find good cause to waive notice and comment procedures as contrary to the public interest with regard to the RNHCI home benefit. We are, however, providing a 60-day period for public comment.

XIV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether OMB should approve an information collection, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

Section 403.766 Requirements for Coverage/Payment of Home Services

In summary, § 403.766 states the RNHCI provider must submit a written letter of intent to us if they choose to participate in offering the home service benefit.

The burden associated with this requirement is the time and effort of the RNHCI provider to prepare and submit a letter of intention. It is estimated that this two-sentence letter should take no longer than 15 minutes to prepare and submit. There are currently 16 RNHCI providers and, if all elected to participate, it would result in a one-time burden of 4 hours.

We have submitted a copy of this final rule with comment to OMB for its review of the information collection requirements described above. These requirements are not effective until they have been approved by OMB.

Section 410.16 Initial Preventive Physical Examination: Conditions for Limitations on Coverage

In summary, § 410.16 requires the furnishing of education, counseling and referral services as part of an initial preventive physical examination, a written plan for obtaining the appropriate screening and other preventive services which are also covered as separate Medicare B Part services.

The burden associated with this requirement is the time required of the physician or practitioner to provide beneficiaries with education, counseling, and referral services and to develop and provide a written plan for obtaining screening and other preventive services.

While these requirements are subject to the PRA; we believe the burden associated with these requirements to be usual and customary business practice; therefore, the burden for this collection requirement is exempt under 5 CFR 1320.3(b)(2)&(3).

Section 411.404 Criteria for Determining That a Beneficiary Knew That Services Were Excluded From Coverage as Custodial Care or as Not Reasonable and Necessary

In summary, § 411.404 requires that written notice must be given to a beneficiary, or someone acting on his or her behalf, that the services were not covered because they did not meet Medicare coverage guidelines.

Although this section is subject to the PRA, the burden associated with this requirement is currently captured and accounted for in two currently approved information collections under OMB numbers 0938–0566 and 0938–0781.

Section 418.205 Special Requirements for Hospice Pre-Election Evaluations and Counseling Services

In summary, § 418.205 states that written documentation is required and must be maintained for referral requests and services furnished.

While these information collection requirements are subject to the PRA, the burden associated with them is exempt as defined in 5 CFR 1320.3(b)(2).

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following: Centers for Medicare & Medicaid Services Office of Strategic Operations and Regulatory Affairs, Attn: Melissa Musotto (CMS–1429–FC) Room C5–13–28, 7500 Security Boulevard, Baltimore, MD 21244–1850; and Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Christopher Martin, CMS Desk Officer (CMS–1429–P), *Christopher Martin@omb.eop.gov.* FAX (202) 395–6974.

XV. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the ''DATES'' section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

XVI. Regulatory Impact Analysis

We have examined the impact of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980 Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibilities of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis must be prepared for final rules with economically significant effects (that is, a final rule that would have an annual effect on the economy of $100 million or more in any 1 year, or would adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities).

As indicated in more detail below, we expect that the physician fee schedule provisions included in this final rule will redistribute more than $100 million in 1 year. We also anticipate that the combined effect of several provisions of the MMA implemented in this final rule will increase spending by more than $100 million. Other MMA provisions implemented in this final rule are expected to reduce spending by more than $100 million. We are considering this final rule to be economically significant because its provisions are expected to result in an increase, decrease or aggregate redistribution of Medicare spending that will exceed $100 million. Therefore, this final rule is a major rule and we have prepared a regulatory impact analysis.

The RFA requires that we analyze regulatory options for small businesses and other entities. We prepare a regulatory flexibility analysis unless we certify that a rule would not have a significant economic impact on a substantial number of small entities. The analysis must include a justification concerning the reason action is being taken, the kinds and number of small entities the rule affects, and an explanation of any meaningful options that achieve the objectives with less significant adverse economic impact on the small entities.

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any final rule that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside a Metropolitan Statistical Area and has fewer than 100 beds. We have determined that this final rule would have minimal impact on small hospitals located in rural areas. Of 517 hospital-based ESRD facilities located in rural areas, only 40 are affiliated with hospitals with fewer than 100 beds.

For purposes of the RFA, physicians, nonphysician practitioners, and suppliers are considered small businesses if they generate revenues of $6 million or less. Approximately 95 percent of physicians are considered to be small entities. There are about 875,000 physicians, other practitioners and medical suppliers that receive Medicare payment under the physician fee schedule. There are in excess of 20,000 physicians and other practitioners that receive Medicare payment for drugs. As noted previously in this final rule and described further below, we are implementing significant changes to the payments for drugs.) The 20,000 physicians that receive payments for drugs are generally concentrated in the specialties of oncology, urology, rheumatology and infectious disease. Of the physicians in these specialties, approximately 40 percent are in oncology and 45 percent in urology.

For purposes of the RFA, approximately 98 percent of suppliers of durable medical equipment (DME) and prosthetic devices are considered small businesses according to the Small Business Administration's (SBA) size standards. We estimate that 106,000 entities bill Medicare for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) each year. Total annual estimated Medicare revenues for DME suppliers exceed approximately $4.0 billion. Of this amount, approximately $1.6 billion are for DME drugs. These suppliers will be affected by the payment changes being made in this final rule for drugs.

In addition, most ESRD facilities are considered small entities, either based on nonprofit status, or by having revenues of $29 million or less in any year. We consider a substantial number of entities to be affected if the rule is estimated to impact more than 5 percent of the total number of small entities. Based on our analysis of the 785 nonprofit ESRD facilities considered small entities in accordance with the above definitions, we estimate that the combined impact of the changes to payment for renal dialysis services included in this rule would have a 1.6 percent increase in payments relative to current composite rate payments.

The analysis and discussion provided in this section, as well as elsewhere in this final rule, complies with the RFA requirements. Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditures in any year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. Medicare beneficiaries are considered to be part of the private sector for this purpose. The net impact of the provisions of this rule, including those related to the MMA, are estimated to result in a savings to beneficiaries of nearly $485 million for FY 2005. However, we note that this savings figure compares FY 2005 beneficiary costs occurring as a result of provisions of this final rule to FY 2005 estimated beneficiary costs in the absence of final rule implementation (that is, the savings figure compare beneficiary costs with implementation of the ASP drug payment provisions to continuing the AWP drug payment methodology). The specific effects of the provisions being implemented in this final rule are explained in greater detail below.

We have examined this final rule in accordance with Executive Order 13132 and have determined that this regulation would not have any significant impact on the rights, roles, or responsibilities of State, local, or tribal governments.

We have prepared the following analysis, which, together with the information provided in the rest of this preamble, meets all assessment requirements. It explains the rationale for and purposes of the rule; details the costs and benefits of the rule; analyzes alternatives; and presents the measures we use to minimize the burden on small entities. As indicated elsewhere in this final rule, we are refining resource-based practice expense RVUs and making a variety of other changes to our regulations, payments, or payment policy to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services. We are also implementing several changes resulting from the MMA, including changes to Medicare payment rates for outpatient drugs, changes to the payment for renal dialysis services, creating new preventive health care benefits and creating incentive payment program improvements for physician scarcity.

We are providing information for each of the policy changes in the relevant sections of this final rule. We are unaware of any relevant Federal rules that duplicate, overlap or conflict with this final rule. The relevant sections of this final rule contain a description of significant alternatives if applicable.

A. Resource-Based Practice Expense and Malpractice Relative Value Units

Under section 1848(c)(2) of the Act, adjustments to RVUs may not cause the amount of expenditures to differ by more than $20 million from the amount of expenditures that would have resulted without such adjustments. We are implementing several changes that would result in a change in expenditures that would exceed $20 million if we made no offsetting adjustments to either the conversion factor or RVUs.

With respect to practice expense RVUs, our policy has been to meet the budget-neutrality requirements in the statute by incorporating a rescaling adjustment in the practice expense methodologies. That is, we estimate the aggregate number of practice expense RVUs that will be paid under current and revised policy in CY 2005. We

apply a uniform adjustment factor to make the aggregate number of revised practice expense RVUs equal the number estimated that would be paid under current policy. While we are continuing to apply this policy for general changes in coding and RVUs, we are increasing aggregate physician fee schedule payments to account for the higher payments for drug administration. These increases in payment are being made under the authority of section 1848(c)(2)(J) of the Act that exempts the changes in payments for drug administration from the budget neutrality requirements of section 1848(c)(2)(B)(iv) of the Act.

Table 36 shows the specialty level impact on payment of the practice expense and malpractice RVU changes being implemented for CY 2005. Our estimates of changes in Medicare revenues for physician fee schedule services compare payment rates for 2005 with payment rates for 2004 using 2003 Medicare utilization for both years. We are using 2003 Medicare claims processed and paid through June 30, 2004, that we estimate are 98.5 percent complete, and have adjusted the figures to reflect a full year of data. Thus, because we are using a single year of utilization, the estimated changes in revenues reflect payment changes only between 2004 and 2005. To the extent that there are year-to-year changes in the volume and mix of services provided by physicians, the actual impact on total Medicare revenues will be different than those shown here. The payment impacts reflect averages for each specialty based on Medicare utilization. The payment impact for an individual physician would be different from the average, based on the mix of services the physician provides. The average change in total revenues would be less than the impact displayed here because physicians furnish services to both Medicare and non-Medicare patients and specialties may receive substantial Medicare revenues for services that are not paid under the physician fee schedule. For instance, independent laboratories receive approximately 80 percent of their Medicare revenues from clinical laboratory services that are not paid under the physician fee schedule. The table shows only the payment impact on physician fee schedule services.

The column labeled ''NPRM Impacts'' shows the effect of the changes in payment attributable to practice expense and malpractice RVUs from the proposed rule. (*See* 69 FR 47556 through 47559 for a complete description of the payment changes shown in this column). We have also made some additional changes to the practice expense and malpractice RVUs since the proposed rule in response to comments and additional information that became available to us during the comment period. The additional changes in payment based on further refinements of the practice expense RVUs generally have no specialty level impact. The 1 percent increase in payment for vascular surgery shown in the practice expense refinements column is attributed to substitution of a vascular ultrasound room for a general ultrasound room in the equipment resources for CPT code 93880. Similarly, the increase in practice expense RVUs for diagnostic testing facilities is also attributable to the increase in payment for 93880 and 93925 due to the substitution of a vascular ultrasound room for a general ultrasound room in the equipment resources.

The column labeled ''Additional Malpractice RVU Refinements'' show the additional impact of changes in the malpractice expense RVUs since the proposed rule on total payment for physician fee schedule services. As explained earlier, we are making several changes to malpractice RVUs that will change the impacts we illustrated in the proposed rule. We are removing assistants-at-surgery from the Medicare utilization that goes into determining the malpractice RVUs. Relative to the proposed rule, this change will increase total payments to neurosurgeons by nearly 1 percent. We also increased the ISO risk classification for the all physician crosswalk used for podiatry increasing their payments by 1 percent relative to the proposed rule. Several specialty groups, including dermatology commented that the major surgery risk factor should not be used for the dermatology codes. Relative to the proposed rule, payments to dermatologists will decrease by approximately 1 percent as a result of this change. The changes also increase payment to the specialty of allergy/immunology by nearly 1 percent relative to the proposed rule. This increase occurs because we are setting a minimum value of 0.01 malpractice RVUs. In the proposed rule, we did show malpractice RVUs in Addendum B if the rounded RVU equaled 0.0.

The column labeled ''Immunizations/Injections'' shows the impact of making separate payment for injections provided on the same day as another physician fee schedule service and the increase in payment for immunizations. These changes generally benefit those specialties that provide injections and immunizations in their offices. The provision is estimated to increase payment by 2 percent to family practice and by 1 percent to general practice, geriatrics, internal medicine and pediatrics. The column labeled ''Total'' shows the combined percentage change in payments resulting from the practice expense and malpractice RVU changes including those that were described in the proposed rule and the additional changes we are making in this final rule.

As explained in the proposed rule, the practice expense refinements will reduce payments to audiologists by approximately 4 percent. Virtually all of the reduction in payment is due to the refinement of procedure code 92547. We accepted the PEAC recommendation to reduce the clinical staff time of the audiologist involved in this service from 71 minutes to 1 minute. The refinement of clinical staff and equipment resulted in a reduction from 1.15 to 0.08 practice expense RVUs producing the 4 percent reduction in payments shown in table 37. However, this impact assumes no change in how frequently these services are performed. While we received comments suggesting that the code was valued based on only one occurrence of the service, the commenter asserted that it is typically performed more than once per day. Currently, CPT allows it only to be billed once per day. If CPT were to change its policy and the service was billed more frequently, the impact shown in table 37 would be less than shown here.

In the proposed rule, we estimated that payments to vascular surgeons would increase by 3 percent as a result of the repricing of medical equipment used in performing noninvasive vascular diagnostic tests. As indicated above, the total increase in payments including the additional refinements we made to equipment will make the total increase in payment from RVU changes equal to 4 percent. We originally estimated that payments to interventional radiology would increase by 2 percent due practice expense refinements and the establishment of nonfacility pricing for procedure codes 35470 to 35476. Due to additional practice expense RVU refinements, we are now estimating that the total increase in payments will be 3 percent. We are estimating slightly less than a 3.5 percent increase in payment to oral and maxillofacial surgeons from the refinement of medical supplies for procedure codes 21210 and 21215. The estimated impact for this specialty is slightly less than we were estimating for the proposed rule. As we indicated in the proposed rule, the 1 percent decrease in payment to nurse practitioners and geriatricians is

attributed to the refinement of the nonfacility practice expense RVUs for nursing facility visits (procedure codes 99301 through 99316). These impacts are unchanged from the proposed rule.

As we indicated in the proposed rule, the increases for pathology and independent laboratories result from use of a practice expense survey provided by the College of American Pathology (CAP). The increases in the final rule are similar to the figures we estimated for the proposed rule. We further note that independent laboratories receive approximately 20 percent of their total Medicare revenues from physician fee schedule services. The remaining 80 percent of their Medicare revenues are from clinical diagnostic laboratory services that will be unchanged by use of the CAP survey data. Thus, total Medicare revenues to independent laboratories as a result of using the CAP survey will increase by slightly more than 1 percent (or 20 percent of the 6 percent increase in physician fee schedule revenues). There will be little or no impact on all other specialties from use of the CAP survey.

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TABLE 36:
Impact of Practice Expense and Malpractice RVU Changes on Total Medicare Allowed Charges by Physician, Practitioner and Supplier Subcategory

Specialty	Medicare Allowed Charges ($ in Millions)	NPRM Impacts	Additional Practice Expense Refinements	Additional Malpractice RVU Refinements	Injections Immunizations	Total
Physicians:						
ALLERGY/IMMUNOLOGY	$ 161	-2%	0%	1%	0%	-1%
ANESTHESIOLOGY	$ 1,422	0%	0%	0%	0%	0%
CARDIAC SURGERY	$ 359	0%	0%	1%	0%	1%
CARDIOLOGY	$ 6,579	0%	0%	0%	0%	0%
COLON AND RECTAL SURGERY	$ 110	1%	0%	0%	0%	1%
CRITICAL CARE	$ 130	0%	0%	0%	0%	0%
DERMATOLOGY	$ 1,864	1%	0%	-1%	0%	0%
EMERGENCY MEDICINE	$ 1,687	0%	0%	0%	0%	0%
ENDOCRINOLOGY	$ 279	0%	0%	0%	0%	0%
FAMILY PRACTICE	$ 4,456	0%	0%	0%	2%	1%
GASTROENTEROLOGY	$ 1,634	0%	0%	0%	0%	0%
GENERAL PRACTICE	$ 1,003	0%	0%	0%	1%	1%
GENERAL SURGERY	$ 2,264	1%	0%	0%	0%	1%
GERIATRICS	$ 116	-1%	0%	0%	1%	0%
HAND SURGERY	$ 57	0%	0%	0%	0%	0%
INTERNAL MEDICINE	$ 8,784	0%	0%	0%	1%	1%
INTERVENTIONAL RADIOLOGY	$ 191	2%	1%	0%	0%	3%
NEPHROLOGY	$ 747	1%	0%	0%	0%	1%

NEUROLOGY	$	1,197	0%	0%	0%	0%	0%
NEUROSURGERY	$	492	-1%	0%	1%	0%	0%
NUCLEAR MEDICINE	$	85	0%	0%	0%	0%	0%
OPHTHALMOLOGY	$	4,566	-1%	0%	0%	0%	-1%
ORTHOPEDIC SURGERY	$	2,903	0%	0%	0%	0%	0%
OTOLARNGOLOGY	$	814	0%	0%	0%	0%	0%
PATHOLOGY	$	846	2%	0%	0%	0%	2%
PEDIATRICS	$	60	-1%	0%	0%	1%	0%
PHYSICAL MEDICINE	$	680	0%	0%	0%	0%	0%
PLASTIC SURGERY	$	283	1%	0%	0%	0%	0%
PSYCHIATRY	$	1,109	0%	0%	0%	0%	0%
PULMONARY DISEASE	$	1,446	0%	0%	0%	0%	0%
RADIATION ONCOLOGY	$	1,163	0%	0%	0%	0%	0%
RADIOLOGY	$	4,693	0%	0%	0%	0%	0%
THORACIC SURGERY	$	464	0%	0%	0%	0%	1%
VASCULAR SURGERY	$	487	3%	1%	0%	0%	4%
Practitioners:							
AUDIOLOGIST	$	28	-4%	0%	0%	0%	-4%
CHIROPRACTOR	$	658	-1%	0%	0%	0%	-1%
CLINICAL PSYCHOLOGIST	$	494	0%	0%	0%	0%	0%
CLINICAL SOCIAL WORKER	$	317	0%	0%	0%	0%	0%
NURSE ANESTHETIST	$	485	0%	0%	0%	0%	0%
NURSE PRACTITIONER	$	556	-1%	0%	0%	0%	-1%
OPTOMETRY	$	666	0%	0%	0%	0%	0%
ORAL/MAXILLOFACIAL SURGERY	$	36	4%	0%	0%	0%	4%
PHYSICAL/OCCUPATIONAL THERAPY	$	998	-2%	0%	0%	0%	-2%
PHYSICIAN ASSISTANT	$	414	0%	0%	0%	0%	0%
PODIATRY	$	1,392	-1%	0%	1%	0%	1%
Suppliers:							
DIAGNOSTIC TESTING FACILITY	$	879	1%	1%	0%	0%	2%

INDEPENDENT LABORATORY	$	452	6%	0%	0%	0%	6%	0%	1%	0%
PORTABLE X-RAY SUPPLIER	$	92	0%	0%	0%	0%	0%	0%	0%	0%
Other:										
ALL OTHER	$	93	2%	0%	0%	0%	0%	0%	0%	0%
ALL PHYSICIAN FEE SCHEDULE	$	65,803	0%	0%	0%	0%	0%	0%	0%	0%

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As discussed in section II.C of this rule, we are making changes to the malpractice RVUs based on more current malpractice premium data. As anticipated from past revisions to the malpractice RVUs, use of more current malpractice premium data results in minimal impacts on the specialty level payments. The table below shows the impact on total physician fee schedule revenues from the changes to the malpractice RVUs, the additional changes resulting from this final rule and the total impact. See Table 37, ''Impact of Malpractice RVU Changes Proposed Rule and Final Rule'', for a breakdown of the impacts of these revisions on individual specialties. As described above, policies we are adopting in this final rule will increase payments for allergy, neurosurgery and podiatry and decrease payments for dermatology relative to the proposed rule. These changes will also slightly increase payments to cardiac surgery, orthopedic surgery, thoracic surgery and result in a smaller increase in payment for vascular surgery.

Table 37:
Impact Malpractice RVU Changes
Proposed Rule and Final Rule

Specialty	Medicare Allowed Charges ($ in Millions)	NPRM Impacts	Change due to Final Rule	% Change in Total Payment from MP RVU Changes
Physicians:				
ALLERGY/IMMUNOLOGY	$ 161	-0.9%	0.8%	-0.1%
ANESTHESIOLOGY	$ 1,422	0.0%	0.0%	0.1%
CARDIAC SURGERY	$ 359	-0.1%	0.5%	0.4%
CARDIOLOGY	$ 6,579	0.0%	-0.2%	-0.1%
COLON AND RECTAL SURGERY	$ 110	0.6%	0.1%	0.7%
CRITICAL CARE	$ 130	0.5%	-0.2%	0.3%
DERMATOLOGY	$ 1,864	0.7%	-0.9%	-0.2%
EMERGENCY MEDICINE	$ 1,687	0.0%	0.0%	0.0%
ENDOCRINOLOGY	$ 279	0.1%	-0.1%	0.0%
FAMILY PRACTICE	$ 4,456	0.0%	-0.1%	-0.1%
GASTROENTEROLOGY	$ 1,634	0.5%	0.1%	0.6%
GENERAL PRACTICE	$ 1,003	0.0%	-0.1%	-0.1%
GENERAL SURGERY	$ 2,264	0.5%	0.1%	0.6%
GERIATRICS	$ 116	0.3%	-0.2%	0.1%
HAND SURGERY	$ 57	-0.1%	0.1%	0.0%
HEMATOLOGY/ONCOLOGY	$ 1,747	0.0%	-0.1%	0.0%
INFECTIOUS DISEASE	$ 401	0.4%	-0.3%	0.1%
INTERNAL MEDICINE	$ 8,784	0.1%	-0.1%	0.0%
INTERVENTIONAL RADIOLOGY	$ 191	0.0%	0.0%	-0.1%
NEPHROLOGY	$ 747	0.1%	-0.1%	0.0%
NEUROLOGY	$ 1,197	0.2%	-0.1%	0.2%
NEUROSURGERY	$ 492	-0.6%	0.9%	0.3%
NUCLEAR MEDICINE	$ 85	-0.1%	0.0%	-0.1%
OBSTETRICS/GYNECOLOGY	$ 582	0.1%	0.0%	0.1%
OPHTHALMOLOGY	$ 4,566	0.0%	0.0%	0.0%
ORTHOPEDIC SURGERY	$ 2,903	-0.4%	0.4%	0.0%
OTOLARNGOLOGY	$ 814	-0.1%	0.0%	-0.1%
PATHOLOGY	$ 846	0.2%	0.0%	0.2%
PEDIATRICS	$ 60	-0.1%	0.0%	0.0%
PHYSICAL MEDICINE	$ 680	0.2%	-0.1%	0.1%
PLASTIC SURGERY	$ 283	0.6%	-0.5%	0.2%
PSYCHIATRY	$ 1,109	0.3%	-0.3%	0.0%
PULMONARY DISEASE	$ 1,446	0.3%	-0.2%	0.1%
RADIATION ONCOLOGY	$ 1,163	0.0%	0.0%	0.0%
RADIOLOGY	$ 4,693	-0.3%	0.0%	-0.3%
RHEUMATOLOGY	$ 412	-0.1%	0.0%	-0.1%
THORACIC SURGERY	$ 464	0.0%	0.4%	0.4%
UROLOGY	$ 1,695	0.0%	0.0%	-0.1%
VASCULAR SURGERY	$ 487	0.1%	0.2%	0.3%
Practitioners:				
AUDIOLOGIST	$ 28	-0.1%	0.1%	0.0%
CHIROPRACTOR	$ 658	-0.2%	0.0%	-0.2%
CLINICAL PSYCHOLOGIST	$ 494	-0.1%	0.0%	-0.1%
CLINICAL SOCIAL WORKER	$ 317	0.0%	0.0%	0.0%

NURSE ANESTHETIST	$	485	0.0%	0.0%	0.0%
NURSE PRACTITIONER	$	556	0.2%	-0.2%	0.1%
OPTOMETRY	$	666	0.2%	-0.1%	0.1%
ORAL/MAXILLOFACIAL SURGERY	$	36	0.6%	0.0%	0.6%
PHYSICAL/OCCUPATIONAL THERAPY	$	998	-1.3%	-0.1%	-1.4%
PHYSICIAN ASSISTANT	$	414	-0.1%	0.1%	0.1%
PODIATRY	$	1,392	-0.4%	1.1%	0.7%
Suppliers:					
DIAGNOSTIC TESTING FACILITY	$	879	0.0%	0.0%	0.0%
INDEPENDENT LABORATORY	$	452	0.2%	0.0%	0.2%
PORTABLE X-RAY SUPPLIER	$	92	-0.1%	0.0%	-0.1%
Other:					
ALL OTHER	$	93	0.0%	0.0%	0.0%
ALL PHYSICIAN FEE SCHEDULE	$	65,803	0.0%	0.0%	0.0%

Section 1848(d) and (f) of the Act requires the Secretary to set the physician fee schedule update under the sustainable growth rate (SGR) system. For 2004 and 2005, the statute requires the update to be no less than 1.5 percent. Using the statutory formula in section 1848(d)(4) will produce an update of less than 1.5 percent for 2005. Therefore, the physician fee schedule update for 2005 will be 1.5 percent. We have included a complete discussion of our methodology for calculating the SGR and physician fee schedule update in another section of this final rule. Table 38 below shows the estimated change in average payments by specialty resulting from changes to the practice expense and malpractice RVUs and the 2005 physician fee schedule update. (Please note that the table does not include the specialties of Hematology/Oncology, Urology, Rheumatology, Obstetrics/Gynecology and Infectious Disease. There are unique issues related to drug administration that will further affect these specialties that are presented in detail below).

Table 38:

Impact of Practice Expense and Malpractice RVU Changes
and Physician Fee Schedule Update on Total Medicare Allowed Charges
by Physician, Practitioner and Supplier Subcategory

Specialty	Medicare Allowed Charges ($ in Millions)	Practice Expense & Malpractice RVU Changes	Physician Fee Schedule Update	Total
Physicians:				
ALLERGY/IMMUNOLOGY	$ 161	-1%	1.5%	1%
ANESTHESIOLOGY	$ 1,422	0%	1.5%	2%
CARDIAC SURGERY	$ 359	1%	1.5%	2%
CARDIOLOGY	$ 6,579	0%	1.5%	2%
COLON AND RECTAL SURGERY	$ 110	1%	1.5%	2%
CRITICAL CARE	$ 130	0%	1.5%	2%
DERMATOLOGY	$ 1,864	0%	1.5%	2%
EMERGENCY MEDICINE	$ 1,687	0%	1.5%	2%
ENDOCRINOLOGY	$ 279	0%	1.5%	2%
FAMILY PRACTICE	$ 4,456	1%	1.5%	3%
GASTROENTEROLOGY	$ 1,634	0%	1.5%	2%
GENERAL PRACTICE	$ 1,003	1%	1.5%	2%
GENERAL SURGERY	$ 2,264	1%	1.5%	2%
GERIATRICS	$ 116	0%	1.5%	1%
HAND SURGERY	$ 57	0%	1.5%	2%
INTERNAL MEDICINE	$ 8,784	1%	1.5%	2%
INTERVENTIONAL RADIOLOGY	$ 191	3%	1.5%	4%
NEPHROLOGY	$ 747	1%	1.5%	2%
NEUROLOGY	$ 1,197	0%	1.5%	2%
NEUROSURGERY	$ 492	0%	1.5%	2%
NUCLEAR MEDICINE	$ 85	0%	1.5%	2%
OPHTHALMOLOGY	$ 4,566	-1%	1.5%	0%
ORTHOPEDIC SURGERY	$ 2,903	0%	1.5%	1%
OTOLARNGOLOGY	$ 814	0%	1.5%	2%
PATHOLOGY	$ 846	2%	1.5%	4%

PEDIATRICS	$	60	0%	1.5%	2%
PHYSICAL MEDICINE	$	680	0%	1.5%	1%
PLASTIC SURGERY	$	283	0%	1.5%	2%
PSYCHIATRY	$	1,109	0%	1.5%	1%
PULMONARY DISEASE	$	1,446	0%	1.5%	2%
RADIATION ONCOLOGY	$	1,163	0%	1.5%	1%
RADIOLOGY	$	4,693	0%	1.5%	2%
THORACIC SURGERY	$	464	1%	1.5%	2%
VASCULAR SURGERY	$	487	4%	1.5%	6%
Practitioners:					
AUDIOLOGIST	$	28	-4%	1.5%	-2%
CHIROPRACTOR	$	658	-1%	1.5%	1%
CLINICAL PSYCHOLOGIST	$	494	0%	1.5%	1%
CLINICAL SOCIAL WORKER	$	317	0%	1.5%	1%
NURSE ANESTHETIST	$	485	0%	1.5%	2%
NURSE PRACTITIONER	$	556	-1%	1.5%	0%
OPTOMETRY	$	666	0%	1.5%	1%
ORAL/MAXILLOFACIAL SURGERY	$	36	4%	1.5%	5%
PHYSICAL/OCCUPATIONAL THERAPY	$	998	-2%	1.5%	-1%
PHYSICIAN ASSISTANT	$	414	0%	1.5%	1%
PODIATRY	$	1,392	1%	1.5%	2%
Suppliers:					
DIAGNOSTIC TESTING FACILITY	$	879	2%	1.5%	3%
INDEPENDENT LABORATORY	$	452	6%	1.5%	8%
PORTABLE X-RAY SUPPLIER	$	92	0%	1.5%	1%
Other:					
ALL OTHER	$	93	1%	1.5%	3%
ALL PHYSICIAN FEE SCHEDULE	$	65,803	0%	1.5%	2%

Table 39 shows the impact on payments for selected high-volume procedures of all of the changes previously discussed. We selected these procedures because they are the most commonly provided procedures by a broad spectrum of physician specialties, or they are of particular interest to the physician community (for example, the initial preventive physical exam and EKG, codes G0344, G0366, G0367 and G0368). We note that the table below shows Medicare payment for the administration of an influenza vaccine, G0008, increasing from $8.21 to $18.57, or 126 percent. As explained earlier, we are establishing the same RVUs for the administration of a vaccine and an injection. For 2005 only, we will pay 3 percent more for the injection ($19.13) because of the transitional adjustment required by section 303. After 2005, the payment for the administration of a vaccine and an injection will be the same. This table shows the combined impact of the change in the practice expense and malpractice RVUs and the estimated physician fee schedule update on total payment for the procedure. There are separate columns that show the change in the facility rates and the nonfacility rates. For an explanation of facility and nonfacility practice expense RVUs refer to § 414.22(b)(5)(i). The table shows the estimated change in payment rates based on provisions of this final rule and the estimated physician fee schedule update.

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Table 39:

Impact of Final Rule and Physician Fee Schedule Update
on Medicare Payment for Selected Procedures

			Non-Facility			Facility		
CODE	MOD	DESCRIPTION	Old	New	% Change	Old	New	% Change
11721		Debride nail, 6 or more	$ 38.08	$ 38.66	2%	$ 29.87	$ 29.94	0%
17000		Destroy benign/premlg lesion	$ 60.49	$ 61.39	1%	$ 35.84	$ 45.10	26%
27130		Total hip arthroplasty	N/A	N/A	N/A	$1,370.28	$1,383.26	1%
27244		Treat thigh fracture	N/A	N/A	N/A	$1,115.27	$1,128.97	1%
27447		Total knee arthroplasty	N/A	N/A	N/A	$1,475.95	$1,493.16	1%
33533		CABG, arterial, single	N/A	N/A	N/A	$1,882.18	$1,905.49	1%
35301		Rechanneling of artery	N/A	N/A	N/A	$1,114.89	$1,122.52	1%
43239		Upper GI endoscopy, biopsy	$321.85	$333.88	4%	$ 159.43	$ 162.58	2%
66821		After cataract laser surgery	$240.83	$248.23	3%	$ 237.09	$ 230.42	-3%
66984		Cataract surg w/iol, 1 stage	N/A	N/A	N/A	$ 684.39	$ 684.05	0%
67210		Treatment of retinal lesion	$577.98	$599.54	4%	$ 560.81	$ 573.39	2%
71010	26	Chest x-ray	$ 9.33	$ 9.47	2%	$ 9.33	$ 9.47	2%
76091	26	Mammogram, both breasts	$ 44.80	$ 45.10	1%	$ 44.80	$ 45.10	1%
76091		Mammogram, both breasts	$ 96.33	$ 97.40	1%	N/A	N/A	N/A
76092	26	Mammogram, screening	$ 36.22	$ 36.38	0%	$ 36.22	$ 36.38	0%
76092		Mammogram, screening	$ 84.76	$ 85.65	1%	N/A	N/A	N/A
77427		Radiation tx management, x5	$169.14	$172.05	2%	$ 169.14	$ 172.05	2%
78465	26	Heart image (3d), multiple	$ 76.17	$ 77.31	1%	$ 76.17	$ 77.31	1%
88305	26	Tissue exam by pathologist	$ 41.44	$ 42.07	2%	$ 41.44	$ 42.07	2%
90801		Psy dx interview	$150.84	$153.48	2%	$ 142.26	$ 144.39	1%
90862		Medication management	$ 51.15	$ 52.30	2%	$ 48.17	$ 49.27	2%
90935		Hemodialysis, one evaluation	N/A	N/A	N/A	$ 72.06	$ 73.14	1%
92012		Eye exam established pat	$ 63.47	$ 65.18	3%	$ 36.22	$ 37.14	3%
92014		Eye exam & treatment	$ 93.34	$ 96.26	3%	$ 58.99	$ 60.64	3%
92980		Insert intracoronary stent	N/A	N/A	N/A	$ 812.09	$ 830.33	2%
93000		Electrocardiogram, complete	$ 26.51	$ 27.29	3%	N/A	N/A	N/A
93010		Electrocardiogram report	$ 8.96	$ 9.10	2%	$ 8.96	$ 9.10	2%
93015		Cardiovascular stress test	$106.78	$108.39	2%	N/A	N/A	N/A
93307	26	Echo exam of heart	$ 49.29	$ 49.27	0%	$ 49.29	$ 49.27	0%
93510	26	Left heart catheterization	$252.77	$257.32	2%	$ 252.77	$ 257.32	2%
98941		Chiropractic manipulation	$ 36.22	$ 36.76	1%	$ 31.74	$ 31.83	0%
99203		Office/outpatient visit, new	$ 95.96	$ 97.02	1%	$ 71.69	$ 72.38	1%
99213		Office/outpatient visit, est	$ 52.65	$ 52.68	0%	$ 35.47	$ 35.62	0%
99214		Office/outpatient visit, est	$ 82.14	$ 82.62	1%	$ 57.87	$ 59.12	2%

99222	Initial hospital care	N/A	N/A	N/A	$ 111.27	$ 112.93	1%
99223	Initial hospital care	N/A	N/A	N/A	$ 154.95	$ 157.27	1%
99232	Subsequent hospital care	N/A	N/A	N/A	$ 54.89	$ 56.09	2%
99233	Subsequent hospital care	N/A	N/A	N/A	$ 78.04	$ 79.58	2%
99236	Observ/hosp same date	N/A	N/A	N/A	$ 226.26	$ 223.60	-1%
99239	Hospital discharge day	N/A	N/A	N/A	$ 95.21	$ 96.64	2%
99243	Office consultation	$120.60	$122.79	2%	$ 92.22	$ 93.99	2%
99244	Office consultation	$170.63	$172.81	1%	$ 136.65	$ 138.70	2%
99253	Initial inpatient consult	N/A	N/A	N/A	$ 97.45	$ 98.91	1%
99254	Initial inpatient consult	N/A	N/A	N/A	$ 140.39	$ 142.12	1%
99261	Follow-up inpatient consult	N/A	N/A	N/A	$ 22.40	$ 22.36	0%
99262	Follow-up inpatient consult	N/A	N/A	N/A	$ 44.80	$ 45.48	2%
99263	Follow-up inpatient consult	N/A	N/A	N/A	$ 66.09	$ 67.46	2%
99283	Emergency dept visit	N/A	N/A	N/A	$ 61.61	$ 62.15	1%
99284	Emergency dept visit	N/A	N/A	N/A	$ 95.58	$ 97.02	2%
99291	Critical care, first hour	$242.69	$256.57	6%	$ 203.12	$ 207.68	2%
99292	Critical care, addÏl 30 min	$107.91	$114.07	6%	$ 101.56	$ 104.22	3%
99302	Nursing facility care	$ 97.82	$ 87.92	-10%	$ 82.52	$ 87.92	7%
99303	Nursing facility care	$120.97	$108.39	-10%	$ 102.68	$ 108.39	6%
99312	Nursing fac care, subseq	$ 63.10	$ 56.85	-10%	$ 51.53	$ 56.85	10%
99313	Nursing fac care, subseq	$ 86.25	$ 79.96	-7%	$ 72.43	$ 79.96	10%
99348	Home visit, est patient	$ 75.42	$ 72.01	-5%	N/A	$ 68.22	N/A
99350	Home visit, est patient	$169.89	$165.23	-3%	N/A	$ 160.31	N/A
G0008	Admin influenza virus vac	$ 8.21	$ 18.57	126%	N/A	N/A	N/A
G0317	ESRDrelsvc 4+/mo;20+yr	$303.18	$307.73	2%	$ 303.18	$ 307.73	2%
G0344	Initial preventive exam	N/A	$ 97.40	N/A	N/A	$ 72.76	N/A
G0366	EKG for initial prevent exam	N/A	$ 27.29	N/A	N/A	N/A	N/A
G0367	EKG tracing for initial prev	N/A	$ 17.81	N/A	N/A	N/A	N/A
G0368	EKG interpret & report preve	N/A	$ 9.10	N/A	N/A	$ 9.10	N/A

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Section 303(a)(1) of the MMA amended section 1848(c)(2) of the Act to require increased work and practice expense RVUs for drug administration services. Section 303(a)(4) of the MMA required an additional temporary increase in payment to specific drug administration services of 32 percent for 2004 and 3 percent for 2005. Table 41 shows the payment amounts for selected high-volume drug administration CPT codes from 2002 to 2006 including the effect of the transition adjustment of 32 percent required for 2004 and 3 percent for 2005. Because we may also pay an additional $130 per encounter under the national demonstration project in 2005, we are also including the effect of this additional payment where applicable. Table 42 that follows table 41 shows the payment amount for 2004 and 2005 without the additional transition adjustment required by the MMA and national demonstration payment amount. By showing the payment amounts without the transition and demonstration, we can isolate the permanent change in the payment amounts that is occurring as a result of the MMA, the CPT/RUC review and the physician fee schedule update. The amounts shown in the table include the effect of the 1.5 percent update for 2004 and 2005. As described above, the CPT and RUC have recommended changes to the coding and payment for drug administration services. The CPT/RUC review was undertaken at our request under the authority of section 1848(c)(2)(J) of the Act that requires the Secretary to promptly evaluate existing drug administration codes using existing processes. While this review was completed expeditiously, CPT did not have sufficient time to adopt the coding recommendations into the 2005 version of CPT. For this reason, we are establishing new G-codes for 2005 that correspond with the new CPT codes that will become active in 2006.

Tables 41 and 42 show the payment amounts for the most frequently performed drug administration services from 2002 to 2004 under the CPT codes and payment for the comparable service in 2005 using the G code. For instance, a therapeutic injection was previously billed under the CPT code 90782. This same service will now be billed using HCPCS code G0351. As a result of the RUC review, our acceptance of their recommendations for refinements to the practice expense inputs, our policy of pooling the utilization for the injection with vaccine administration, and the required reduction in the transitional adjustment, payment for this service will be reduced from $24.64 in 2004 to $19.13 in 2005. However, the 2004 transition adjustment largely accounts for the decline. If the transitional adjustment of 32 percent for 2004 and 3 percent for 2005 were not applied, payment for the injection would be virtually the same in 2005 as in 2004, a decline of $0.10 from $18.67 to $18.57. This table shows the permanent large increase in payment for this code from 2002 to 2005. The payment for a therapeutic injection increased from $3.98 in 2002 to $19.13 in 2005, a 381

percent increase (or $18.57 if the transitional adjustment were not applied, a 367 percent increase).

CPT is also recommending separate codes for the administration of hormonal anti-neoplastic subcutaneous/intramuscular (SC/IM) injections from other anti-neoplastic injections. Under the current CPT codes, all anti-neoplastics administered SC/IM are billed using CPT code 96400. HCPCS code G0356 will be used for the administration of hormonal anti-neoplastic injections. CPT code 96400 is currently paid $64.07. Its comparable code for 2005 (G0356) will be paid $36.69 or a reduction of 43 percent. Without the transition, payment for the code would have been reduced from $48.54 to $35.62 or 27 percent between 2004 and 2005. However, payment for this code increased from $5.07 to $35.62 (without the transition) between 2002 and 2005 or by 603 percent.

There is currently one CPT code for anti-neoplastic drugs administered by intravenous (IV) push (96408). In 2004, physicians are receiving $154.76 for CPT code 96408. Payment in 2005 for G0351 (the comparable code) will be $125.69. In addition, Medicare may also pay an additional $130.00 per encounter under the demonstration increasing the total payment to $255.69 or an increase of 65 percent between 2004 and 2005. Without the transitional adjustments or the demonstration, payment for this service would have increased from $117.24 in 2004 to $122.03 in 2003 or by 4 percent. From 2002 to 2005, payment will have increased from $35.11 to $122.03 (without the transition), or a 248 percent increase.

CPT will be creating new codes that distinguish between the first and subsequent administration of a drug by IV push to the same patient on the same day. The RUC is recommending fewer inputs for the subsequent administration of a drug by IV push than the initial drug. We are creating code G0358 for each subsequent drug administered by IV push for 2005. Before the enactment of the MMA, Medicare allowed CPT code 96408 to be paid only once per patient per day. However, as a result of the MMA, we changed our policy and allowed physicians to bill and be paid for more than one administration of a chemotherapy drug by IV push to the same patient on a single day (see 69 FR 1094–1095). Thus, because separate codes do not currently exist for the multiple administrations of chemotherapy drugs by IV push on a single day, physicians currently are paid at the rate for 96408 (or $154.76) for each subsequent administration. Using the CPT's and RUC recommendations, we will pay $72.99 for subsequent drugs administered by IV push using HCPCS code G0358. While the payment is less in 2005 and 2004, payment remains higher in 2005 than in 2003 and prior years when Medicare provided no payment for the subsequent administration of a drug by IV push.

We are creating HCPCS codes G0359 and G0360 for the initial and subsequent hour respectively of chemotherapy drugs administered by IV infusion. As described in the drug administration section, CPT has changed its definition of chemotherapy to include infusion of substances such as monoclonal antibody agents or other biologic response modifiers in addition to anti-neoplastic drugs. Thus, services previously billed under the CPT code 90780 (initial hour) and 90781 (each additional hour) that meet this new definition of chemotherapy will now be billed under CPT code G0359 (initial hour) and G0360 (each additional hour). Payment for the infusion of substances such as monoclonal antibody agents or other biologic response modifiers paid under CPT code 90780 will be increasing from $117.79 in 2004 to $177.61 in 2005 using HCPCS code G0359, a 51 percent increase. Without including the transition adjustment, payment for these services will have increased by 93 percent from $89.24 in 2004 to $172.43 in 2005 or by 325 percent from the 2002 rate of $40.54. Payment for the subsequent hour infusion under CPT code 90781 will increase from $33.02 in 2004 to $40.21 in 2005 under HCPCS code G0360 or by 22 percent. Without including the transition adjustment, payment for the subsequent hour infusion will have increased 56 percent from $25.02 in 2004 to $39.03 in 2005 or 93 percent from its 2002 rate of $20.27.

Anti-neoplastic agents that were previously billed under CPT code 96410 (initial hour) and 96412 (each additional hour) will also be billed under codes G0359 and G0360. We have listed codes G0359 and G0360 twice to reflect that Medicare payment for each respective code is paid under two different CPT codes for services rendered prior to January 1, 2005. Payment for the initial hour of an anti-neoplastic agent administered by infusion under CPT code 96410 will be going from $217.35 in 2004 to $177.61 in 2005. Including the $130.00 per encounter demonstration payment in this amount brings the total payment to $307.61, an increase of 65 percent. Without including the transition adjustment, payment for these services will have increased by 5 percent from $164.66 in 2004 to $172.43 in 2005 or by 209 percent from the 2002 rate of $55.75. Payment for the subsequent hour infusion under CPT code 96412 will decrease from $48.30 in 2004 to $40.21 in 2005 under HCPCS code G0360 or by 17 percent. Without including the transition adjustment, payment for the subsequent hour infusion will have increased 7 percent from $36.59 in 2004 to $39.03 in 2005. Payment for the subsequent hour infusion of an anti-neoplastic agent has been reduced by 6 percent from its 2002 rate of $41.63. The reduction in payment is occurring because resource-based pricing replaced the use of charge-based RVUs when the services were removed from the nonphysician work pool in 2004.

The CPT is also recommending a new code for the initial hour of a subsequent chemotherapy drug administered by infusion. The new code would recognize that there are higher resources associated with the first hour of infusion of a subsequent drug than there are in the subsequent hour of the initial drug. Under current CPT coding, the first hour of a subsequent drug administered by IV infusion is paid under CPT code 96412. In 2004, Medicare pays $48.30 for this service. In 2005, we will pay $86.66 or 79 percent more for HCPCS code G0362 that will be used for the initial hour of a subsequent drug administered by IV infusion. Without including the transition adjustment, payment for this service will have increased 130 percent from $36.59 in 2004 to $84.13 in 2005 or 102 percent from the 2002 rate of $41.63.

The volume-weighted average permanent increase in payment among all drug administration services is approximately 117 percent from 2003 to 2005 including the effect of the CPT/RUC recommendations but excluding the effect of the transition adjustment. Including the effect of the transition (but not the demonstration payment) makes the volume-weighted increase in payment for these codes more than 120 percent from 2003 to 2005.

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Table 40:

Impact of Final Rule and Physician Fee Schedule Update
on Medicare Payment for Selected Drug Administration Services
Including the Effect of the 32 and 3% Transition Adjustments and Demonstration Project

Old Code	New Code	Description	2002 Payment	2003 Payment	2004 Payment with Transition	2005 Payment with Transition	2005 Demo Payment*	2005 w/Transition and Demo	% Change 04 to 05
90782	G0351	Therapeutic/diagnostic injec	$ 3.98	$ 4.41	$ 24.64	$ 19.13	N/A	$ 19.13	-22%
96400	G0356	Hormonal anti-neoplastic	$ 5.07	$ 37.52	$ 64.07	$ 36.69	N/A	$ 36.69	-43%
96408	G0357	IV push single/initial subst	$ 35.11	$ 37.52	$ 154.76	$ 125.69	$130.00	$ 255.69	65%
N/A	G0358	IV push each additional drug	N/A	N/A	$ 154.76	$ 72.99	N/A	$ 72.99	-53%
96410	G0359	Chemotherapy IV one hr initi	$ 55.75	$ 59.22	$ 217.35	$ 177.61	$130.00	$ 307.61	42%
90780	G0359	Chemotherapy IV one hr initi	$ 40.54	$ 42.67	$ 117.79	$ 177.61	N/A	$ 177.61	51%
96412	G0360	Each additional hr 1-8 hrs	$ 41.63	$ 44.14	$ 48.30	$ 40.21	N/A	$ 40.21	-17%
90781	G0360	Each additional hr 1-8 hrs	$ 20.27	$ 21.70	$ 33.02	$ 40.21	N/A	$ 40.21	22%
96412	G0362	Each add sequential infusion	$ 41.63	$ 44.14	$ 48.30	$ 86.66	N/A	$ 86.66	79%

- The demonstration payments will only be made once per day per patient with a diagnosis of cancer. Thus, we are only showing them as an additional payment to an initial drug administration service when an anti-neoplastic agent is administered.

Table 41:

Impact of Proposed Rule and Physician Fee Schedule Update on Medicare Payment for Selected Drug Administration Services Excluding the Effect of the 32 and 3% Transition Adjustments and Demonstration Project

Old Code	New Code	Description	2002 Payment	2003 Payment	2004 Payment without Transition	2005 Payment without Transition
90782	G0351	Therapeutic/diagnostic injec	$ 3.98	$ 4.41	$ 18.67	$ 18.57
96400	G0356	Hormonal anti-neoplastic	$ 5.07	$ 37.52	$ 48.54	$ 35.62
96408	G0357	IV push single/initial subst	$ 35.11	$ 37.52	$ 117.24	$ 122.03
N/A	G0358	IV push each additional drug	N/A	N/A	$ 117.24	$ 70.87
96410	G0359	Chemotherapy IV one hr initi	$ 55.75	$ 59.22	$ 164.66	$ 172.43
90780	G0359	Chemotherapy IV one hr initi	$ 40.54	$ 42.67	$ 89.24	$ 172.43
96412	G0360	Each additional hr 1-8 hrs	$ 41.63	$ 44.14	$ 36.59	$ 39.03
90781	G0360	Each additional hr 1-8 hrs	$ 20.27	$ 21.70	$ 25.02	$ 39.03
96412	G0362	Each add sequential infusion	$ 41.63	$ 44.14	$ 36.59	$ 84.13

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Table 42 below shows the impact of physician fee schedule changes for selected specialties that receive a significant portion of their total Medicare revenues from drugs. Table 43 that follows table 42 shows the combined impact of the physician fee schedule and drug payment changes on total Medicare revenues. Our estimates of changes in Medicare revenues for drugs and physician fee schedule services compare payment rates for 2005 with payment rates for 2004 using 2003 Medicare utilization for both years. For physician fee schedule services, we mapped the 2003 Medicare utilization to the code set in use for 2005 based on assumptions about how the new drug administration codes will be billed. These assumptions are based on our consultations with the American Society of Clinical Oncology and other physician specialty societies that participated in the CPT's Drug Administration workgroup. We are using 2003 Medicare claims processed and paid through June 30, 2004 that we

estimate are 98.5 complete and have adjusted the figures to reflect a full year of data. Thus, because we are using a single year of utilization, the estimated changes in revenues reflect payment changes only between 2004 and 2005. To the extent that there are year-to-year changes in the volume and mix of drugs and physician fee schedule services provided by physicians, the actual impact on total Medicare revenues will be different than those shown here.

The column labeled ''NPRM Impacts'' shows the impact of the practice expense and malpractice RVU changes described earlier. The refinements of the practice expense RVUs and 5-year review of malpractice will have little or no impact on physician fee schedule payments for the 5 specialties shown. The column labeled ''Coding and RVU Changes'' shows the impact of our adoption of the CPT/RUC recommended revisions to the codes and payment amount for drug administration services. We estimate that the changes from the CPT/RUC process will increase physician fee schedule payments for oncologists by 5 percent. This impact is generally attributable to higher permanent increases in payment for the administration of drugs by IV push (G0357), infusion (G0359 and G0360) and the ability to be paid at a higher rate for the initial hour of infusion of a subsequent drug administered. We estimate that the changes from the CPT/RUC process will increase payments to rheumatologists by 4 percent. This impact is due to the change in the definition of the chemotherapy that will allow rheumatologists to bill substances such as monoclonal antibody agents or other biologic response modifiers using the chemotherapy administration codes. The CPT/RUC changes will have little or no specialty level impact on other specialties that administer drugs.

The next column shows the effect of the drug administration transition on Medicare physician fee schedule revenues for the specialties shown. As explained earlier, section 303(a)(4) requires that the transition adjustment percentage be reduced from 32 percent in 2004 to 3 percent in 2005. The change to the transition payment percentage will reduce payments for the specialties that provide drug administration services. The reduction has a larger impact on oncologists than the other physician specialties shown because drug administration services represent a larger proportion of their physician fee schedule revenues.

The column labeled ''Additional Payments for Injections'' shows the effect of paying for injections (as well as non-chemotherapy drugs administered by IV push) provided on the same day as other physician fee schedule services. We estimate that this policy change will increase payment an estimated 3 percent for oncologists and 1 percent for other specialties. This policy change will also modestly increase payment to other specialties that provide injections (primarily family practitioners and internists) and has been incorporated into the earlier impact tables.

The next column shows the impact of the 1.5 percent physician fee schedule update. The column labeled ''One-Year Demonstration Project'' shows the impact of our plan to establish a national demonstration project that will pay oncologists $130 for providing specific services to their patients and reporting patient quality data. If oncologists participate in this demonstration project and provide the required services and requested information, we estimate that their payments will increase by 15 percent. Taken together, we estimate that the coding and RVU changes, the change to the transition amount for drug administration, the additional payments for injections, the physician fee schedule update and the national demonstration project will increase physician fee schedule payments to oncologists by 10 percent. The combined impact of these factors (other than the national demonstration project) will increase physician fee schedule payments by 1 percent urologists, 5 percent for rheumatologists, 1 percent for obstetrics/gynecologists and 0 percent for infectious disease.

Table 43 shows the combined impact of changes we are making to Medicare drug and physician fee schedule payments for the same specialties shown in table 42. The payment impacts for drugs are based on the 2nd quarter ASP submissions from drug manufacturer's and reflect ¾ of an annualized increase in drug prices between the 2nd quarter of 2004 and the 1st quarter of 2005 of 3.39 percent or 2.54 percent. The drug payment impacts are based on ASP prices for drugs accounting for approximately 94 percent of Medicare's total drug payments. Of Medicare's total payments for drugs, at least 4 percent are paid under ''not otherwise classified (NOC)'' codes (*i.e.* J3490 and J0999). Thus, we based our impacts on ASP prices for drugs accounting for approximately 98 percent of Medicare revenues that are not in the NOC category.

The column labeled ''% of Total Medicare Revenues from Fee Schedule'' shows the proportion of total Medicare revenues received from physician fee schedule services. The following column shows the physician fee schedule payment impact. All of the payment impacts are the same as those shown in Table 43. The following column shows the proportion of total Medicare revenues received from drugs, while the next column shows the payment impact from adoption of the ASP drug payment methodology. The next 3 columns show combined Medicare revenues from all sources and the combined Medicare payment impact from the earlier described changes being adopted for 2005.

Our estimates of changes in Medicare revenues for both drugs and drug administration services compare payment rates for 2005 with payment rates for 2004 using the same utilization in both years. We used 2003 utilization for these comparative impacts since they are the latest data available. Thus, the estimated changes in revenues reflect *purely* price changes between 2004 and 2005. We note that these impacts and percentages represent averages for each specialty or supplier. The percentages and impacts for any individual physician are dependent on the mix of drugs and physician fee schedule services they provide to Medicare beneficiaries. For this analysis, we are also supplementing the data showing the change in revenues with volume growth based on historical trends.

As indicated in Table 43, physician fee schedule services account for approximately 28 percent of oncology's 2004 Medicare revenues. The changes we are adopting in this final rule are estimated to increase Medicare payments for physician fee schedule services by 10 percent from 2004 to 2005. We estimate that approximately 69 percent of total 2004 Medicare revenues for oncologists are attributed to drugs and the adoption of the ASP pricing methodology will reduce these revenues by 13 percent. We based our analysis on drugs accounting for approximately 92 percent of total oncology drug revenues (and 99 percent of oncology drug revenues not paid under NOC codes). The actual impact on oncologists' total Medicare revenues will be different from these estimated impacts to the extent that utilization of drugs and drug administration services does increase. In recent years, increasing utilization, for example, drug spending growth in excess of 20 percent per year, has occurred. The weighted average of the drug and physician fee schedule changes assuming no change in utilization would decrease Medicare revenues to oncology by 6 percent. However, if the volume of drugs and physician fee schedule services

increased at historical rates, total Medicare revenues for oncologists are estimated to increase by 4 percent between 2004 and 2005, excluding the demonstration project. If we include the demonstration project, Medicare revenues to oncologists are estimated to increase by 8 percent between 2004 and 2005. We note that our actuaries' estimates of section 303 with the drug prices and policy changes in this final rule match earlier estimates of the FY 2005 and 10-year savings figures.

We estimate that urology receives approximately 57 percent of their 2004 total revenues from physician fee schedule services and 35 percent from drugs. We estimate that physician fee schedule revenues for urologists will increase by approximately 1 percent from 2004 to 2005. Based on ASP prices for drugs accounting for 100 percent of urologists' drug revenues, we estimate a 40 percent reduction assuming no growth in the volume of services provided. In this scenario, combined Medicare payments to urologists would decline approximately 14 percent. However, if the volume of physician fee schedule services and drugs were to grow at historical rates, we estimate that Medicare revenues to urologists would decline by 8 percent.

We estimate that physician fee schedule revenues account for approximately 49 percent of rheumatology's total revenues. Drugs account for approximately 44 percent rheumatology's total revenues. Physician fee schedule revenues are estimated to increase 5 percent for rheumatology and revenues from drugs are estimated to decline by 8 percent. Assuming no growth in utilization, the combined reduction in rheumatologists' revenues would be 1 percent. If the volume of drugs and physician fee schedule services grew at historical rates, rheumatologists' revenues from Medicare would increase by 9 percent.

We estimate that physician fee schedule revenues account for approximately 87 percent of total revenues for obstetrics/gynecology. These revenues are anticipated to increase by 1 percent. Drug revenues represent 13 percent of total Medicare revenues for obstetrics/gynecology and are estimated to decline by 21 percent. Assuming no growth in utilization, we estimated that obstetrics/gynecology's combined Medicare revenues would decline by 2 percent. Using the historical projected rates of growth for the volume of drugs and physician fee schedule services would make the estimated change in revenues equal an increase of 4 percent.

We estimate that physician fee schedule revenues account for approximately 94 percent of total revenues for infectious disease physicians. These payments are not estimated to change. The remainder of Medicare revenues for infectious disease physicians can be attributed to drugs. These payments are expected to decline by 25 percent. The weighted average change in infectious disease revenues from the changes we are adopting in this final rule is -2 percent assuming no growth in the volume of drugs and physician fee schedule services. If future growth in the volume of drugs and physician fee schedule services were to grow at historical rates, revenues to infectious disease physicians would increase would increase 7 percent.

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Table 42:

Impact of Drug and Physician Fee Schedule Payment Changes
on Total Medicare Allowed Charges
for Selected Specialties

		Physician Fee Schedule						
Specialty	Medicare Allowed Charges ($ in Millions)	NPRM Impacts	Coding and RVU Changes	Drug Administration Transition	Additional Payments for Injections	Physician Fee Schedule Update	One-Year Demonstration Project	Total
HEMATOLOGY/ONCOLOGY	$ 1,747	0%	5%	-12%	3%	1.5%	15%	10%
UROLOGY	$ 1,695	0%	0%	-1%	0%	1.5%	N/A	1%
RHEUMATOLOGY	$ 582	0%	4%	-2%	1%	1.5%	N/A	5%
OBSTETRICS/GYNECOLOGY	$ 412	0%	0%	-1%	0%	1.5%	N/A	1%
INFECTIOUS DISEASE	$ 401	0%	0%	-1%	0%	1.5%	N/A	0%

Table 43:
Combined Payment Impact
Drug and Physician Fee Schedule Payment Changes
for Selected Specialties

	Physician Fee Schedule		Drugs			All Revenues			
Specialty	% of Total Medicare Revenues from Fee Schedule	% Change Medicare Physician Fee Schedule Revenues	% of Total Medicare Revenues from Drugs	% Change Medicare Drug Revenues	Combined Medicare Revenues All Sources ($ in Millions)	Combined % Change All Medicare Revenues Constant Utilization	Combined % Change All Medicare Revenues** w/Utilization Growth
HEMATOLOGY/ONCOLOGY	28%	10%	69%	-13%	$ 6,346	-6%	8%
UROLOGY	57%	1%	35%	-40%	$ 2,967	-14%	-8%
RHEUMATOLOGY	49%	5%	44%	-8%	$ 844	-1%	16%
OBSTETRICS/GYNECOLOGY	87%	1%	13%	-21%	$ 667	-2%	5%
INFECTIOUS DISEASE	94%	0%	6%	-25%	$ 428	-2%	7%

** Note: We estimate that Medicare payments to oncologists would increase by 8% between 2004 and 2005 if growth in the volume of drugs and physician fee schedule services were to continue growing at historical rates and the effect of the demonstration project was included. Revenue projections including price and volume changes for the other specialties are shown as well.

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B. Geographic Practice Cost Indices

As discussed in section II.B, in this rule, we are proposing changes to the work and practice expense GPCIs based on new census data. The resulting geographic redistributions would not result in an overall increase in the current geographic adjustment indices by more than 3.5 percent or a decrease by more than 1.6 percent for any given locality in 2005. These geographic redistributions would not result in an overall increase in the current geographic adjustment indices by more than 7 percent or a decrease by more than 3.5 percent for any given locality in 2006. Addenda F and G illustrate the

locality specific overall impact of this proposal. The GAF, as displayed in Addenda F and G is a weighted composite index of the individual revisions to the work, practice expense, and malpractice expense GPCIs, respectively. The malpractice GPCI was updated as part of the November 7, 2003 final rule, and the MMA provisions were addressed in the final rule published on January 7, 2004.

C. Coding Issues

1. Additions to the List of Medicare Telehealth Services

In section II.D, we are adding end stage renal disease (ESRD) services, as represented by HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, G03178 to the list of telehealth services. We believe that this change will have little effect on Medicare expenditures.

2. National Pricing of G0238/G0239 (Respiratory Therapy Service Codes)

As discussed earlier in the preamble, we are using the nonphysician workpool to value two respiratory therapy service codes (G0238 and G0239) that are currently carrier priced. We believe that this change will eliminate the uncertainty surrounding payment of these codes when performed in comprehensive outpatient rehabilitation facilities that are paid under the physician fee schedule through fiscal intermediaries. We do not anticipate that nationally pricing these services will have a significant impact on Medicare expenditures.

3. New HCPCS Code for Bone Marrow Aspiration

We are implementing a new HCPCS add-on code, GO367 for instances when a bone marrow aspiration and a bone marrow biopsy are performed on the same day through a single incision. While this coding change will allow for a small additional payment for the second procedure performed through a single incision on the same day, we anticipate that the costs will be insignificant.

4. New HCPCS Code for Venous Mapping

As stated earlier in the preamble, we are implementing a new HCPCS code G0365, for mapping of vessels for hemodialysis access. Payment for this code will be crosswalked by CPT code 93990, Doppler Flow Testing. We anticipate that the costs of this change will be minor and may result in improved care to Medicare beneficiaries and less long-term costs to Medicare.

D. MMA Provisions

1. Section 611—Preventive Physical Examination

As discussed earlier in this preamble, the MMA authorizes coverage of an initial preventive physical examination effective January 1, 2005, subject to certain eligibility and other limitations. This new benefit will result in an increase in Medicare expenditures for new payments made to physicians and other practitioners who provide these examinations and for any medically necessary follow-up tests, counseling, or treatment that may be required as a result of the coverage of these examinations. The impact of this provision is shown in the following table.

TABLE 44:
Medicare Cost Estimates for MMA Provision 611
(in millions)

MMA provision	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Sec. 611	$40	$40	$40	$40	$40

2. Section 613—Diabetes Screening

Section 613 of the MMA adds subsection (yy) to section 1861 of the Social Security Act and mandates coverage of diabetes screening tests, effective on or after January 1, 2005. We expect that this change in coverage for certain beneficiaries will result in an increase in Medicare payments. These payments will be made to physicians' office laboratories and other laboratory suppliers who perform these tests as a result of the increased frequency of coverage of these tests. The impact of this provision is shown in Table 45 that follows.

3. Section 612—Cardiovascular Screening

Section 612 of the MMA provides for Medicare coverage for cholesterol and other lipid or triglyceride levels of cardiovascular screening blood tests for the early detection of abnormalities associated with an elevated risk for such diseases effective on or after January 1, 2005. We estimate that this change in coverage for certain beneficiaries will result in an increase in Medicare payments. These payments will be made to physician office laboratories and other laboratory suppliers who perform these tests as a result of the increased frequency of coverage of these tests. Increased Medicare program expenditures for this provision are shown in Table 45 below.

TABLE 45:
Medicare Cost Estimates for MMA Provisions 612 and 613
(in millions)

MMA Provision	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Sec. 612 Cholesterol and Blood Lipid	50	80	90	90	100
Sec. 613 Diabetes Screening	20	40	50	60	80

4. Section 413—Incentive Payment for Physician Scarcity

a. Physician Scarcity Areas

Section 413(a) of the MMA provides a new 5-percent incentive payment to physicians who furnish services in physician scarcity areas. The MMA provides for paying primary care physicians furnishing services in a primary care scarcity area, and specialty physicians furnishing services in a specialist care scarcity county, an additional amount equal to 5 percent of the amount paid for their professional services under the fee schedule from January 1, 2005 to December 31, 2007. We estimate that this new incentive payment for physicians' services will result in an increase in Medicare payments that are shown in Table 46.

b. Improvement to Medicare HPSA Incentive Payment Program

Section 413(b) of the MMA amended section 1833(m) of the Act to mandate that we automate payment of the 10 percent HPSA incentive payment to eligible physicians. Since the inception of the HPSA incentive payment program, physicians have been required to determine their eligibility and correctly code their Medicare claims using modifiers. We estimate that this change to the HPSA incentive payment program to provide for automation of payment will result in an increase in Medicare payments because many eligible physicians are not applying for bonuses due to the burden of verifying eligibility. The impact of this provision is shown in Table 46.

TABLE 46:
Medicare Cost Estimates for MMA Provisions
(in millions)

MMA Provision	FY05	FY06	FY07	FY08	FY09
Sec. 413(a) Physician Scarcity Areas	30	50	50	20	-
Sec. 413(b) Improvement to HPSA	20	30	30	30	30

5. Sections 303–304—Payment for Covered Outpatient Drugs and Biologicals and Section 305—Payment for Inhalation Drugs

Sections 303 and 304 of the MMA make changes to Medicare payment for covered outpatient drugs and biologicals and changes to the administration of those drugs. Section 305 makes changes to payment for inhalation drugs. We implemented provisions of sections 303 through 305 changing payments in 2004 for drugs and their administration in the January 7, 2004 **Federal Register** (69 FR 1084). In this final rule, we are making further changes to Medicare's payment for drugs and drug administration for 2005 required by sections 303 through 305 of the MMA. As indicated earlier in this final rule, we are revising the codes and payments for drug administration based on recommendations of the CPT Editorial Board and the Relative Value Update Committee. Consistent with section 1848(c)(2)(J) of the Act (as amended by section 303(a) of the MMA), the increase in payment resulting from this review are exempt from the budget neutrality requirements that apply to changes in RVUs. We are further increasing payments to physicians that treat patients with cancer who participate in a national demonstration project. In addition, we are also paying a supplying fee of $50 per month for the first month and $24 for each subsequent month for Medicare Part B oral drug prescriptions. We are also proposing to pay a furnishing fee of $0.14 per unit of clotting factor and a dispensing fee of $57 per month for inhalation drugs. Taking all of these provisions into account, we estimate Medicare savings for section 303–305 as follows:

TABLE 47:

Medicare Cost (Savings)
Estimates for MMA Provision 303-305
(in millions)

Provision	FY05	FY06	FY07	FY08	FY09
303-305	(730)	(1,300)	(1,650)	(1,820)	(1,990)

6. Section 952—Reassignment

The reassignment provisions discussed in section III.F is currently estimated to have no significant impact on Medicare expenditures.

7. Section 623—Payment for Renal Dialysis Services

a. Effects on the Medicare Program (Budgetary Effect)

Because the basic case mix adjusted composite payment rate and the revised payment for ESRD drugs must be budget neutral in accordance with section 623(d)(1) of the MMA, except for the statutorily required 1.6 percent increase set forth in section 623(a), we estimate that there would be no budgetary impact for the Medicare program beyond this increase. The impact of this provision (net of beneficiary liability) is shown in the following table:

TABLE 48:

Medicare Cost Estimates for MMA Provision 623
(in millions)

Provision	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Section 623	$40	$50	$50	$60	$60

b. Impact on ESRD Providers

To understand the impact of the changes affecting payments to ESRD facilities that result from enactment of the MMA on different categories of ESRD facilities, it is necessary to compare estimated payments under the current payment system (current payments) to estimated payments under the revisions to the composite rate payment system as set forth in this final rule (MMA payments). To estimate the impact among various classes of ESRD facilities, it is imperative that the estimates of current payments and MMA payments contain similar inputs. Therefore, we simulated MMA payments only for those ESRD facilities for which we are able to calculate both current payment and MMA payment.

Due to data limitations, we are unable estimate current and MMA payments for 461 facilities that bill for ESRD drugs. ESRD providers were grouped into the categories based on characteristics provided in the Online Survey and Certification and Reporting (OSCAR) file and the most recent cost report data from HCRIS. We also used the June 2004 update of CY 2003 Standard Analytical File (SAF) claims as a basis for Medicare dialysis treatments and separately billable drugs and biologicals. As we stated in the proposed rule, this final rule impact on providers uses updated OSCAR, cost report and claims data.

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Table 49:

Impact of MMA Section 623
Payments to Hospital Based and Independent ESRD Facilities
(Includes Drug and Composite Rate Payments)

[Percent change in total payments to ESRD facilities (both program and beneficiaries)]

	Number Of facilities	Number of Dialysis Treatments (in millions)	Effect of Changes In Drug Payments 1/	Effect of 1.6% Composite rate Update on Total Payments 2/	Effect of Case Mix 3/	Overall Effect 4/
All	3,907	31.0	0.0	1.0	0.0	1.0
Independent	3,390	27.5	-0.6	1.0	0.0	0.4
Hospital Based	517	3.5	5.2	1.1	0.3	6.6
Size						
Small <5000 treatment per year	1,274	3.9	0.2	1.0	0.5	1.5
Medium 5000-10000 treatments per yr	1,586	11.5	-0.3	1.0	0.1	0.7
Large > 10000 treatments per year	1,047	15.6	0.2	1.0	-0.2	1.0
Type of Ownership						
For-profit	2,782	22.6	-0.7	1.0	-0.2	0.1
Not-for-profit	785	5.8	3.0	1.1	0.4	4.3
Other	340	2.6	0.5	1.0	0.6	1.8
Urban	2,903	25.0	0.0	1.0	-0.1	0.9
Rural	1,004	6.0	-0.1	1.0	0.4	1.1
Region						
New England	128	1.1	0.8	1.0	-0.3	1.7
Middle Atlantic	498	4.3	0.5	1.0	-0.5	1.2

East North Central	570	4.6	0.3	1.0	1.0	1.9
West North Central	270	1.7	1.0	1.0	1.3	2.9
South Atlantic	920	7.2	-0.9	0.9	0.5	0.3
East South Central	317	2.3	-0.9	0.9	1.2	0.7
West South Central	530	4.3	-0.9	1.0	-0.3	-0.1
Mountain	204	1.3	2.4	1.0	-0.7	3.0
Pacific	442	3.8	0.8	1.0	-1.7	0.8
Puerto Rico	28	0.4	0.7	1.0	-4.1	-0.9

1/ This column shows the effect of the changes in drug payments to ESRD providers. These include changes in payment for separately billable drugs and the 8.7% drug add-on.

2/ This column shows the effect of the 1.6% update to the composite rate on total payments to ESRD providers. Note that ESRD providers receive an average of 39% of their total revenues from separately billable drugs which results in an average net increase of 1.0%.

3/ This column shows impact of case-mix adjustments only.

4/ This column shows the overall effect of payments to ESRD facilities with and without the application of MMA Section 623. The MMA provisions include the 1.6% increase, the 8.7% drug add-on, and the case-mix adjustments times treatments plus MMA payment for separately billable drugs. The current payment to ESRD facilities includes the current composite rate times treatments plus current drug payments for separately billable drugs.

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Table 49 shows the impact of MMA Section 623 on hospital based and independent facilities. We have included both composite rate payments as well as payments for separately billable drugs and biologicals because both are effected by section 623 of the MMA. The first column of Table 49 identifies the type of ESRD provider, the second column indicates the number of ESRD facilities for each type, and the third column indicates the number of dialysis treatments.

The fourth column shows the effect of the changes in drug payments to ESRD

providers. The overall effect of changes in drug payments is budget-neutral as required by MMA. The drug add-on adjustment is designed to result in the same aggregate amount of expenditures as would have been made without the statutory policy change.

Current payments for drugs represent 2005 Medicare reimbursement using 95 percent of AWP prices for the top ten drugs. Medicare spending for drugs other than EPO is estimated using 2004 AWP prices updated by a 3 percent inflation factor times actual drug utilization from 2003 claims. EPO is priced $10 per 1000 units (EPO units are estimated using payments because the units field on bills represents the number of EPO administrations rather than the number EPO units). Medicare spending under the MMA is 2003 average acquisition cost for the top ten drugs updated to 2005 figures (using the PPI for prescriptions drugs) times actual drug utilization from 2003 claims. These inflation factors were 4.81 percent and 3.72 percent for 2004 and 2005, respectively.

Payment for drugs under MMA also includes the 8.7 percent drug add-on to the composite rate. This amount is computed by multiplying the composite rate for each provider (with the 1.6 percent increase) times dialysis treatments from 2003 claims. Column 4 is computed by comparing spending under MMA provisions for drugs including the 8.7 percent drug add-on amount to spending under current payments for drugs. In order to make column 4 comparable with rest of Table 49, current composite rate payments to ESRD facilities were included in both current and MMA spending calculations.

Column 5 shows the effect of the 1.6 percent increase to the composite rate on total payments to ESRD providers. While all ESRD providers will get a 1.6 percent increase to their composite rate, this table shows the net effect of this increase on ESRD providers' total Medicare revenues (both drug and composite rate payments combined), and therefore does not show a 1.6 percent increase.

On average, ESRD providers receive an average of 39 percent of their total revenues from separately billable drugs and 61 percent of their total revenues from composite rate payment. Since the 1.6 percent increase is applied to the 61 percent portion of their total Medicare revenues, the 1.6 percent composite rate increase is also arithmetically equal to a 1.0 percent increase in ESRD providers' total Medicare revenues. Column 5 is computed by combining MMA payment for drugs (including the 8.7 percent drug add-on amount) with: (1) current composite rate times dialysis treatments from 2003 claims or (2) composite rate with 1.6 percent increase times dialysis treatments from 2003 claims. The difference between these two combinations is the net effect of the 1.6 percent increase on total payments to ESRD providers. In order to isolate the effect of the 1.6 percent increase, the computation in Column 5 assumes that drug payments to ESRD providers remain constant.

Column 6 shows the impact of the case-mix adjustments as described earlier in this preamble of this final rule. Because MMA requires this adjustment to be budget-neutral in the aggregate, there is no overall impact on ESRD providers as a whole. While the case-mix adjustment will have an impact within the various provider types, Column 6 shows that the effect between provider groupings is minimal. Column 6 is computed as the difference between payments to ESRD providers with the case-mix adjustments compared to payments to providers without the case-mix adjustments. As described earlier in this preamble, we developed a case-mix budget neutrality factor to meet the MMA requirement that payment be budget-neutral with respect to aggregate payments. Therefore, there is no change for ESRD providers in the aggregate. We note that when applying the case-mix adjustments, we did so at the facility level.

Column 7 shows the overall effect of all changes in drug and composite rate payments to ESRD providers. The overall effect of payments to ESRD facilities is measured as the difference between payment with and without application of MMA section 623 as described in this final rule and current payment. MMA payment is computed by multiplying the composite rate for each provider (with both 1.6 percent increase and the 8.7 percent add-on) times dialysis treatments from 2003 claims times the appropriate case-mix adjustment by provider. In addition, MMA payment includes payments for separately billable drugs under the revised pricing methodology as described in this preamble. Current payment is the current composite rate for each provider times dialysis treatments from 2003 claims plus current drug payments for separately billable drugs.

The overall impact to ESRD providers in aggregate is 1.0 percent. Among the three separately shown effects, the effect of changes in drug payments has the most variation among provider type and contributes most to the overall effect. Separately billable ESRD drugs are paid differently to hospital-based and independent ESRD providers. As discussed earlier in this preamble, we are using a single drug add-on to the composite rates for both hospital based and independent facilities. The 6.6 percent increase in payments to hospital-based providers is largely due to the single drug add-on to the composite rate.

8. Section 731—Coverage of Routine Costs for Category A Clinical Trials

The coverage of routine costs associated with certain Category A clinical trials as discussed in MMA section 731(b) will have no significant impact on Medicare expenditures.

9. Section 629—Part B Deductible

As explained earlier in the preamble, section 629 of the MMA provides for annual updates to the Medicare Part B deductible. The MMA stipulates that the Medicare Part B deductible will be $110 for calendar year 2005, and, for subsequent years, the deductible will be the previous year's deductible increased by the annual percentage increase in the monthly actuarial rate under section 1839(a)(1) of the Act, ending with that subsequent year (rounded to the nearest dollar). We note that while this MMA provision results in a savings to the Medicare program, it also increases beneficiary costs by an equal amount and was implemented in a **Federal Register** notice published on September 9, 2004 (69 FR 54675).

TABLE 50: ESTIMATED MEDICARE SAVINGS FOR MMA PROVISION 629

[in millions]

MMA provision	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Sec. 629	110	290	440	590	770

10. Section 512—Hospice Consultation Service

As explained in section III.K of this preamble, effective January 1, 2005, section 512 of the MMA provides for payment to be made to a hospice for specified services furnished by a physician who is either the medical director of, or an employee of, a hospice agency. We estimate that this MMA provision will increase Medicare expenditures by $10 million per year beginning in 2005.

11. Section 706 Coverage of Religious Nonmedical Health Care Institution (RNHCI) Services Furnished in the Home

We anticipate that the time limited RNHCI home benefit will either meet or fall short of the annual $700,000 per calendar year statutory spending limit and therefore will not have a significant financial impact on the Medicare program.

E. Other Issues

1. Outpatient Therapy Services Performed ''Incident To'' Physicians' Services

As discussed in section IV.A, we are amending the regulations to include the statutory requirement that only individuals meeting the existing qualification and training standards for therapists (with the exception of licensure) consistent with § 484.4 qualify to provide therapy services incident to physicians' services. We believe that while this will have little impact on Medicare expenditures, it will assist in ensuring the quality of services provided to beneficiaries.

2. Supervision Requirements for Therapy Assistants in Private Practice

As discussed earlier in section IV.A, we are revising the regulations at § 410.59 and § 410.60 to replace a requirement to provide personal supervision and instead require direct supervision of physical therapist assistants and occupational therapy assistants when therapy services are provided by physical therapists or occupational therapists in private practice. This policy change will provide beneficiaries access to medically necessary therapy services, under a physician-certified plan of care. We believe that this change could result in a 5 percent increase in therapy billing in therapy private practice settings with an estimated cost of $9 million for FY 2005. Projected costs for FY 2006 are $17 million while each subsequent year would only increase by $1 million each year, assuming the therapy caps are applied.

3. Low Osmolar Contrast Media

As discussed earlier in the preamble, we are revising the regulations at § 414.38 to eliminate the restrictive criteria for the payment of LOCM. This regulation will make payment for LOCM consistent across Medicare payment systems. Shown in the following table are estimates of program costs due to the removal of the restrictive criteria for administering LOCM, assuming increased utilization and removal of the 8 percent reduction. Without current ASP data, we could not include the additional impact of the change in payment for LOCM to ASP plus 6 percent, effective April 1, 2005. Contrast-enhanced procedures that most commonly use LOCM, the typical ranges of LOCM amounts used by modality, and the cost ranges for LOCM in the marketplace were considered in valuing the additional program costs.

TABLE 51:

Regulatory Provision	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
LOCM	20	30	30	30	30

4. Payments for Physicians and Practitioners Managing Patients on Dialysis

We believe that the proposals with respect to ESRD-related services furnished to patients in observation settings and payment for outpatient ESRD-related services for partial month scenarios discussed earlier in section xx provide clarification of current policy surrounding these issues. We do not believe these proposals will have a significant impact on Medicare expenditures.

5. Supervision of Clinical Psychological Testing

We are changing the supervision requirements regarding who can supervise diagnostic psychological testing services. As previously discussed, having ancillary staff supervised by clinical psychologists will enable these practitioners with a higher level of expertise to oversee psychological testing and potentially relieve burdens on physicians and healthcare facilities.

Additionally, in rural areas, we anticipate that permitting psychologists to supervise diagnostic psychological testing services will reduce delays in testing, diagnosis, and treatment that could result from the unavailability of physicians to supervise the tests. We believe that this revision to the supervision requirements will have little impact on Medicare expenditures.

6. Care Plan Oversight

As discussed earlier in the preamble, we are revising § 414.39 to clarify that NPPs can perform home health care plan oversight even though they cannot certify a patient for home health services and sign the plan of care. We do not expect that this change will have an impact on Medicare expenditures, since it is primarily a clarification in policy.

7. Assignment of Medicare Claims

The changes with respect to assignment of Medicare claims are currently estimated to have no significant impact on Medicare expenditures. However, as stated earlier in this preamble at section IV.G, we believe the changes will reduce the paperwork burden on beneficiaries and suppliers.

F. Alternatives Considered

This final rule contains a range of policies, including proposals related to specific MMA provisions. The preamble provides descriptions of the statutory provisions that are addressed, identifies those policies when discretion has been exercised and presents rationale for our decisions and, when possible, alternatives that were considered.

G. Impact on Beneficiaries

There are a number of changes made in this rule that would have an effect on

beneficiaries. In general, we believe these changes will improve beneficiary access to services that are currently covered or will expand the Medicare benefit package to include new services. As explained in more detail below, the MMA or regulatory provisions may increase beneficiary liability in some cases. Any changes in aggregate beneficiary liability from a particular provision will be a function of the coinsurance (20 percent if applicable for the particular provision after the beneficiary has met the deductible) and the effect of the aggregate cost (savings) of the provision on the calculation of the Medicare Part B premium rate (generally 25 percent of the provision's cost or savings).

The MMA provisions that expand Medicare benefits include: Section 611, adding an initial preventive physical exam for newly eligible Medicare beneficiaries; section 612 providing coverage of cardiovascular screening blood tests; and section 613, providing coverage for diabetes screening tests for Medicare beneficiaries at risk for diabetes. While the initial preventive physical examination for newly eligible Medicare beneficiaries is subject to deductible and coinsurance, we believe Medicare beneficiaries will continue to benefit from expanded coverage for this service. We believe many beneficiaries have supplemental insurance coverage or Medicaid that pays the Medicare deductible on their behalf and there will be no immediate additional out-of-pocket cost. Further, even if a beneficiary pays nearly all of the costs of this new benefit, the preventive office visit will substitute for another service a beneficiary may need to meet the annual deductible and the beneficiary will receive more covered benefits at little additional cost. There are no out-of-pocket costs to the beneficiary for the cardiovascular screening blood tests and diabetes screening tests.

Other proposals in this rule related to the MMA will also impact beneficiary liability, with the most significant related to indexing of the part B deductible (section 629 of the MMA) and the drug administration payment changes (sections 303 and 305 of the MMA). MMA provisions that improve administration of the 10 percent HPSA bonus and provide an additional 5 percent bonus payment to physicians in Medicare scarcity areas will have no impact on beneficiary liability because the bonus payments are applied to the amount Medicare pays the physician net of beneficiary liability. These provisions will also improve access for Medicare beneficiaries by increasing payments to physicians in areas that traditionally have had a low ratio of physicians to population.

We are summarizing the impact of all of the changes we are adopting in this rule in table 52. We note that Medicare savings estimates are relative to projected expenditures that would occur if the provisions of the MMA and this final regulation were not implemented. Thus, the savings figures are reductions in beneficiary liability relative to the amounts they otherwise would have paid. The figures do not necessarily mean that we are estimating that beneficiaries will have lower out-of-pocket costs in 2005 than 2004.

TABLE 52:
Estimated Medicare Beneficiary
Impact of MMA Provisions Being Implemented
In this Final Rule
(in millions)

Provision	FY 05	FY06	FY07	FY08	FY09
Sections 303-305	-$570	-$930	-$1,090	-$1,200	-$1,320
Section 611	20	20	20	20	20
Section 612	13	20	23	23	25
Section 613	5	10	13	15	20
Section 413(a)	8	13	13	5	-
Section 413(b)	5	8	8	8	8
Section 623	20	25	25	30	30
Section 629	110				
Section 512	5	5	5	5	5
LOCM	10	15	15	15	15
Physical Therapy	0	10	10	10	10

The implementation of MMA provisions related to drugs and drug administration will reduce Medicare beneficiary liability for Medicare covered services even after including the additional increases in payment for drug administration and establishing a supplying fee for immunosuppressive drugs, a furnishing fee for the clotting factor and a dispensing fee for immunosuppressive drugs. We do not believe that the drug and drug administration payment changes required by the MMA are intended to lessen beneficiary access to care. As indicated earlier, the changes we are making to Medicare payments for the administration of drugs are permanently increasing them by a weighted average of more than 117 percent between 2003 and 2005 and they are being increased by an additional 3 percent for 2005 only. While payments for drugs are being reduced between 2004 and 2005, the statute requires Medicare to pay for them at 6 percent more than their average sales price or the price they are purchased at in the market after taking into account rebates and discounts. Nevertheless, we acknowledge that there is a concern among physicians and others that the large changes in Medicare's payments may affect their ability or willingness to continue making drugs and related services available. CMS' Office of Research

Demonstrations and Information is analyzing Medicare utilization for drugs and drug administration beginning in 2002 and plans to continue to analyze the data for shifts or changes in utilization patterns as the information becomes available to us. To date, we have no evidence that beneficiaries are having any problems with access to drugs. While we do not believe the payment changes for drugs and drug administration will result in access problems, we plan to continue studying this issue. We also note that the MMA requires the Medicare Payment Advisory Commission (MedPAC) to study related issues. Specifically, section 303(a)(5) of the MMA requires MedPAC to study items and services furnished by oncologists and drug administration services furnished by other specialists.

We are also undertaking several changes using our administrative authority that will affect Medicare beneficiaries. Our proposal to remove restrictions that limit Medicare payment for use of low osmolar contrast material to specific indications would update Medicare's payment policy to be consistent with the standard practice of medicine and will improve the quality of care for beneficiaries.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 403

Grant programs-health, Health insurance, Hospitals, Intergovernmental relations, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 405

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medical devices, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 410

Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 411

Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 414

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 418

Health facilities, Hospice care, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 424

Emergency medical services, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 484

Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 486

Grant programs-health, Health facilities, Medicare, Reporting and recordkeeping requirements, X-rays.

■ For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as follows:

PART 403—SPECIAL PROGRAMS AND PROJECTS

Subpart G—Religious Nonmedical Health Care Institutions—Benefits, Conditions of Participation, and Payment

■ 1. The authority citation for part 403 continues to read as follows:

Authority: 42 U.S.C. 1359b–3 and secs 1102 and 1871 of the Social Security act (42 U.S.C. 1302 and 1395hh).

■ 2. Section 403.746 is amended by adding a new paragraph (c) to read as follows:

§ 403.746 Condition of participation: Utilization review.

* * * * *

(c) *Standard: Utilization review committee role in RNHCI home services.* In addition to the requirements in paragraphs (a) and (b) of this section, the utilization review committee is responsible for:

(1) The admission, and at least every 30 days, the continued care review of each patient in the RHNCI home services program.

(2) Oversight and monitoring of the home services program, including the purchase and utilization of designated durable medical equipment items for beneficiaries in the program.

■ 3. In subpart G, § 403.764 through § 403.770 are added to read as follows:

§ 403.764 Basis and purpose of religious nonmedical health care institutions providing home service.

(a) *Basis.* This subpart implements sections 1821, 1861, 1861(e), 1861(m), 1861(y), 1861(ss) and 1861(aaa), 1869 and 1878 of the Act regarding Medicare payment for items and services provided in the home setting furnished to eligible beneficiaries by religious nonmedical health care institutions (RNHCIs).

(b) *Purpose.* The home benefit provides for limited durable medical equipment (DME) items and RNHCI services in the home setting that are fiscally limited to $700,000 per calendar year, with an expiration date of December 31, 2006, or the date on which the 2006 spending limit is reached.

§ 403.766 Requirements for coverage and payment of RNHCI home services.

(a) Medicare Part B pays for RNHCI home services if the RNHCI provider does the following:

(1) Submit a notice of intent to CMS to exercise the option of providing home service.

(2) Provide RNHCI services to eligible beneficiaries,

(3) Arrange with suppliers to furnish appropriate DME items as required to meet documented eligible beneficiary needs.

(4) Arrange for RNHCI nurse home visits to eligible beneficiaries.

(5) Have a utilization committee that assumes the additional responsibility for the oversight and monitoring of the items and RNHCI nursing services provided under the home benefit.

(6) Meet all applicable requirements set forth in subpart G of this part.

(b) To be an eligible beneficiary to RNHCI home services the beneficiary must:

(1) Have an effective election in place.

(2) Be confined to the home, as specified in § 409.42(a) of this chapter.

(3) Have a condition that makes him or her eligible to receive services covered under Medicare home health.

(4) Receive home services and DME items from a RNHCI.

(5) Be responsible for deductible and coinsurance for DME, as specified in § 409.50 of this chapter.

§ 403.768 Excluded services.

In addition to items and services excluded in § 409.49 of this chapter, items and services are also excluded if they are provided by:

(a) A HHA that is not a RNHCI.

(b) A supplier who is not providing RNHCI designated items under arrangement with a RNHCI.

(c) A nurse who is not providing RNHCI home nursing services under arrangement with a RNHCI.

§ 403.770 Payments for home services.

(a) The RNHCI nursing visits are paid at the modified low utilization payment

adjusted (LUPA) rate used under the home health prospective payment system at § 484.230 of this chapter.

(b) Appropriate DME items are paid as priced by Medicare, minus the deductible and coinsurance liability of the beneficiary.

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

■ 4. The authority citation for part 405 continues to read as follows:

Authority: Secs. 1102, 1861, 1862(a), 1871, 1874, 1881, and 1886(k) of the Social Security Act (42 U.S.C. 1302, 1395x, 1395y(a), 1395hh, 1395kk, 1395rr, and 1395ww(k)), and sec. 353 of the Public Health Service Act (42 U.S.C. 263a).

■ 5. Section 405.207 is amended by revising paragraph (b) to read as follows:

§ 405.207 Services related to a noncovered device.

* * * * *

(b) *When payment is made.* Medicare payment may be made for—

(1) Covered services to treat a condition or complication that arises due to the use of a noncovered device or a noncovered device-related service; or

(2) Routine care services related to experimental/investigational (Category A) devices as defined in § 405.201(b); and furnished in conjunction with an FDA-approved clinical trial. The trial must meet criteria established through the national coverage determination process; and if the trial is initiated before January 1, 2010, the device must be determined as intended for use in the diagnosis, monitoring or treatment of an immediately life-threatening disease or condition.

(3) Routine care services related to a non-experimental/investigational (Category B) device defined in § 405.201(b) that is furnished in conjunction with an FDA-approved clinical trial.

■ 6. Section 405.517 is amended by adding a new paragraph (a)(3) to read as follows:

§ 405.517 Payment for drugs and biologicals that are not paid on a cost or prospective payment basis.

(a) *Applicability.* * * *

(3) *Payment for drugs and biologicals on or after January 1, 2005.* Effective January 1, 2005, payment for drugs and biologicals that are not paid on a cost or prospective payment basis are paid in accordance with part 414, subpart K of this chapter.

* * * * *

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

■ 7. The authority citation for part 410 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

■ 8. Section 410.1 is amended by adding a new paragraph (a)(6) to read as follows:

§ 410.1 Basis and scope.

(a) * * *

(6) Section 1842(o)—Payment for drugs and biologicals not paid on a cost or prospective payment basis.

* * * * *

■ 9. Section 410.10 is amended by adding new paragraph (y) to read as follows:

§ 410.10 Medical and other health services: Included services.

* * * * *

(y) Intravenous immune globulin administered in the home for the treatment of primary immune deficiency diseases.

■ 10. Section 410.16 is added to read as follows:

§ 410.16 Initial preventive physical examination: Conditions for and limitations on coverage.

(a) *Definitions.* As used in this section, the following definitions apply:

Eligible beneficiary means an individual who receives his or her initial preventive physical examination within 6 months after the effective date of his or her first Medicare Part B coverage period, but only if that first Part B coverage period begins on or after January 1, 2005.

Initial preventive physical examination means all of the following services furnished to an eligible beneficiary by a physician or other qualified nonphysician practitioner with the goal of health promotion and disease detection:

(1) Review of the beneficiary's medical and social history with attention to modifiable risk factors for disease, as those terms are defined in this section.

(2) Review of the beneficiary's potential (risk factors) for depression, including current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the physician or other qualified nonphysician practitioner may select from various available standardized screening tests designed for this purpose and recognized by national professional medical organizations.

(3) Review of the beneficiary's functional ability, and level of safety as those terms are defined in this section, as described in paragraph (4) of this definition, based on the use of appropriate screening questions or a screening questionnaire, which the physician or other qualified nonphysician practitioner may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations.

(4) An examination to include measurement of the beneficiary's height, weight, blood pressure, a visual acuity screen, and other factors as deemed appropriate, based on the beneficiary's medical and social history, and current clinical standards.

(5) Performance and interpretation of an electrocardiogram.

(6) Education, counseling, and referral, as deemed appropriate by the physician or qualified nonphysician practitioner, based on the results of the review and evaluation services described in this section.

(7) Education, counseling, and referral, including a brief written plan such as a checklist provided to the beneficiary for obtaining the appropriate screening and other preventive services that are covered as separate Medicare Part B benefits as described in section 1861(s)(10), section 1861(jj), section 1861(nn), section 1861(oo), section 1861(pp), section 1861(qq)(1), section 1861(rr), section 1861(uu), section 1861(vv), section 1861(xx)(1), and section 1861(yy) of the Act.

Medical history is defined to include, at a minimum, the following:

(1) Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments.

(2) Current medications and supplements, including calcium and vitamins.

(3) Family history, including a review of medical events in the beneficiary's family, including diseases that may be hereditary or place the individual at risk.

A *physician* for purposes of this section means a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Act).

A qualified nonphysician practitioner for purposes of this section means a physician assistant, nurse practitioner, or clinical nurse specialist (as authorized under section 1861(s)(2)((K)(i) and section

1861(s)(2)((K)(ii) of the Act and defined in section 1861(aa)(5) of the Act, or in § 410.74, § 410.75, and § 410.76).

Review of the beneficiary's functional ability and level of safety must include, at a minimum, a review of the following areas:

(1) Hearing impairment.
(2) Activities of daily living.
(3) Falls risk.
(4) Home safety

Social history is defined to include, at a minimum, the following:

(1) History of alcohol, tobacco, and illicit drug use.
(2) Diet.
(3) Physical activities.

(b) *Condition for coverage of an initial preventive physical examination.* Medicare Part B pays for an initial preventive physical examination provided to an eligible beneficiary, as described in this section, if it is furnished by a physician or other qualified nonphysician practitioner, as defined in this section.

(c) *Limitations on coverage of initial preventive physical examinations.* Payment may not be made for an initial preventive physical preventive examination that is performed for an individual who is not an eligible beneficiary as described in this section.

■ 11. A new § 410.17 is added to read as follows:

§ 410.17 Cardiovascular disease screening tests.

(a) *Definition.* For purposes of this subpart, the following definition apply:

Cardiovascular screening blood test means:

(1) A lipid panel consisting of a total cholesterol, HDL cholesterol, and triglyceride. The test is performed after a 12-hour fasting period.

(2) Other blood tests, previously recommended by the U.S. Preventive Services Task Force (USPSTF), as determined by the Secretary through a national coverage determination process.

(3) Other non-invasive tests, for indications that have a blood test recommended by the USPSTF, as determined by the Secretary through a national coverage determination process.

(b) *General conditions of coverage.* Medicare Part B covers cardiovascular disease screening tests when ordered by the physician who is treating the beneficiary (*see* § 410.32(a)) for the purpose of early detection of cardiovascular disease in individuals without apparent signs or symptoms of cardiovascular disease.

(c) *Limitation on coverage of cardiovascular screening tests.* Payment may be made for cardiovascular screening tests performed for an asymptomatic individual only if the individual has not had the screening tests paid for by Medicare during the preceding 59 months following the month in which the last cardiovascular screening tests were performed.

■ 12. A new § 410.18 is added to read as follows:

§ 410.18 Diabetes screening tests.

(a) *Definitions.* For purposes of this section, the following definitions apply:

Diabetes means diabetes mellitus, a condition of abnormal glucose metabolism diagnosed using the following criteria: a fasting blood sugar greater than or equal to 126 mg/dL on two different occasions; a 2-hour post-glucose challenge greater than or equal to 200 mg/dL on two different occasions; or a random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes.

Pre-diabetes means a condition of abnormal glucose metabolism diagnosed using the following criteria: a fasting glucose level of 100—125 mg/dL, or a 2-hour post-glucose challenge of 140—199 mg/dL. The term pre-diabetes includes the following conditions:

(1) Impaired fasting glucose.
(2) Impaired glucose tolerance.

(b) *General conditions of coverage.* Medicare Part B covers diabetes screening tests after a referral from a physician or qualified nonphysician practitioner to an individual at risk for diabetes for the purpose of early detection of diabetes.

(c) *Types of tests covered.* The following tests are covered if all other conditions of this subpart are met:

(1) Fasting blood glucose test.

(2) Post-glucose challenges including, but not limited to, an oral glucose tolerance test with a glucose challenge of 75 grams of glucose for non-pregnant adults, a 2-hour post glucose challenge test alone.

(3) Other tests as determined by the Secretary through a national coverage determination.

(d) *Amount of testing covered.* Medicare covers the following for individuals:

(1) Diagnosed with pre-diabetes, two screening tests per calendar year.

(2) Previously tested who were not diagnosed with pre-diabetes, or who were never tested before, one screening test per year.

(e) *Eligible risk factors.* Individuals with the following risk factors are eligible to receive the benefit:

(1) Hypertension.
(2) Dyslipidemia.
(3) Obesity, defined as a body mass index greater than or equal to 30 kg/m^2.
(4) Prior identification of impaired fasting glucose or glucose intolerance.
(5) Any two of the following characteristics:
(i) Overweight, defined as body mass index greater than 25, but less than 30 kg/m^2.
(ii) A family history of diabetes.
(iii) 65 years of age or older.
(iv) A history of gestational diabetes mellitus or delivery of a baby weighing more than 9 pounds.

■ 13. Section 410.26 is amended by revising paragraph (c) to read as follows:

§ 410.26 Services and supplies incident to a physician's professional services: Conditions.

* * * * *

(c) *Limitations.* (1) Drugs and biologicals are also subject to the limitations specified in § 410.29.

(2) Physical therapy, occupational therapy and speech-language pathology services provided incident to a physician's professional services are subject to the provisions established in § 410.59(a)(3)(iii), § 410.60(a)(3)(iii), and § 410.62(a)(3)(ii).

■ 14. Section 410.32 is amended by revising paragraph (b)(2)(iii) to read as follows:

§ 410.32 Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions.

* * * * *

(b) * * *
(2) * * *

(iii) Diagnostic psychological testing services when—

(A) Personally furnished by a clinical psychologist or an independently practicing psychologist as defined in program instructions; or

(B) Furnished under the general supervision of a physician or a clinical psychologist.

* * * * *

■ 15. Section 410.59 is amended by—
■ A. Revising paragraph (a) introductory text and paragraph (a)(3)(ii).
■ B. Adding new paragraph (a)(3)(iii).
■ C. Revising paragraph (b) heading.
■ C. Revising paragraph (c)(2).
■ D. Adding new paragraph (e)(1)(iii).

The additions and revisions read as follows:

§ 410.59 Outpatient occupational therapy services: Conditions.

(a) *Basic rule.* Except as specified in paragraph (a)(3)(iii) of this section, Medicare Part B pays for outpatient occupational therapy services only if they are furnished by an individual meeting the qualifications in § 484.4 of

this chapter for an occupational therapist or by an appropriately supervised occupational therapy assistant but only under the following conditions:

* * * * *

(3) * * *

(ii) By, or under the direct supervision of, an occupational therapist in private practice as described in paragraph (c) of this section; or

(iii) By, or incident to the service of, a physician, physician assistant, clinical nurse specialist, or nurse practitioner when those professionals may perform occupational therapy services within the scope of State law. When an occupational therapy service is provided incident to the service of a physician, physician assistant, clinical nurse specialist, or nurse practitioner, by anyone other than a physician, physician assistant, clinical nurse specialist, or nurse practitioner, the service and the person who furnishes the service must meet the standards and conditions that apply to occupational therapy and occupational therapists, except that a license to practice occupational therapy in the State is not required.

(b) *Conditions for coverage of outpatient therapy services furnished to certain inpatients of a hospital or a CAH or SNF.* * * *

(c) * * *

(2) *Supervision of occupational therapy services.* Occupational therapy services are performed by, or under the direct supervision of, an occupational therapist in private practice. All services not performed personally by the therapist must be performed by employees of the practice, directly supervised by the therapist, and included in the fee for the therapist's services.

* * * * *

(e) * * *

(1) * * *

(iii) The limitation is not applied for services furnished from December 8, 2003 through December 31, 2005.

* * * * *

■ 16. Section 410.60 is amended by—

■ A. Revising paragraph (a) introductory text.

■ B. Revising paragraph (a)(3)(ii).

■ C. Adding new paragraph (a)(3)(iii).

■ D. Revising paragraph (b) heading.

■ E. Revising paragraph (c)(2).

■ F. Adding new paragraph (e)(1)(iii).

The additions and revisions read as follows:

§ 410.60 Outpatient physical therapy services: Conditions.

(a) *Basic rule.* Except as specified in paragraph (a)(3)(iii) of this section, Medicare Part B pays for outpatient physical therapy services only if they are furnished by an individual meeting the qualifications in § 484.4 of this chapter for a physical therapist or by an appropriately supervised physical therapist assistant but only under the following conditions:

* * * * *

(3) * * *

(ii) By, or under the direct supervision of a physical therapist in private practice as described in paragraph (c) of this section; or

(iii) By, or incident to the service of, a physician, physician assistant, clinical nurse specialist, or nurse practitioner when those professionals may perform physical therapy services under State law. When a physical therapy service is provided incident to the service of a physician, physician's assistant, clinical nurse specialist, or nurse practitioner, by anyone other than a physician, physician assistant, clinical nurse specialist, or nurse practitioner, the service and the person who furnishes the service must meet the standards and conditions that apply to physical therapy and physical therapists, except that a license to practice physical therapy in the State is not required.

(b) *Condition for coverage of outpatient physical therapy services furnished to certain inpatients of a hospital or a CAH or SNF.* * * *

(c) * * *

(2) *Supervision of physical therapy services.* Physical therapy services are performed by, or under the direct supervision of, a physical therapist in private practice. All services not performed personally by the therapist must be performed by employees of the practice, directly supervised by the therapist, and included in the fee for the therapist's services.

* * * * *

(e) * * *

(1) * * *

(iii) The limitation is not applied for services furnished from December 8, 2003 through December 31, 2005.

* * * * *

■ 17. Section 410.62 is amended by—

■ A. Revising paragraph (a) introductory text and (a)(2)(i), (a)(2)(iii) and (a)(3).

■ B. Revising paragraphs (b) and (c).

The revisions read as follows:

§ 410.62 Outpatient speech-language pathology services: Conditions and exclusions.

(a) *Basic rule.* Except as specified in paragraph (a)(3)(ii) of this section, Medicare Part B pays for outpatient speech-language pathology services only if they are furnished by an individual who meets the qualifications for a speech-language pathologist in § 484.4 of this chapter and only under the following conditions:

* * * * *

(2) * * *

(i) Is established by a physician or, effective January 1, 1982, by either a physician or the speech-language pathologist who provides the services to the particular individual;

(ii) * * *

(iii) Meets the requirements of § 410.61.

(3) They are furnished—

(i) By a provider as defined in § 489.2 of this chapter, or by others under arrangements with, and under the supervision of, a provider; or

(ii) By, or incident to the service of, a physician, physician assistant, clinical nurse specialist, or nurse practitioner when those professionals may perform speech-language pathology services under State law. When a speech-language pathology service is provided incident to the services of a physician, physician assistant, clinical nurse specialist, or nurse practitioner, by anyone other than a physician, physician assistant, clinical nurse specialist, or nurse practitioner, the service and the person who furnishes the service must meet the standards and conditions that apply to speech-language pathology and speech-language pathologists, except that a license to practice speech-language pathology services in the State is not required.

(b) *Condition for coverage of outpatient speech-language pathology services to certain inpatients of a hospital, CAH, or SNF.* Medicare Part B pays for outpatient speech-language pathology services furnished to an inpatient of a hospital, CAH, or SNF who requires the services but has exhausted or is otherwise ineligible for benefit days under Medicare Part A.

(c) Excluded services. No service is included as an outpatient speech-language pathology service if it is not included as an inpatient hospital service if furnished to a hospital or CAH inpatient.

* * * * *

■ 18. Section 410.63 is amended by—

■ A. Revising paragraph (b) heading.

■ B. Adding a new paragraph (c).

The revision and addition reads as follows:

§ 410.63 Hepatitis B vaccine and blood clotting factors: Conditions.

* * * * *

(b) *Blood clotting factors: Conditions.* * * *

(c) *Blood clotting factors: Furnishing Fee.*

(1) Effective January 1, 2005, a furnishing fee of $0.14 per unit of clotting factor is paid to entities that furnish blood clotting factors unless the costs associated with furnishing the clotting factor are paid through another payment system, for example, hospitals that furnish clotting factor to patients during a Part A covered inpatient hospital stay.

(2) The furnishing fee for blood clotting factors furnished in 2006 or a subsequent year is be equal to the furnishing fee paid the previous year increased by the percentage increase in the consumer price index for medical care for the 12-month period ending with June of the previous year.

■ 19. Section 410.78 is amended by—
■ A. Revising paragraph (a)(4).
■ B. Revising paragraph (b) introductory text.

The revisions read as follows:

§ 410.78 Telehealth services.

* * *

(4) *Originating site* means the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. For asynchronous store and forward telecommunications technologies, the only originating sites are Federal telemedicine demonstration programs conducted in Alaska or Hawaii.

(b) *General rule.* Medicare Part B pays for office and other outpatient visits, professional consultation, psychiatric diagnostic interview examination, individual psychotherapy, pharmacologic management and end stage renal disease related services included in the monthly capitation payment (except for one visit per month to examine the access site) furnished by an interactive telecommunications system if the following conditions are met:

* * * * *

■ 20. Section 410.160 is amended by revising paragraph (f) to read as follows:

§ 410.160 Part B annual deductible.

* * * * *

(f) *Amount of the Part B annual deductible.* (1) Beginning with expenses for services furnished during calendar year 2006, and for all succeeding years, the annual deductible is the previous year's deductible plus the annual percentage increase in the monthly actuarial rate for Medicare enrollees age 65 and over, rounded to the nearest dollar.

(2) For 2005, the deductible is $110.

(3) From 1991 through 2004, the deductible was $100.

(4) From 1982 through 1990, the deductible was $75.

(5) From 1973 through 1981, the deductible was $60.

(6) From 1966 through 1972, the deductible was $50.

* * * * *

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

■ 21. The authority citation for part 411 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

■ 22. Section 411.15 is amended by—
■ A. Revising paragraph (a)(1).
■ B. Adding paragraph (k)(11).

The revision and addition read as follows:

§ 411.15 Particular services excluded from coverage.

* * * * *

(a) * * *

(1) Examinations performed for a purpose other than treatment or diagnosis of a specific illness, symptoms, complaint, or injury, except for screening mammography, colorectal cancer screening tests, screening pelvic exams, prostate cancer screening tests, glaucoma screening exams, or initial preventive physical examinations that meet the criteria specified in paragraphs (k)(6) through (k)(11) of this section.

* * * * *

(k) * * *

(11) In the case of initial preventive physical examinations, with the goal of health promotion and disease prevention, subject to the conditions and limitations specified in § 410.16 of this chapter.

* * * * *

■ 23. Section 411.404 is amended by revising paragraph (b) to read as follows:

§ 411.404 Criteria for determining that a beneficiary knew that services were excluded from coverage as custodial care or as not reasonable and necessary.

* * * * *

(b) *Written notice.* (1) Written notice is given to the beneficiary, or to someone acting on his or her behalf, that the services were not covered because they did not meet Medicare coverage guidelines.

(2) A notice concerning similar or reasonably comparable services furnished on a previous occasion also meets this criterion.

(3) After a beneficiary is notified that there is no Medicare payment for a service that is not covered by Medicare, he or she is presumed to know that there is no Medicare payment for any form of subsequent treatment for the non-covered condition.

* * * * *

PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES.

■ 24. The authority citation for part 414 continues to read as follows:

Authority: Secs. 1102, 1871, and 1881(b)(1) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395rr(b)(1)).

§ 414.38 [Removed]

■ 25. Section 414.38 is removed.
■ 26. Section 414.39 is amended by—
■ A. Revising paragraph (a).
■ B. Adding paragraph (c).

The revision and addition read as follows:

§ 414.39 Special rules for payment of care plan oversight.

(a) *General.* Except as specified in paragraphs (b) and (c) of this section, payment for care plan oversight is included in the payment for visits and other services under the physician fee schedule. For purposes of this section a nonphysician practitioner (NPP) is a nurse practitioner, clinical nurse specialist or physician assistant.

* * * * *

(c) *Special rules for payment of care plan oversight provided by nonphysician practitioners for beneficiaries who receive HHA services covered by Medicare.*

(1) An NPP can furnish physician care plan oversight (but may not certify a patient as needing home health services) if the physician who signs the plan of care provides regular ongoing care under the same plan of care as does the NPP billing for care plan oversight and either:

(i) The physician and NPP are part of the same group practice; or

(ii) If the NPP is a nurse practitioner or clinical nurse specialist, the physician signing the plan of care also has a collaborative agreement with the NPP; or

(iii) If the NPP is a physician assistant, the physician signing the plan of care is also the physician who provides general supervision of physician assistant services for the practice.

(2) Payment may be made for care plan oversight services furnished by an NPP when:

(i) The NPP providing the care plan oversight has seen and examined the patient;

(ii) The NPP providing care plan oversight is not functioning as a

consultant whose participation is limited to a single medical condition rather than multi-disciplinary coordination of care; and

(iii) The NPP providing care plan oversight integrates his or her care with that of the physician who signed the plan of care.

■ 27. Section 414.65 is amended by revising paragraph (a)(1) to read as follows:

§ 414.65 Payment for telehealth services.

(a) * * *

(1) The Medicare payment amount for office or other outpatient visits, consultation, individual psychotherapy, psychiatric diagnostic interview examination, pharmacologic management and end stage renal disease related services included in the monthly capitation payment (except for one visit per month to examine the access site) furnished via an interactive telecommunications system is equal to the current fee schedule amount applicable for the service of the physician or practitioner.

* * * * *

■ 28. Section 414.66 is added to subpart B to read as follows:

§ 414.66 Incentive payments for physician scarcity areas.

(a) *Definition.* As used in this section, the following definitions apply.

Physician scarcity area is defined as an area with a shortage of primary care physicians or specialty physicians to the Medicare population in that area.

Primary care physician is defined as a general practitioner, family practice practitioner, general internist, obstetrician or gynecologist.

(b) Physicians' services furnished to a beneficiary in a Physician Scarcity Area (PSA) for primary or specialist care are eligible for a 5 percent incentive payment.

(c) Primary care physicians furnishing services in primary care PSAs are entitled to an additional 5 percent incentive payment above the amount paid under the physician fee schedule for their professional services furnished on or after January 1, 2005 and before January 1, 2008.

(d) Physicians, as defined in section 1861(r)(1) of the Act, furnishing services in specialist care PSAs are entitled to an additional 5 percent payment above the amount paid under the physician fee schedule for their professional services furnished on or after January 1, 2005 and before January 1, 2008.

■ 29. Section 414.67 is added to subpart B to read as follows:

§ 414.67 Incentive payments for Health Professional Shortage Areas.

(a) Physicians' services furnished to a beneficiary in a geographic-based Health Professional Shortage Area (HPSA) are eligible for a 10 percent incentive payment above the amount paid for their professional services under the physician fee schedule.

(b) Physicians furnishing services in a geographic-based primary medical care HPSA are entitled to a 10 percent incentive payment above the amount paid for their professional services under the physician fee schedule.

(c) Psychiatrists furnishing services in a mental health HPSA are entitled to a 10 percent incentive payment above the amount paid for their professional services under the physician fee schedule. (The only physicians eligible to receive the 10 percent incentive payment in mental health HPSAs that do not overlap with primary care HPSAs are psychiatrists.)

■ 30. Part 414 is amended by adding a new subpart K to read as follows:

Subpart K—Payment for Drugs and Biologicals in 2005

Sec.

Subpart K—Payment for Drugs and Biologicals in 2005

§ 414.900 Basis.

(a) This subpart implements section 1842(o) of the Act by specifying the methodology for determining the payment allowance limit for drugs and biologicals covered under Medicare Part B that are not paid on a cost or prospective payment system basis.

(b) Examples of drugs that are subject to the requirements specified in this subpart are:

(1) Drugs furnished incident to a physician's service; durable medical equipment (DME) drugs.

(2) Separately billable drugs at independent dialysis facilities not under the ESRD composite rate.

(3) Statutorily covered drugs, for example—

(i) Influenza.

(ii) Pneumococcal and hepatitis vaccines.

(iii) Antigens.

(iv) Hemophilia blood clotting factor.

(v) Immunosuppressive drugs.

(vi) Certain oral anti-cancer drugs.

§ 414.902 Definitions.

As used in this subpart, unless the context indicates otherwise—

Drug means both drugs and biologicals.

Manufacturer's average sales price means the price calculated and reported by a manufacturer under part 414, subpart J of this chapter.

Multiple source drug means a drug described by section 1847A(c)(6)(C) of the Act.

Single source drug means a drug described by section 1847A(c)(6)(D) of the Act.

Unit is defined as in part 414, subpart J of this chapter.

Wholesale acquisition cost (WAC) means the price described by section 1847A(c)(6)(B) of the Act.

§ 414.904 Basis of payment.

(a) *Method of payment.* Payment for a drug for calendar year 2005 is based on the lesser of—

(1) The actual charge on the claim for program benefits; or

(2) 106 percent of the average sales price, subject to the applicable limitations specified in paragraph (d) of this section or subject to the exceptions described in paragraph (e) of this section.

(b) *Multiple source drugs.* (1) *Average sales prices.* The average sales price for all drug products included within the same multiple source drug billing and payment code is the volume-weighted average of the manufacturers' average sales prices for those drug products.

(2) *Calculation of the average sales price.* The average sales price is determined by—

(i) Computing the sum of the products (for each National Drug Code assigned to the drug products) of the manufacturer's average sales price and the total number of units sold; and

(ii) Dividing that sum by the sum of the total number of units sold for all NDCs assigned to the drug products.

(c) *Single source drugs.* (1) *Average sales price.* The average sales price is the volume-weighted average of the manufacturers' average sales prices for all National Drug Codes assigned to the drug or biological product.

(2) *Calculation of the average sales price.* The average sales price is determined by computing—

(i) The sum of the products (for each National Drug Code assigned to the drug product) of the manufacturer's average sales price and the total number of units sold; and

(ii) Dividing that sum by the sum of the total number of units sold for all NDCs assigned to the drug product.

(d) *Limitations on the average sales price.* (1) *Wholesale acquisition cost for a single source drug.* The payment limit for a single source drug product is the lesser of 106 percent of the average sales price for the product or 106 percent of

the wholesale acquisition cost for the product.

(2) *Payment limit for a drug furnished to an end-stage renal disease patient.* (i) Effective for drugs and biologicals furnished in 2005, the payment for such drugs and biologicals, including erythropoietin, furnished to an end-stage renal disease patient that is separately billed by an end-stage renal disease facility and not paid on a cost basis is acquisition cost as determined by the Inspector General report as required by section 623(c) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 inflated by the percentage increase in the Producer Price Index.

(ii) Except as provided in paragraph (a) of this section, the payment for drugs and biologicals, furnished to an end-stage renal disease patient that is separately billed by an end-stage renal disease facility, is based on 106 percent of the average sales price.

(3) *Widely available market price and average manufacturer price.* If the Inspector General finds that the average sales price exceeds the widely available market price or the average manufacturer price by 5 percent or more in calendar year 2005, the payment limit in the quarter following the transmittal of this information to the Secretary is the lesser of the widely available market price or 103 percent of the average manufacturer price.

(e) *Exceptions to the average sales price.* (1) *Vaccines.* The payment limits for hepatitis B vaccine furnished to individuals at high or intermediate risk of contracting hepatitis B (as determined by the Secretary), pneumococcal vaccine, and influenza vaccine and are calculated using 95 percent of the average wholesale price.

(2) *Infusion drugs furnished through a covered item of durable medical equipment.* The payment limit for an infusion drug furnished through a covered item of durable medical equipment is calculated using 95 percent of the average wholesale price in effect on October 1, 2003 and is not updated in 2005.

(3) *Blood and blood products.* In the case of blood and blood products (other than blood clotting factors), the payment limits are determined in the same manner as the payment limits were determined on October 1, 2003.

(4) *Payment limit in a case where the average sales price during the first quarter of sales is unavailable.* In the case of a drug during an initial period (not to exceed a full calendar quarter) in which data on the prices for sales of the drug are not sufficiently available from the manufacturer to compute an average sales price for the drug, the payment limit is based on the wholesale acquisition cost or the applicable Medicare Part B drug payment methodology in effect on November 1, 2003.

(f) Except as otherwise specified (see paragraph (e)(2) of this section) for infusion drugs, the payment limits are updated quarterly.

(g) The payment limit is computed without regard to any special packaging, labeling, or identifiers on the dosage form or product or package.

(h) The payment amount is subject to applicable deductible and coinsurance.

■ 31. Part 414 is amended by adding a new subpart L to read as follows:

Subpart L—Supplying and Dispensing Fees

Sec.
414.1000 Purpose.
414.1001 Basis of Payment.

§ 414.1000 Purpose.

This subpart implements section 1842(o)(2) and section 1842(o)(6) of the Act, as added by section 303(e)(2) of the MMA, by specifying a supplying fee for drugs and biologicals covered under Part B of Title XVIII of the Act that are described in sections 1861(s)(2)(J), 1861(s)(2)(Q), and 1861(s)(2)(T) of the Act.

§ 414.1001 Basis of payment.

(a) A supplying fee of $24 shall be paid to a pharmacy for each supplied prescription of drugs and biologicals described in sections 1861(s)(2)(J), 1861(s)(2)(Q), and 1861(s)(2)(T) of the Act.

(b) A supplying fee of $50 is paid to a pharmacy for the initial supplied prescription of drugs and biologicals described in sections 1861(s)(2)(J) of the Act provided to a patient during the first month following a transplant.

(c) During 2005, a dispensing fee of $57 is paid to a supplier for each dispensed 30-day supply of inhalation drugs furnished through durable medical equipment covered under section 1861(n) of the Act, regardless of the number of partial shipments of that 30-day supply.

(d) During 2005, a dispensing fee of $80 is paid to a supplier for each dispensed 90-day supply of inhalation drugs furnished through durable medical equipment covered under section 1861(n) of the Act, regardless of the number of partial shipments of that 90-day supply.

PART 418—HOSPICE CARE

■ 32. The authority citation for part 418 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

■ 33. Section 418.205 is added to subpart F to read as follows:

§ 418.205 Special requirements for hospice pre-election evaluation and counseling services.

(a) *Definition.* As used in this section the following definition applies.

Terminal illness has the same meaning as defined in § 418.3.

(b) *General.* Effective January 1, 2005, payment for hospice pre-election evaluation and counseling services as specified in §418.304(d) may be made to a hospice on behalf of a Medicare beneficiary if the requirements of this section are met.

(1) *The beneficiary.* The beneficiary:

(i) Has been diagnosed as having a terminal illness as defined in § 418.3.

(ii) Has not made a hospice election.

(iii) Has not previously received hospice pre-election evaluation and consultation services specified under this section.

(2) *Services provided.* The hospice pre-election services include an evaluation of an individual's need for pain and symptom management and counseling regarding hospice and other care options. In addition, the services may include advising the individual regarding advanced care planning.

(3) *Provision of pre-election hospice services.*

(i) The services must be furnished by a physician.

(ii) The physician furnishing these services must be an employee or medical director of the hospice billing for this service.

(iii) The services cannot be furnished by hospice personnel other than employed physicians, such as but not limited to nurse practitioners, nurses, or social workers, physicians under contractual arrangements with the hospice or by the beneficiary's physician, if that physician is not an employee of the hospice.

(iv) If the beneficiary's attending physician is also the medical director or a physician employee of the hospice, the attending physician may not provide nor may the hospice bill for this service because that physician already possesses the expertise necessary to furnish end-of-life evaluation and management, and counseling services.

(4) *Documentation.* (i) If the individual's physician initiates the request for services of the hospice medical director or physician, appropriate documentation is required.

(ii) The request or referral must be in writing, and the hospice medical

director or physician employee is expected to provide a written note on the patient's medical record.

(iii) The hospice agency employing the physician providing these services is required to maintain a written record of the services furnished.

(iv) If the services are initiated by the beneficiary, the hospice agency is required to maintain a record of the services and documentation that communication between the hospice medical director or physician and the beneficiary's physician occurs, with the beneficiary's permission, to the extent necessary to ensure continuity of care.

■ 34. Section 418.304 is amended by adding paragraph (d) to read as follows.

§ 418.304 Payment for physician services.

* * * * *

(d) *Payment for hospice pre-election evaluation and counseling services.* The intermediary makes payment to the hospice for the services established in § 418.205. Payment for this service is set at an amount established under the physician fee schedule, for an office or other outpatient visit for evaluation and management associated with presenting problems of moderate severity and requiring medical decision-making of low complexity other than the portion of the amount attributable to the practice expense component. Payment for this pre-election service does not count towards the hospice cap amount.

PART 424—CONDITIONS FOR MEDICARE PAYMENT

■ 35. The authority citation for part 424 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

■ 36. Section 424.55 is amended by adding new paragraph (c) to read as follows:

§ 424.55 Payment to the supplier.

* * * * *

(c) *Exception.* In situations when payment under the Act can only be made on an assignment-related basis or when payment is for services furnished by a participating physician or supplier, the beneficiary (or the person authorized to request payment on the beneficiary's behalf) is not required to assign the claim to the supplier in order for an assignment to be effective.

■ 37. Section 424.71 is amended as follows:

■ A. The definition of ''Health care delivery system or system'' is removed.

■ B. The definition of the term ''Entity'' is added in alphabetical order.

The addition reads as follows:

§ 424.71 Definitions.

* * * * *

Entity means a person, group, or facility that is enrolled in the Medicare program.

* * * * *

■ 38. Section 424.80 is amended by—

■ A. Revising paragraph (a).

■ B. Revising paragraph (b)(2).

■ C. Removing paragraph (b)(3).

■ D. Redesignating paragraphs (b)(4) through (6) as paragraphs (b)(3) through (5), respectively.

■ E. Revising paragraph (c).

■ F. Adding a new paragraph (d).

The revisions and addition read as follows:

§ 424.80 Prohibition of reassignment of claims by suppliers.

(a) *Basic prohibition.* Except as specified in paragraph (b) of this section, Medicare does not pay amounts that are due a supplier under an assignment to any other person under reassignment, power of attorney, or any other direct arrangement. Nothing in this section alters a party's obligations under the anti-kickback statute (section 1128B(b) of the Act), the physician self-referral prohibition (section 1877 of the Act), the rules regarding physician billing for purchased diagnostic tests (§ 414.50 of this chapter), the rules regarding payment for services and supplies incident to a physician's professional services (§ 410.26 of this chapter), or other laws, rules, and regulations.

(b) * * *

(1) * * *

(2) *Payment to an entity under a contractual arrangement.* Medicare may pay an entity enrolled in the Medicare program if there is a contractual arrangement between the entity and the supplier under which the entity bills for the supplier's services, subject to the provisions of paragraph (d) of this section.

* * * * *

(c) *Rules applicable to an employer or entity.* An employer or entity that may receive payment under paragraph (b)(1) or (b)(2) of this section is considered the supplier of those services for purposes of subparts C, D, and E of this part, subject to the provisions of paragraph (d) of this section.

(d) *Reassignment to an entity under a contractual arrangement: Conditions and limitations.* (1) *Liability of the parties.* An entity enrolled in the Medicare program that receives payment under a contractual arrangement under paragraph (b)(2) of this section and the supplier that otherwise receives payment are jointly and severally responsible for any Medicare overpayment to that entity.

(2) *Access to records.* The supplier furnishing the service has unrestricted access to claims submitted by an entity for services provided by that supplier.

PART 484—HOME HEALTH SERVICES

■ 39. The authority citation for part 484 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

§ 484.4 [Amended]

■ 40. In § 484.4 in the definition of physical therapy assistant the term ''physical therapy assistant'' is removed and the term ''physical therapist assistant'' is added in its place wherever it appears.

PART 486—CONDITIONS FOR COVERAGE OF SPECIALIZED SERVICES FURNISHED BY SUPPLIERS

■ 41. The authority citation for part 486 continues to read as follows:

Authority: Sections 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart D—[Removed and Reserved]

■ 42. Part 486 subpart D, consisting of § 486.150 through § 486.163, is removed and reserved.

(Catalog of Federal Domestic Assistance Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: November 1, 2004.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Dated: November 1, 2004.

Tommy G. Thompson,

Secretary.

Note: These addenda will not appear in the Code of Federal Regulations.

Addendum A—Explanation and Use of Addenda B

The addenda on the following pages provide various data pertaining to the Medicare fee schedule for physicians' services furnished in 2005. Addendum B contains the RVUs for work, non-facility practice expense, facility practice expense, and malpractice expense, and other information for all services included in the physician fee schedule.

In previous years, we have listed many services in Addendum B that are not paid under the physician fee schedule. To avoid publishing as many pages of codes for these services, we are not including clinical laboratory codes and most alphanumeric

codes (Healthcare Common Procedure Coding System (HCPCS) codes not included in CPT) in Addendum B.

Addendum B—2005 Relative Value Units and Related Information Used in Determining Medicare Payments for 2005

This addendum contains the following information for each CPT code and alphanumeric HCPCS code, except for alphanumeric codes beginning with B (enteral and parenteral therapy), E (durable medical equipment), K (temporary codes for nonphysicians' services or items), or L (orthotics), and codes for anesthesiology.

1. *CPT/HCPCS code.* This is the CPT or alphanumeric HCPCS number for the service. Alphanumeric HCPCS codes are included at the end of this addendum.

2. *Modifier.* A modifier is shown if there is a technical component (modifier TC) and a professional component (PC) (modifier -26) for the service. If there is a PC and a TC for the service, Addendum B contains three entries for the code: one for the global values (both professional and technical); one for modifier -26 (PC); and one for modifier TC. The global service is not designated by a modifier, and physicians must bill using the code without a modifier if the physician furnishes both the PC and the TC of the service.

Modifier -53 is shown for a discontinued procedure. There will be RVUs for the code (CPT code 45378) with this modifier.

3. *Status indicator.* This indicator shows whether the CPT/HCPCS code is included in the physician fee schedule and whether it is separately payable if the service is covered.

A = Active code. These codes are separately payable under the fee schedule if covered. There will be RVUs for codes with this status. The presence of an ''A'' indicator does not mean that Medicare has made a national decision regarding the coverage of the service. Carriers remain responsible for coverage decisions in the absence of a national Medicare policy.

B = Bundled code. Payment for covered services is always bundled into payment for other services not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident. (An example is a telephone call from a hospital nurse regarding care of a patient.)

C = Carrier-priced code. Carriers will establish RVUs and payment amounts for these services, generally on a case-by-case basis following review of documentation, such as an operative report.

E = Excluded from physician fee schedule by regulation. These codes are for items or services that we chose to exclude from the physician fee schedule payment by regulation. No RVUs are shown, and no payment may be made under the physician fee schedule for these codes. Payment for them, if they are covered, continues under reasonable charge or other payment procedures.

I = Not valid for Medicare purposes. Medicare uses another code for the reporting of, and the payment for these services. (Code not subject to a 90-day grace period.)

N = Noncovered service. These codes are noncovered services. Medicare payment may not be made for these codes. If RVUs are shown, they are not used for Medicare payment.

P = Bundled or excluded code. There are no RVUs for these services. No separate payment should be made for them under the physician fee schedule.

—If the item or service is covered as incident to a physician's service and is furnished on the same day as a physician's service, payment for it is bundled into the payment for the physician's service to which it is incident (an example is an elastic bandage furnished by a physician incident to a physician's service).

—If the item or service is covered as other than incident to a physician's service, it is excluded from the physician fee schedule (for example, colostomy supplies) and is paid under the other payment provisions of the Act.

R = Restricted coverage. Special coverage instructions apply. If the service is covered and no RVUs are shown, it is carrier-priced.

T = Injections. There are RVUs for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the service(s) for which payment is made.

X = Exclusion by law. These codes represent an item or service that is not within the definition of ''physicians' services'' for physician fee schedule payment purposes. No RVUs are shown for these codes, and no payment may be made under the physician fee schedule. (Examples are ambulance services and clinical diagnostic laboratory services.)

4. *Description of code.* This is an abbreviated version of the narrative description of the code.

5. *Physician work RVUs.* These are the RVUs for the physician work for this service in 2005. Codes that are not used for Medicare payment are identified with a ''+.''

6. *Facility practice expense RVUs.* These are the fully implemented resource-based practice expense RVUs for facility settings.

7. *Non-facility practice expense RVUs.* These are the fully implemented resource-based practice expense RVUs for non-facility settings.

8. *Malpractice expense RVUs.* These are the RVUs for the malpractice expense for the service for 2005.

9. *Facility total.* This is the sum of the work, fully implemented facility practice expense, and malpractice expense RVUs.

10. *Non-facility total.* This is the sum of the work, fully implemented non-facility practice expense, and malpractice expense RVUs.

11. *Global period.* This indicator shows the number of days in the global period for the code (0, 10, or 90 days). An explanation of the alpha codes follows:

MMM = The code describes a service furnished in uncomplicated maternity cases including antepartum care, delivery, and postpartum care. The usual global surgical concept does not apply. See the 1999 Physicians' Current Procedural Terminology for specific definitions.

XXX = The global concept does not apply.

YYY = The global period is to be set by the carrier (for example, unlisted surgery codes).

ZZZ = Code related to another service that is always included in the global period of the other service. (Note: Physician work and practice expense are associated with intra-service time and in some instances the post-service time.)

BILLING CODE 4120–01–P

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
0003T		C	Cervicography	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0008T		C	Upper gi endoscopy w/suture	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0010T		C	Tb test, gamma interferon	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0016T		C	Thermotx choroid vasc lesion	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0017T		C	Photocoagulat macular drusen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0018T		C	Transcranial magnetic stimul	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0019T		I	Extracorp shock wave tx, ms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0020T		C	Extracorp shock wave tx, ft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0021T		C	Fetal oximetry, trnsvag/cerv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0023T		C	Phenotype drug test, hiv 1	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0024T		C	Transcath cardiac reduction	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0026T		C	Measure remnant lipoproteins	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0027T		C	Endoscopic epidural lysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0028T		C	Dexa body composition study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0029T		C	Magnetic tx for incontinence	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0030T		C	Antiprothrombin antibody	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0031T		C	Speculoscopy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0032T		C	Speculoscopy w/direct sample	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0033T		C	Endovasc taa repr incl subcl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0034T		C	Endovasc taa repr w/o subcl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0035T		C	Insert endovasc prosth, taa	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0036T		C	Endovasc prosth, taa, add-on	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0037T		C	Artery transpose/endovas taa	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0038T		C	Rad endovasc taa rpr w/cover	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0039T		C	Rad s/i, endovasc taa repair	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0040T		C	Rad s/i, endovasc taa prosth	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0041T		C	Detect ur infect agnt w/cpas	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0042T		C	Ct perfusion w/contrast, cbf	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0043T		C	Co expired gas analysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0044T		C	Whole body photography	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0045T		C	Whole body photography	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0046T		C	Cath lavage, mammary duct(s	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0047T		C	Cath lavage, mammary duct(s)	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0048T		C	Implant ventricular device	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0049T		C	External circulation assist	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0050T		C	Removal circulation assist	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0051T		C	Implant total heart system	0.00	0.00	0.00	0.00	0.00	0.00	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
0052T		C	Replace component heart syst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0053T		C	Replace component heart syst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0054T		C	Bone surgery using computer	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0055T		C	Bone surgery using computer	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0056T		C	Bone surgery using computer	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0058T		C	Cryopreservation, ovary tiss	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0059T		C	Cryopreservation, oocyte	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0060T		C	Electrical impedance scan	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0061T		C	Destruction of tumor, breast	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0062T		C	Rep intradisc annulus;1 lev	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0063T		C	Rep intradisc annulus;>1lev	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0064T		C	Spectroscop eval expired gas	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0065T		C	Ocular photoscreen bilat	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0066T		C	Ct colonography;screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0067T		C	Ct colonography;dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0068T		C	Interp/rept heart sound	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0069T		C	Analysis only heart sound	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0070T		C	Interp only heart sound	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0071T		C	U/s leiomyomata ablate <200	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0072T		C	U/s leiomyomata ablate >200	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0073T		A	Delivery, comp imrt	0.00	18.02	NA	0.13	18.15	NA	XXX
0074T		C	Online physician e/m	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0075T		C	Perq stent/chest vert art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0076T		C	S&i stent/chest vert art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0077T		C	Cereb therm perfusion probe	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0078T		C	Endovasc aort repr w/device	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0079T		C	Endovasc visc extnsn repr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0080T		C	Endovasc aort repr rad s&i	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0081T		C	Endovasc visc extnsn s&i	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0082T		C	Stereotactic rad delivery	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0083T		C	Stereotactic rad tx mngmt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0084T		C	Temp prostate urethral stent	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0085T		C	Breath test heart reject	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0086T		C	L ventricle fill pressure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0087T		C	Sperm eval hyaluronan	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0088T		C	Rf tongue base vol reduxn	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0500F		I	Initial prenatal care visit	0.00	0.00	0.00	0.00	0.00	0.00	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
0501F		I	Prenatal flow sheet	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0502F		I	Subsequent prenatal care	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0503F		I	Postpartum care visit	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1000F		I	Tobacco use, smoking, assess	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1001F		I	Tobacco use, non-smoking	0.00	0.00	0.00	0.00	0.00	0.00	XXX
10021		A	Fna w/o image	1.27	2.15	0.54	0.10	3.52	1.91	XXX
10022		A	Fna w/image	1.27	2.54	0.42	0.08	3.89	1.77	XXX
1002F		I	Assess anginal symptom/level	0.00	0.00	0.00	0.00	0.00	0.00	XXX
10040		A	Acne surgery	1.18	1.01	0.79	0.06	2.25	2.03	010
10060		A	Drainage of skin abscess	1.17	1.21	0.93	0.12	2.50	2.22	010
10061		A	Drainage of skin abscess	2.40	1.82	1.50	0.26	4.48	4.16	010
10080		A	Drainage of pilonidal cyst	1.17	3.10	1.11	0.11	4.38	2.39	010
10081		A	Drainage of pilonidal cyst	2.45	4.07	1.50	0.25	6.77	4.20	010
10120		A	Remove foreign body	1.22	2.17	0.97	0.12	3.51	2.31	010
10121		A	Remove foreign body	2.69	3.51	1.78	0.32	6.52	4.79	010
10140		A	Drainage of hematoma/fluid	1.53	1.77	1.29	0.19	3.49	3.01	010
10160		A	Puncture drainage of lesion	1.20	1.60	1.08	0.14	2.94	2.42	010
10180		A	Complex drainage, wound	2.25	2.98	1.98	0.33	5.56	4.56	010
11000		A	Debride infected skin	0.60	0.58	0.22	0.07	1.25	0.89	000
11001		A	Debride infected skin add-on	0.30	0.23	0.11	0.03	0.56	0.44	ZZZ
11004		A	Debride genitalia & perineum	10.31	NA	3.90	0.67	NA	14.88	000
11005		A	Debride abdom wall	13.75	NA	5.56	0.96	NA	20.27	000
11006		A	Debride genit/per/abdom wall	12.61	NA	4.85	1.28	NA	18.74	000
11008		A	Remove mesh from abd wall	5.00	NA	2.02	0.61	NA	7.63	ZZZ
11010		A	Debride skin, fx	4.19	6.87	2.62	0.60	11.66	7.41	010
11011		A	Debride skin/muscle, fx	4.94	8.16	2.34	0.70	13.80	7.98	000
11012		A	Debride skin/muscle/bone, fx	6.87	12.10	3.84	1.12	20.09	11.83	000
11040		A	Debride skin, partial	0.50	0.52	0.21	0.06	1.08	0.77	000
11041		A	Debride skin, full	0.82	0.66	0.33	0.10	1.58	1.25	000
11042		A	Debride skin/tissue	1.12	0.97	0.44	0.13	2.22	1.69	000
11043		A	Debride tissue/muscle	2.38	3.38	2.59	0.29	6.05	5.26	010
11044		A	Debride tissue/muscle/bone	3.06	4.45	3.75	0.40	7.91	7.21	010
11055		R	Trim skin lesion	0.43	0.56	0.17	0.05	1.04	0.65	000
11056		R	Trim skin lesions, 2 to 4	0.61	0.64	0.23	0.07	1.32	0.91	000
11057		R	Trim skin lesions, over 4	0.79	0.74	0.30	0.10	1.63	1.19	000
11100		A	Biopsy, skin lesion	0.81	1.25	0.37	0.04	2.10	1.22	000
11101		A	Biopsy, skin add-on	0.41	0.33	0.19	0.02	0.76	0.62	ZZZ

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
11200		A	Removal of skin tags	0.77	1.04	0.76	0.05	1.86	1.58	010
11201		A	Remove skin tags add-on	0.29	0.16	0.12	0.02	0.47	0.43	ZZZ
11300		A	Shave skin lesion	0.51	0.99	0.21	0.03	1.53	0.75	000
11301		A	Shave skin lesion	0.85	1.11	0.38	0.05	2.01	1.28	000
11302		A	Shave skin lesion	1.05	1.30	0.46	0.05	2.40	1.56	000
11303		A	Shave skin lesion	1.24	1.58	0.52	0.07	2.89	1.83	000
11305		A	Shave skin lesion	0.67	0.85	0.27	0.07	1.59	1.01	000
11306		A	Shave skin lesion	0.99	1.10	0.42	0.08	2.17	1.49	000
11307		A	Shave skin lesion	1.14	1.29	0.49	0.08	2.51	1.71	000
11308		A	Shave skin lesion	1.41	1.45	0.59	0.13	2.99	2.13	000
11310		A	Shave skin lesion	0.73	1.11	0.32	0.05	1.89	1.10	000
11311		A	Shave skin lesion	1.05	1.23	0.49	0.06	2.34	1.60	000
11312		A	Shave skin lesion	1.20	1.42	0.55	0.06	2.68	1.81	000
11313		A	Shave skin lesion	1.62	1.80	0.72	0.10	3.52	2.44	000
11400		A	Exc tr-ext b9+marg 0.5 < cm	0.85	1.99	0.88	0.07	2.91	1.80	010
11401		A	Exc tr-ext b9+marg 0.6-1 cm	1.23	2.05	1.02	0.10	3.38	2.35	010
11402		A	Exc tr-ext b9+marg 1.1-2 cm	1.51	2.22	1.08	0.13	3.86	2.72	010
11403		A	Exc tr-ext b9+marg 2.1-3 cm	1.79	2.39	1.32	0.17	4.35	3.28	010
11404		A	Exc tr-ext b9+marg 3.1-4 cm	2.06	2.70	1.40	0.21	4.97	3.67	010
11406		A	Exc tr-ext b9+marg > 4.0 cm	2.76	3.06	1.65	0.32	6.14	4.73	010
11420		A	Exc h-f-nk-sp b9+marg 0.5 <	0.98	1.76	0.93	0.10	2.84	2.01	010
11421		A	Exc h-f-nk-sp b9+marg 0.6-1	1.42	2.06	1.11	0.13	3.61	2.66	010
11422		A	Exc h-f-nk-sp b9+marg 1.1-2	1.63	2.25	1.33	0.15	4.03	3.11	010
11423		A	Exc h-f-nk-sp b9+marg 2.1-3	2.01	2.58	1.45	0.20	4.79	3.66	010
11424		A	Exc h-f-nk-sp b9+marg 3.1-4	2.43	2.80	1.60	0.25	5.48	4.28	010
11426		A	Exc h-f-nk-sp b9+marg > 4 cm	3.77	3.48	2.10	0.42	7.67	6.29	010
11440		A	Exc face-mm b9+marg 0.5 < cm	1.06	2.20	1.31	0.08	3.34	2.45	010
11441		A	Exc face-mm b9+marg 0.6-1 cm	1.48	2.33	1.49	0.13	3.94	3.10	010
11442		A	Exc face-mm b9+marg 1.1-2 cm	1.72	2.54	1.57	0.15	4.41	3.44	010
11443		A	Exc face-mm b9+marg 2.1-3 cm	2.29	2.91	1.81	0.21	5.41	4.31	010
11444		A	Exc face-mm b9+marg 3.1-4 cm	3.14	3.47	2.18	0.29	6.90	5.61	010
11446		A	Exc face-mm b9+marg > 4 cm	4.48	4.04	2.77	0.42	8.94	7.67	010
11450		A	Removal, sweat gland lesion	2.73	5.03	2.02	0.34	8.10	5.09	090
11451		A	Removal, sweat gland lesion	3.94	6.60	2.54	0.51	11.05	6.99	090
11462		A	Removal, sweat gland lesion	2.51	5.11	2.01	0.30	7.92	4.82	090
11463		A	Removal, sweat gland lesion	3.94	6.82	2.68	0.51	11.27	7.13	090
11470		A	Removal, sweat gland lesion	3.25	5.06	2.26	0.39	8.70	5.90	090

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
11471		A	Removal, sweat gland lesion	4.40	6.70	2.76	0.55	11.65	7.71	090
11600		A	Exc tr-ext mlg+marg 0.5 < cm	1.31	2.63	0.97	0.10	4.04	2.38	010
11601		A	Exc tr-ext mlg+marg 0.6-1 cm	1.80	2.70	1.22	0.12	4.62	3.14	010
11602		A	Exc tr-ext mlg+marg 1.1-2 cm	1.95	2.82	1.26	0.13	4.90	3.34	010
11603		A	Exc tr-ext mlg+marg 2.1-3 cm	2.19	3.07	1.33	0.16	5.42	3.68	010
11604		A	Exc tr-ext mlg+marg 3.1-4 cm	2.40	3.37	1.39	0.20	5.97	3.99	010
11606		A	Exc tr-ext mlg+marg > 4 cm	3.42	4.06	1.73	0.36	7.84	5.51	010
11620		A	Exc h-f-nk-sp mlg+marg 0.5 <	1.19	2.59	0.95	0.10	3.88	2.24	010
11621		A	Exc h-f-nk-sp mlg+marg 0.6-1	1.76	2.70	1.24	0.12	4.58	3.12	010
11622		A	Exc h-f-nk-sp mlg+marg 1.1-2	2.09	2.96	1.39	0.14	5.19	3.62	010
11623		A	Exc h-f-nk-sp mlg+marg 2.1-3	2.61	3.33	1.58	0.20	6.14	4.39	010
11624		A	Exc h-f-nk-sp mlg+marg 3.1-4	3.06	3.74	1.77	0.27	7.07	5.10	010
11626		A	Exc h-f-nk-sp mlg+mar > 4 cm	4.29	4.63	2.39	0.44	9.36	7.12	010
11640		A	Exc face-mm malig+marg 0.5 <	1.35	2.65	1.11	0.10	4.10	2.56	010
11641		A	Exc face-mm malig+marg 0.6-1	2.16	3.02	1.53	0.16	5.34	3.85	010
11642		A	Exc face-mm malig+marg 1.1-2	2.59	3.40	1.71	0.19	6.18	4.49	010
11643		A	Exc face-mm malig+marg 2.1-3	3.10	3.80	1.96	0.25	7.15	5.31	010
11644		A	Exc face-mm malig+marg 3.1-4	4.02	4.68	2.45	0.37	9.07	6.84	010
11646		A	Exc face-mm mlg+marg > 4 cm	5.94	5.75	3.47	0.60	12.29	10.01	010
11719		R	Trim nail(s)	0.17	0.25	0.07	0.02	0.44	0.26	000
11720		A	Debride nail, 1-5	0.32	0.34	0.12	0.04	0.70	0.48	000
11721		A	Debride nail, 6 or more	0.54	0.44	0.21	0.07	1.05	0.82	000
11730		A	Removal of nail plate	1.13	1.03	0.43	0.14	2.30	1.70	000
11732		A	Remove nail plate, add-on	0.57	0.44	0.22	0.07	1.08	0.86	ZZZ
11740		A	Drain blood from under nail	0.37	0.55	0.35	0.04	0.96	0.76	000
11750		A	Removal of nail bed	1.86	2.16	1.75	0.22	4.24	3.83	010
11752		A	Remove nail bed/finger tip	2.67	2.99	2.99	0.35	6.01	6.01	010
11755		A	Biopsy, nail unit	1.31	1.57	0.77	0.15	3.03	2.23	000
11760		A	Repair of nail bed	1.58	2.62	1.78	0.20	4.40	3.56	010
11762		A	Reconstruction of nail bed	2.89	2.88	2.34	0.36	6.13	5.59	010
11765		A	Excision of nail fold, toe	0.69	1.78	0.76	0.08	2.55	1.53	010
11770		A	Removal of pilonidal lesion	2.61	3.48	1.50	0.31	6.40	4.42	010
11771		A	Removal of pilonidal lesion	5.73	5.64	3.31	0.73	12.10	9.77	090
11772		A	Removal of pilonidal lesion	6.97	7.50	5.07	0.88	15.35	12.92	090
11900		A	Injection into skin lesions	0.52	0.65	0.21	0.03	1.20	0.76	000
11901		A	Added skin lesions injection	0.80	0.66	0.35	0.03	1.49	1.18	000
11920		R	Correct skin color defects	1.61	3.70	1.09	0.23	5.54	2.93	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
11921		R	Correct skin color defects	1.93	3.96	1.27	0.28	6.17	3.48	000
11922		R	Correct skin color defects	0.49	1.14	0.25	0.07	1.70	0.81	ZZZ
11950		R	Therapy for contour defects	0.84	1.14	0.39	0.06	2.04	1.29	000
11951		R	Therapy for contour defects	1.19	1.49	0.51	0.11	2.79	1.81	000
11952		R	Therapy for contour defects	1.69	1.85	0.68	0.16	3.70	2.53	000
11954		R	Therapy for contour defects	1.85	2.44	0.90	0.24	4.53	2.99	000
11960		A	Insert tissue expander(s)	9.07	NA	10.39	1.28	NA	20.74	090
11970		A	Replace tissue expander	7.05	NA	6.13	1.03	NA	14.21	090
11971		A	Remove tissue expander(s)	2.13	9.11	3.79	0.30	11.54	6.22	090
11975		N	Insert contraceptive cap	+1.48	1.42	0.57	0.17	3.07	2.22	XXX
11976		R	Removal of contraceptive cap	1.78	1.72	0.68	0.21	3.71	2.67	000
11977		N	Removal/reinsert contra cap	+3.30	2.27	1.26	0.37	5.94	4.93	XXX
11980		A	Implant hormone pellet(s)	1.48	1.08	0.54	0.13	2.69	2.15	000
11981		A	Insert drug implant device	1.48	1.70	0.68	0.12	3.30	2.28	XXX
11982		A	Remove drug implant device	1.78	1.94	0.83	0.17	3.89	2.78	XXX
11983		A	Remove/insert drug implant	3.30	2.28	1.47	0.24	5.82	5.01	XXX
12001		A	Repair superficial wound(s)	1.70	1.98	0.77	0.16	3.84	2.63	010
12002		A	Repair superficial wound(s)	1.86	2.04	0.90	0.18	4.08	2.94	010
12004		A	Repair superficial wound(s)	2.24	2.32	1.01	0.22	4.78	3.47	010
12005		A	Repair superficial wound(s)	2.86	2.82	1.20	0.28	5.96	4.34	010
12006		A	Repair superficial wound(s)	3.66	3.39	1.51	0.38	7.43	5.55	010
12007		A	Repair superficial wound(s)	4.11	3.82	1.81	0.44	8.37	6.36	010
12011		A	Repair superficial wound(s)	1.76	2.13	0.78	0.17	4.06	2.71	010
12013		A	Repair superficial wound(s)	1.99	2.27	0.93	0.19	4.45	3.11	010
12014		A	Repair superficial wound(s)	2.46	2.57	1.06	0.23	5.26	3.75	010
12015		A	Repair superficial wound(s)	3.19	3.13	1.25	0.30	6.62	4.74	010
12016		A	Repair superficial wound(s)	3.92	3.55	1.52	0.38	7.85	5.82	010
12017		A	Repair superficial wound(s)	4.70	NA	1.89	0.49	NA	7.08	010
12018		A	Repair superficial wound(s)	5.52	NA	2.25	0.61	NA	8.38	010
12020		A	Closure of split wound	2.62	3.82	1.92	0.30	6.74	4.84	010
12021		A	Closure of split wound	1.84	1.82	1.41	0.23	3.89	3.48	010
12031		A	Layer closure of wound(s)	2.15	2.28	0.96	0.18	4.61	3.29	010
12032		A	Layer closure of wound(s)	2.47	3.84	1.79	0.17	6.48	4.43	010
12034		A	Layer closure of wound(s)	2.92	3.19	1.45	0.26	6.37	4.63	010
12035		A	Layer closure of wound(s)	3.42	5.19	2.15	0.38	8.99	5.95	010
12036		A	Layer closure of wound(s)	4.04	5.55	2.54	0.52	10.11	7.10	010
12037		A	Layer closure of wound(s)	4.66	6.09	2.96	0.62	11.37	8.24	010

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
12041		A	Layer closure of wound(s)	2.37	2.54	1.13	0.20	5.11	3.70	010
12042		A	Layer closure of wound(s)	2.74	3.26	1.46	0.19	6.19	4.39	010
12044		A	Layer closure of wound(s)	3.14	3.21	1.60	0.29	6.64	5.03	010
12045		A	Layer closure of wound(s)	3.63	5.26	2.28	0.40	9.29	6.31	010
12046		A	Layer closure of wound(s)	4.24	6.50	2.75	0.51	11.25	7.50	010
12047		A	Layer closure of wound(s)	4.64	6.34	3.08	0.56	11.54	8.28	010
12051		A	Layer closure of wound(s)	2.47	3.27	1.45	0.20	5.94	4.12	010
12052		A	Layer closure of wound(s)	2.77	3.22	1.43	0.19	6.18	4.39	010
12053		A	Layer closure of wound(s)	3.12	3.24	1.53	0.24	6.60	4.89	010
12054		A	Layer closure of wound(s)	3.45	3.56	1.63	0.30	7.31	5.38	010
12055		A	Layer closure of wound(s)	4.42	4.48	2.12	0.45	9.35	6.99	010
12056		A	Layer closure of wound(s)	5.23	6.75	3.05	0.57	12.55	8.85	010
12057		A	Layer closure of wound(s)	5.95	6.13	3.75	0.54	12.62	10.24	010
13100		A	Repair of wound or lesion	3.12	4.05	2.30	0.27	7.44	5.69	010
13101		A	Repair of wound or lesion	3.91	4.66	2.68	0.28	8.85	6.87	010
13102		A	Repair wound/lesion add-on	1.24	1.17	0.57	0.13	2.54	1.94	ZZZ
13120		A	Repair of wound or lesion	3.30	4.14	2.34	0.28	7.72	5.92	010
13121		A	Repair of wound or lesion	4.32	4.85	2.79	0.29	9.46	7.40	010
13122		A	Repair wound/lesion add-on	1.44	1.51	0.63	0.15	3.10	2.22	ZZZ
13131		A	Repair of wound or lesion	3.78	4.36	2.68	0.28	8.42	6.74	010
13132		A	Repair of wound or lesion	5.94	5.90	4.16	0.35	12.19	10.45	010
13133		A	Repair wound/lesion add-on	2.19	1.66	1.03	0.18	4.03	3.40	ZZZ
13150		A	Repair of wound or lesion	3.80	4.87	2.76	0.34	9.01	6.90	010
13151		A	Repair of wound or lesion	4.44	4.80	3.14	0.32	9.56	7.90	010
13152		A	Repair of wound or lesion	6.32	6.03	4.04	0.42	12.77	10.78	010
13153		A	Repair wound/lesion add-on	2.38	1.93	1.14	0.25	4.56	3.77	ZZZ
13160		A	Late closure of wound	10.46	NA	7.16	1.49	NA	19.11	090
14000		A	Skin tissue rearrangement	5.88	7.85	5.46	0.59	14.32	11.93	090
14001		A	Skin tissue rearrangement	8.46	9.41	7.07	0.83	18.70	16.36	090
14020		A	Skin tissue rearrangement	6.58	8.61	6.53	0.64	15.83	13.75	090
14021		A	Skin tissue rearrangement	10.04	9.98	8.28	0.83	20.85	19.15	090
14040		A	Skin tissue rearrangement	7.86	8.80	7.20	0.65	17.31	15.71	090
14041		A	Skin tissue rearrangement	11.47	10.59	8.67	0.76	22.82	20.90	090
14060		A	Skin tissue rearrangement	8.49	8.78	7.43	0.68	17.95	16.60	090
14061		A	Skin tissue rearrangement	12.27	11.60	9.50	0.77	24.64	22.54	090
14300		A	Skin tissue rearrangement	11.74	11.13	9.17	1.16	24.03	22.07	090
14350		A	Skin tissue rearrangement	9.60	NA	7.14	1.32	NA	18.06	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
15000		A	Skin graft	3.99	3.79	2.18	0.48	8.26	6.65	000
15001		A	Skin graft add-on	1.00	1.35	0.41	0.14	2.49	1.55	ZZZ
15050		A	Skin pinch graft	4.29	6.91	5.11	0.56	11.76	9.96	090
15100		A	Skin split graft	9.04	12.58	7.82	1.25	22.87	18.11	090
15101		A	Skin split graft add-on	1.72	3.73	1.17	0.24	5.69	3.13	ZZZ
15120		A	Skin split graft	9.82	10.72	7.78	1.15	21.69	18.75	090
15121		A	Skin split graft add-on	2.67	4.50	1.84	0.35	7.52	4.86	ZZZ
15200		A	Skin full graft	8.02	9.40	6.20	0.97	18.39	15.19	090
15201		A	Skin full graft add-on	1.32	2.56	0.62	0.18	4.06	2.12	ZZZ
15220		A	Skin full graft	7.86	9.18	6.68	0.83	17.87	15.37	090
15221		A	Skin full graft add-on	1.19	2.32	0.56	0.16	3.67	1.91	ZZZ
15240		A	Skin full graft	9.03	10.20	7.95	0.94	20.17	17.92	090
15241		A	Skin full graft add-on	1.86	2.44	0.91	0.22	4.52	2.99	ZZZ
15260		A	Skin full graft	10.04	10.21	8.58	0.71	20.96	19.33	090
15261		A	Skin full graft add-on	2.23	2.69	1.40	0.21	5.13	3.84	ZZZ
15342		A	Cultured skin graft, 25 cm	1.00	1.85	0.55	0.11	2.96	1.66	010
15343		A	Culture skn graft addl 25 cm	0.25	0.09	0.09	0.03	0.37	0.37	ZZZ
15350		A	Skin homograft	3.99	6.46	3.84	0.49	10.94	8.32	090
15351		A	Skin homograft add-on	1.00	0.36	0.36	0.14	1.50	1.50	ZZZ
15400		A	Skin heterograft	3.99	4.01	4.01	0.46	8.46	8.46	090
15401		A	Skin heterograft add-on	1.00	1.89	0.44	0.14	3.03	1.58	ZZZ
15570		A	Form skin pedicle flap	9.20	11.30	6.76	1.27	21.77	17.23	090
15572		A	Form skin pedicle flap	9.26	9.49	6.45	1.18	19.93	16.89	090
15574		A	Form skin pedicle flap	9.87	10.68	7.79	1.18	21.73	18.84	090
15576		A	Form skin pedicle flap	8.68	9.75	6.88	0.87	19.30	16.43	090
15600		A	Skin graft	1.91	7.60	3.06	0.26	9.77	5.23	090
15610		A	Skin graft	2.42	4.69	3.42	0.34	7.45	6.18	090
15620		A	Skin graft	2.94	7.78	3.88	0.35	11.07	7.17	090
15630		A	Skin graft	3.27	7.04	4.15	0.33	10.64	7.75	090
15650		A	Transfer skin pedicle flap	3.96	7.14	4.21	0.42	11.52	8.59	090
15732		A	Muscle-skin graft, head/neck	17.81	18.04	12.21	1.97	37.82	31.99	090
15734		A	Muscle-skin graft, trunk	17.76	18.11	12.37	2.54	38.41	32.67	090
15736		A	Muscle-skin graft, arm	16.25	18.23	11.22	2.38	36.86	29.85	090
15738		A	Muscle-skin graft, leg	17.89	17.97	11.72	2.61	38.47	32.22	090
15740		A	Island pedicle flap graft	10.23	10.13	8.26	0.68	21.04	19.17	090
15750		A	Neurovascular pedicle graft	11.39	NA	9.04	1.40	NA	21.83	090
15756		A	Free myo/skin flap microvasc	35.18	NA	20.56	4.56	NA	60.30	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
15757		A	Free skin flap, microvasc	35.18	NA	21.59	3.91	NA	60.68	090
15758		A	Free fascial flap, microvasc	35.05	NA	21.57	4.22	NA	60.84	090
15760		A	Composite skin graft	8.73	10.02	7.26	0.85	19.60	16.84	090
15770		A	Derma-fat-fascia graft	7.51	NA	6.68	1.03	NA	15.22	090
15775		R	Hair transplant punch grafts	3.95	4.23	1.30	0.52	8.70	5.77	000
15776		R	Hair transplant punch grafts	5.53	5.35	2.80	0.72	11.60	9.05	000
15780		A	Abrasion treatment of skin	7.28	11.52	8.25	0.67	19.47	16.20	090
15781		A	Abrasion treatment of skin	4.84	6.91	5.36	0.34	12.09	10.54	090
15782		A	Abrasion treatment of skin	4.31	9.85	6.55	0.34	14.50	11.20	090
15783		A	Abrasion treatment of skin	4.28	6.87	4.18	0.28	11.43	8.74	090
15786		A	Abrasion, lesion, single	2.03	3.35	1.32	0.13	5.51	3.48	010
15787		A	Abrasion, lesions, add-on	0.33	1.09	0.16	0.04	1.46	0.53	ZZZ
15788		R	Chemical peel, face, epiderm	2.09	6.71	3.08	0.13	8.93	5.30	090
15789		R	Chemical peel, face, dermal	4.91	8.09	4.80	0.21	13.21	9.92	090
15792		R	Chemical peel, nonfacial	1.86	7.09	4.45	0.13	9.08	6.44	090
15793		A	Chemical peel, nonfacial	3.73	6.28	4.38	0.21	10.22	8.32	090
15810		A	Salabrasion	4.73	NA	3.89	0.50	NA	9.12	090
15811		A	Salabrasion	5.38	5.49	4.77	0.80	11.67	10.95	090
15819		A	Plastic surgery, neck	9.37	NA	7.18	0.97	NA	17.52	090
15820		A	Revision of lower eyelid	5.14	6.97	5.56	0.41	12.52	11.11	090
15821		A	Revision of lower eyelid	5.71	7.35	5.71	0.45	13.51	11.87	090
15822		A	Revision of upper eyelid	4.44	5.83	4.49	0.36	10.63	9.29	090
15823		A	Revision of upper eyelid	7.04	7.85	6.43	0.50	15.39	13.97	090
15824		R	Removal of forehead wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15825		R	Removal of neck wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15826		R	Removal of brow wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15828		R	Removal of face wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15829		R	Removal of skin wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15831		A	Excise excessive skin tissue	12.38	NA	8.16	1.71	NA	22.25	090
15832		A	Excise excessive skin tissue	11.57	NA	8.34	1.64	NA	21.55	090
15833		A	Excise excessive skin tissue	10.62	NA	8.21	1.42	NA	20.25	090
15834		A	Excise excessive skin tissue	10.83	NA	7.69	1.60	NA	20.12	090
15835		A	Excise excessive skin tissue	11.65	NA	7.54	1.59	NA	20.78	090
15836		A	Excise excessive skin tissue	9.33	NA	6.78	1.32	NA	17.43	090
15837		A	Excise excessive skin tissue	8.42	8.55	7.37	1.18	18.15	16.97	090
15838		A	Excise excessive skin tissue	7.12	NA	6.06	0.60	NA	13.78	090
15839		A	Excise excessive skin tissue	9.37	8.82	6.39	1.18	19.37	16.94	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
15840		A	Graft for face nerve palsy	13.24	NA	9.97	1.33	NA	24.54	090
15841		A	Graft for face nerve palsy	23.23	NA	14.99	2.56	NA	40.78	090
15842		A	Flap for face nerve palsy	37.90	NA	22.91	4.89	NA	65.70	090
15845		A	Skin and muscle repair, face	12.55	NA	9.30	0.80	NA	22.65	090
15850		B	Removal of sutures	+0.78	1.56	0.30	0.05	2.39	1.13	XXX
15851		A	Removal of sutures	0.86	1.68	0.31	0.06	2.60	1.23	000
15852		A	Dressing change not for burn	0.86	1.84	0.33	0.09	2.79	1.28	000
15860		A	Test for blood flow in graft	1.95	0.83	0.78	0.25	3.03	2.98	000
15876		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15877		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15878		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15879		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15920		A	Removal of tail bone ulcer	7.94	NA	5.55	1.03	NA	14.52	090
15922		A	Removal of tail bone ulcer	9.89	NA	7.21	1.40	NA	18.50	090
15931		A	Remove sacrum pressure sore	9.23	NA	5.68	1.23	NA	16.14	090
15933		A	Remove sacrum pressure sore	10.83	NA	7.85	1.49	NA	20.17	090
15934		A	Remove sacrum pressure sore	12.67	NA	8.04	1.76	NA	22.47	090
15935		A	Remove sacrum pressure sore	14.55	NA	10.32	2.05	NA	26.92	090
15936		A	Remove sacrum pressure sore	12.36	NA	8.22	1.73	NA	22.31	090
15937		A	Remove sacrum pressure sore	14.19	NA	9.82	2.02	NA	26.03	090
15940		A	Remove hip pressure sore	9.33	NA	6.17	1.29	NA	16.79	090
15941		A	Remove hip pressure sore	11.41	NA	9.45	1.64	NA	22.50	090
15944		A	Remove hip pressure sore	11.44	NA	8.60	1.63	NA	21.67	090
15945		A	Remove hip pressure sore	12.67	NA	9.64	1.79	NA	24.10	090
15946		A	Remove hip pressure sore	21.54	NA	14.37	3.10	NA	39.01	090
15950		A	Remove thigh pressure sore	7.53	NA	5.41	1.01	NA	13.95	090
15951		A	Remove thigh pressure sore	10.70	NA	7.86	1.45	NA	20.01	090
15952		A	Remove thigh pressure sore	11.37	NA	7.75	1.59	NA	20.71	090
15953		A	Remove thigh pressure sore	12.61	NA	8.99	1.78	NA	23.38	090
15956		A	Remove thigh pressure sore	15.50	NA	10.77	2.16	NA	28.43	090
15958		A	Remove thigh pressure sore	15.46	NA	11.04	2.21	NA	28.71	090
15999		C	Removal of pressure sore	0.00	0.00	0.00	0.00	0.00	0.00	YYY
16000		A	Initial treatment of burn(s)	0.89	0.86	0.26	0.08	1.83	1.23	000
16010		A	Treatment of burn(s)	0.87	0.66	0.63	0.09	1.62	1.59	000
16015		A	Treatment of burn(s)	2.35	NA	1.15	0.31	NA	3.81	000
16020		A	Treatment of burn(s)	0.80	1.29	0.58	0.08	2.17	1.46	000
16025		A	Treatment of burn(s)	1.85	1.76	0.96	0.19	3.80	3.00	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
16030		A	Treatment of burn(s)	2.08	2.17	1.12	0.24	4.49	3.44	000
16035		A	Incision of burn scab, initi	3.74	NA	1.58	0.45	NA	5.77	090
16036		A	Escharotomy; add'l incision	1.50	NA	0.60	0.20	NA	2.30	ZZZ
17000		A	Destroy benign/premlg lesion	0.60	0.97	0.54	0.03	1.60	1.17	010
17003		A	Destroy lesions, 2-14	0.15	0.11	0.07	0.01	0.27	0.23	ZZZ
17004		A	Destroy lesions, 15 or more	2.79	2.30	1.59	0.13	5.22	4.51	010
17106		A	Destruction of skin lesions	4.58	4.60	3.33	0.35	9.53	8.26	090
17107		A	Destruction of skin lesions	9.15	7.20	5.45	0.66	17.01	15.26	090
17108		A	Destruction of skin lesions	13.18	9.26	7.66	0.82	23.26	21.66	090
17110		A	Destruct lesion, 1-14	0.65	1.62	0.70	0.05	2.32	1.40	010
17111		A	Destruct lesion, 15 or more	0.92	1.67	0.81	0.05	2.64	1.78	010
17250		A	Chemical cautery, tissue	0.50	1.22	0.34	0.05	1.77	0.89	000
17260		A	Destruction of skin lesions	0.91	1.28	0.67	0.04	2.23	1.62	010
17261		A	Destruction of skin lesions	1.17	1.61	0.83	0.05	2.83	2.05	010
17262		A	Destruction of skin lesions	1.58	1.88	1.02	0.07	3.53	2.67	010
17263		A	Destruction of skin lesions	1.79	2.05	1.09	0.08	3.92	2.96	010
17264		A	Destruction of skin lesions	1.94	2.22	1.12	0.08	4.24	3.14	010
17266		A	Destruction of skin lesions	2.34	2.50	1.22	0.12	4.96	3.68	010
17270		A	Destruction of skin lesions	1.32	1.70	0.87	0.06	3.08	2.25	010
17271		A	Destruction of skin lesions	1.49	1.77	0.98	0.06	3.32	2.53	010
17272		A	Destruction of skin lesions	1.77	1.99	1.11	0.08	3.84	2.96	010
17273		A	Destruction of skin lesions	2.05	2.20	1.21	0.09	4.34	3.35	010
17274		A	Destruction of skin lesions	2.59	2.56	1.44	0.12	5.27	4.15	010
17276		A	Destruction of skin lesions	3.20	2.94	1.68	0.18	6.32	5.06	010
17280		A	Destruction of skin lesions	1.17	1.61	0.81	0.05	2.83	2.03	010
17281		A	Destruction of skin lesions	1.72	1.90	1.09	0.07	3.69	2.88	010
17282		A	Destruction of skin lesions	2.04	2.15	1.24	0.09	4.28	3.37	010
17283		A	Destruction of skin lesions	2.64	2.54	1.49	0.12	5.30	4.25	010
17284		A	Destruction of skin lesions	3.21	2.92	1.75	0.15	6.28	5.11	010
17286		A	Destruction of skin lesions	4.43	3.67	2.44	0.26	8.36	7.13	010
17304		A	1 stage mohs, up to 5 spec	7.59	8.24	3.56	0.32	16.15	11.47	000
17305		A	2 stage mohs, up to 5 spec	2.85	3.89	1.34	0.12	6.86	4.31	000
17306		A	3 stage mohs, up to 5 spec	2.85	3.91	1.35	0.12	6.88	4.32	000
17307		A	Mohs addl stage up to 5 spec	2.85	3.56	1.36	0.12	6.53	4.33	000
17310		A	Mohs any stage > 5 spec each	0.95	1.62	0.46	0.03	2.60	1.44	ZZZ
17340		A	Cryotherapy of skin	0.76	0.37	0.36	0.05	1.18	1.17	010
17360		A	Skin peel therapy	1.43	1.44	0.87	0.06	2.93	2.36	010

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
17380		R	Hair removal by electrolysis	0.00	0.00	0.00	0.00	0.00	0.00	000
17999		C	Skin tissue procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
19000		A	Drainage of breast lesion	0.84	1.98	0.31	0.08	2.90	1.23	000
19001		A	Drain breast lesion add-on	0.42	0.25	0.14	0.04	0.71	0.60	ZZZ
19020		A	Incision of breast lesion	3.56	6.33	2.67	0.44	10.33	6.67	090
19030		A	Injection for breast x-ray	1.53	2.86	0.50	0.09	4.48	2.12	000
19100		A	Bx breast percut w/o image	1.27	2.08	0.42	0.16	3.51	1.85	000
19101		A	Biopsy of breast, open	3.18	4.50	1.91	0.38	8.06	5.47	010
19102		A	Bx breast percut w/image	2.00	3.83	0.66	0.14	5.97	2.80	000
19103		A	Bx breast percut w/device	3.69	11.49	1.23	0.30	15.48	5.22	000
19110		A	Nipple exploration	4.29	5.79	2.86	0.56	10.64	7.71	090
19112		A	Excise breast duct fistula	3.66	6.06	2.68	0.48	10.20	6.82	090
19120		A	Removal of breast lesion	5.55	4.54	3.06	0.72	10.81	9.33	090
19125		A	Excision, breast lesion	6.05	4.78	3.28	0.79	11.62	10.12	090
19126		A	Excision, addl breast lesion	2.93	NA	1.00	0.38	NA	4.31	ZZZ
19140		A	Removal of breast tissue	5.13	7.14	3.39	0.70	12.97	9.22	090
19160		A	Partial mastectomy	5.98	NA	3.42	0.79	NA	10.19	090
19162		A	P-mastectomy w/ln removal	13.51	NA	6.33	1.77	NA	21.61	090
19180		A	Removal of breast	8.79	NA	5.02	1.18	NA	14.99	090
19182		A	Removal of breast	7.72	NA	4.75	1.04	NA	13.51	090
19200		A	Removal of breast	15.47	NA	7.96	1.89	NA	25.32	090
19220		A	Removal of breast	15.70	NA	8.23	2.02	NA	25.95	090
19240		A	Removal of breast	15.98	NA	8.20	2.10	NA	26.28	090
19260		A	Removal of chest wall lesion	15.42	NA	11.15	2.07	NA	28.64	090
19271		A	Revision of chest wall	18.87	NA	17.95	2.59	NA	39.41	090
19272		A	Extensive chest wall surgery	21.52	NA	18.93	2.97	NA	43.42	090
19290		A	Place needle wire, breast	1.27	2.85	0.42	0.08	4.20	1.77	000
19291		A	Place needle wire, breast	0.63	1.21	0.21	0.04	1.88	0.88	ZZZ
19295		A	Place breast clip, percut	0.00	2.69	NA	0.01	2.70	NA	ZZZ
19296		A	Place po breast cath for rad	3.63	125.39	1.53	0.36	129.38	5.52	000
19297		A	Place breast cath for rad	1.72	NA	0.64	0.17	NA	2.53	ZZZ
19298		A	Place breast rad tube/caths	6.00	42.16	2.41	0.43	48.59	8.84	000
19316		A	Suspension of breast	10.67	NA	7.51	1.60	NA	19.78	090
19318		A	Reduction of large breast	15.60	NA	11.17	2.86	NA	29.63	090
19324		A	Enlarge breast	5.84	NA	4.89	0.84	NA	11.57	090
19325		A	Enlarge breast with implant	8.44	NA	6.52	1.30	NA	16.26	090
19328		A	Removal of breast implant	5.67	NA	5.02	0.90	NA	11.59	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
19330		A	Removal of implant material	7.58	NA	6.03	1.21	NA	14.82	090
19340		A	Immediate breast prosthesis	6.32	NA	3.11	1.04	NA	10.47	ZZZ
19342		A	Delayed breast prosthesis	11.18	NA	8.92	1.79	NA	21.89	090
19350		A	Breast reconstruction	8.91	13.84	7.17	1.39	24.14	17.47	090
19355		A	Correct inverted nipple(s)	7.56	10.25	4.70	0.92	18.73	13.18	090
19357		A	Breast reconstruction	18.13	NA	15.61	2.86	NA	36.60	090
19361		A	Breast reconstruction	19.23	NA	12.43	2.86	NA	34.52	090
19364		A	Breast reconstruction	40.94	NA	23.54	6.13	NA	70.61	090
19366		A	Breast reconstruction	21.25	NA	11.58	3.20	NA	36.03	090
19367		A	Breast reconstruction	25.69	NA	16.69	3.95	NA	46.33	090
19368		A	Breast reconstruction	32.37	NA	18.92	5.48	NA	56.77	090
19369		A	Breast reconstruction	29.78	NA	18.40	4.44	NA	52.62	090
19370		A	Surgery of breast capsule	8.04	NA	6.90	1.27	NA	16.21	090
19371		A	Removal of breast capsule	9.34	NA	7.82	1.59	NA	18.75	090
19380		A	Revise breast reconstruction	9.13	NA	7.70	1.42	NA	18.25	090
19396		A	Design custom breast implant	2.17	1.08	0.99	0.30	3.55	3.46	000
19499		C	Breast surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
20000		A	Incision of abscess	2.12	2.69	1.73	0.24	5.05	4.09	010
20005		A	Incision of deep abscess	3.41	3.49	2.25	0.44	7.34	6.10	010
2000F		I	Blood pressure, measured	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20100		A	Explore wound, neck	10.06	NA	4.46	1.24	NA	15.76	010
20101		A	Explore wound, chest	3.22	5.92	1.62	0.42	9.56	5.26	010
20102		A	Explore wound, abdomen	3.93	7.46	1.90	0.49	11.88	6.32	010
20103		A	Explore wound, extremity	5.29	8.58	3.39	0.71	14.58	9.39	010
20150		A	Excise epiphyseal bar	13.67	NA	7.03	2.01	NA	22.71	090
20200		A	Muscle biopsy	1.46	3.03	0.75	0.21	4.70	2.42	000
20205		A	Deep muscle biopsy	2.35	3.89	1.19	0.32	6.56	3.86	000
20206		A	Needle biopsy, muscle	0.99	6.50	0.63	0.07	7.56	1.69	000
20220		A	Bone biopsy, trocar/needle	1.27	4.56	0.79	0.09	5.92	2.15	000
20225		A	Bone biopsy, trocar/needle	1.87	24.45	1.13	0.22	26.54	3.22	000
20240		A	Bone biopsy, excisional	3.23	NA	2.55	0.42	NA	6.20	010
20245		A	Bone biopsy, excisional	7.77	NA	6.57	1.23	NA	15.57	010
20250		A	Open bone biopsy	5.02	NA	3.50	0.98	NA	9.50	010
20251		A	Open bone biopsy	5.55	NA	4.16	1.10	NA	10.81	010
20500		A	Injection of sinus tract	1.23	2.26	1.53	0.12	3.61	2.88	010
20501		A	Inject sinus tract for x-ray	0.76	2.91	0.25	0.04	3.71	1.05	000
20520		A	Removal of foreign body	1.85	2.91	1.76	0.21	4.97	3.82	010

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
20525		A	Removal of foreign body	3.49	9.14	2.62	0.49	13.12	6.60	010
20526		A	Ther injection, carp tunnel	0.94	0.97	0.52	0.12	2.03	1.58	000
20550		A	Inj tendon sheath/ligament	0.75	0.71	0.23	0.08	1.54	1.06	000
20551		A	Inj tendon origin/insertion	0.75	0.68	0.33	0.08	1.51	1.16	000
20552		A	Inj trigger point, 1/2 muscl	0.66	0.72	0.20	0.05	1.43	0.91	000
20553		A	Inject trigger points, =/> 3	0.75	0.82	0.22	0.05	1.62	1.02	000
20600		A	Drain/inject, joint/bursa	0.66	0.65	0.35	0.08	1.39	1.09	000
20605		A	Drain/inject, joint/bursa	0.68	0.76	0.36	0.08	1.52	1.12	000
20610		A	Drain/inject, joint/bursa	0.79	0.95	0.42	0.10	1.84	1.31	000
20612		A	Aspirate/inj ganglion cyst	0.70	0.71	0.36	0.09	1.50	1.15	000
20615		A	Treatment of bone cyst	2.28	3.51	1.84	0.20	5.99	4.32	010
20650		A	Insert and remove bone pin	2.23	2.36	1.55	0.31	4.90	4.09	010
20660		A	Apply, rem fixation device	2.51	3.05	1.61	0.55	6.11	4.67	000
20661		A	Application of head brace	4.88	NA	4.91	1.11	NA	10.90	090
20662		A	Application of pelvis brace	6.06	NA	5.52	0.56	NA	12.14	090
20663		A	Application of thigh brace	5.42	NA	4.83	0.93	NA	11.18	090
20664		A	Halo brace application	8.05	NA	7.04	1.68	NA	16.77	090
20665		A	Removal of fixation device	1.31	2.15	1.35	0.18	3.64	2.84	010
20670		A	Removal of support implant	1.74	11.54	2.10	0.27	13.55	4.11	010
20680		A	Removal of support implant	3.34	8.78	3.72	0.54	12.66	7.60	090
20690		A	Apply bone fixation device	3.51	NA	2.51	0.58	NA	6.60	090
20692		A	Apply bone fixation device	6.40	NA	3.77	1.03	NA	11.20	090
20693		A	Adjust bone fixation device	5.85	NA	5.44	0.98	NA	12.27	090
20694		A	Remove bone fixation device	4.15	7.14	4.04	0.69	11.98	8.88	090
20802		A	Replantation, arm, complete	41.09	NA	20.95	3.78	NA	65.82	090
20805		A	Replant forearm, complete	49.93	NA	34.31	4.80	NA	89.04	090
20808		A	Replantation hand, complete	61.56	NA	42.22	6.81	NA	110.59	090
20816		A	Replantation digit, complete	30.89	NA	37.79	4.49	NA	73.17	090
20822		A	Replantation digit, complete	25.55	NA	34.59	3.55	NA	63.69	090
20824		A	Replantation thumb, complete	30.89	NA	36.54	4.57	NA	72.00	090
20827		A	Replantation thumb, complete	26.37	NA	36.47	3.63	NA	66.47	090
20838		A	Replantation foot, complete	41.35	NA	22.28	1.11	NA	64.74	090
20900		A	Removal of bone for graft	5.57	8.43	5.67	0.92	14.92	12.16	090
20902		A	Removal of bone for graft	7.54	NA	6.88	1.28	NA	15.70	090
20910		A	Remove cartilage for graft	5.33	NA	5.18	0.63	NA	11.14	090
20912		A	Remove cartilage for graft	6.34	NA	5.79	0.71	NA	12.84	090
20920		A	Removal of fascia for graft	5.30	NA	4.22	0.63	NA	10.15	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
20922		A	Removal of fascia for graft	6.60	7.54	4.87	0.71	14.85	12.18	090
20924		A	Removal of tendon for graft	6.47	NA	5.88	1.02	NA	13.37	090
20926		A	Removal of tissue for graft	5.52	NA	4.75	0.81	NA	11.08	090
20930		B	Spinal bone allograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20931		A	Spinal bone allograft	1.81	NA	0.93	0.42	NA	3.16	ZZZ
20936		B	Spinal bone autograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20937		A	Spinal bone autograft	2.79	NA	1.45	0.54	NA	4.78	ZZZ
20938		A	Spinal bone autograft	3.02	NA	1.56	0.62	NA	5.20	ZZZ
20950		A	Fluid pressure, muscle	1.26	6.84	0.99	0.19	8.29	2.44	000
20955		A	Fibula bone graft, microvasc	39.15	NA	24.27	4.81	NA	68.23	090
20956		A	Iliac bone graft, microvasc	39.21	NA	24.74	6.81	NA	70.76	090
20957		A	Mt bone graft, microvasc	40.59	NA	18.94	7.00	NA	66.53	090
20962		A	Other bone graft, microvasc	39.21	NA	26.52	6.16	NA	71.89	090
20969		A	Bone/skin graft, microvasc	43.85	NA	26.63	4.86	NA	75.34	090
20970		A	Bone/skin graft, iliac crest	43.00	NA	25.38	6.55	NA	74.93	090
20972		A	Bone/skin graft, metatarsal	42.93	NA	20.58	5.31	NA	68.82	090
20973		A	Bone/skin graft, great toe	45.69	NA	25.16	5.56	NA	76.41	090
20974		A	Electrical bone stimulation	0.62	0.69	0.54	0.10	1.41	1.26	000
20975		A	Electrical bone stimulation	2.60	NA	1.71	0.50	NA	4.81	000
20979		A	Us bone stimulation	0.62	0.80	0.34	0.09	1.51	1.05	000
20982		A	Ablate, bone tumor(s) perq	7.27	109.54	2.97	0.69	117.50	10.93	000
20999		C	Musculoskeletal surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21010		A	Incision of jaw joint	10.12	NA	7.09	1.05	NA	18.26	090
21015		A	Resection of facial tumor	5.28	NA	5.01	0.68	NA	10.97	090
21025		A	Excision of bone, lower jaw	10.04	12.24	9.35	1.31	23.59	20.70	090
21026		A	Excision of facial bone(s)	4.84	7.86	6.32	0.60	13.30	11.76	090
21029		A	Contour of face bone lesion	7.70	9.37	7.01	0.94	18.01	15.65	090
21030		A	Excise max/zygoma b9 tumor	4.49	6.33	5.03	0.51	11.33	10.03	090
21031		A	Remove exostosis, mandible	3.24	5.17	3.62	0.47	8.88	7.33	090
21032		A	Remove exostosis, maxilla	3.24	5.34	3.51	0.46	9.04	7.21	090
21034		A	Excise max/zygoma mlg tumor	16.15	15.92	12.66	1.69	33.76	30.50	090
21040		A	Excise mandible lesion	4.49	6.39	4.72	0.53	11.41	9.74	090
21044		A	Removal of jaw bone lesion	11.84	NA	9.37	1.14	NA	22.35	090
21045		A	Extensive jaw surgery	16.15	NA	12.35	1.53	NA	30.03	090
21046		A	Remove mandible cyst complex	12.98	NA	11.90	1.83	NA	26.71	090
21047		A	Excise lwr jaw cyst w/repair	18.72	NA	13.44	2.10	NA	34.26	090
21048		A	Remove maxilla cyst complex	13.48	NA	12.13	1.75	NA	27.36	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
21049		A	Excis uppr jaw cyst w/repair	17.97	NA	13.02	1.57	NA	32.56	090
21050		A	Removal of jaw joint	10.75	NA	9.44	1.41	NA	21.60	090
21060		A	Remove jaw joint cartilage	10.21	NA	8.61	1.38	NA	20.20	090
21070		A	Remove coronoid process	8.19	NA	7.10	1.26	NA	16.55	090
21076		A	Prepare face/oral prosthesis	13.40	12.35	10.00	1.96	27.71	25.36	010
21077		A	Prepare face/oral prosthesis	33.70	31.33	26.00	4.51	69.54	64.21	090
21079		A	Prepare face/oral prosthesis	22.31	21.50	17.15	3.05	46.86	42.51	090
21080		A	Prepare face/oral prosthesis	25.06	24.49	19.36	3.64	53.19	48.06	090
21081		A	Prepare face/oral prosthesis	22.85	22.30	17.49	3.18	48.33	43.52	090
21082		A	Prepare face/oral prosthesis	20.84	19.34	15.73	3.08	43.26	39.65	090
21083		A	Prepare face/oral prosthesis	19.27	18.79	14.43	2.85	40.91	36.55	090
21084		A	Prepare face/oral prosthesis	22.48	22.43	17.70	2.24	47.15	42.42	090
21085		A	Prepare face/oral prosthesis	8.99	8.29	6.78	1.21	18.49	16.98	010
21086		A	Prepare face/oral prosthesis	24.88	23.74	19.43	3.68	52.30	47.99	090
21087		A	Prepare face/oral prosthesis	24.88	23.28	19.19	3.42	51.58	47.49	090
21088		C	Prepare face/oral prosthesis	0.00	0.00	0.00	0.00	0.00	0.00	090
21089		C	Prepare face/oral prosthesis	0.00	0.00	0.00	0.00	0.00	0.00	090
21100		A	Maxillofacial fixation	4.21	11.53	4.74	0.35	16.09	9.30	090
21110		A	Interdental fixation	5.20	9.56	8.36	0.65	15.41	14.21	090
21116		A	Injection, jaw joint x-ray	0.81	4.33	0.33	0.06	5.20	1.20	000
21120		A	Reconstruction of chin	4.92	10.58	7.49	0.60	16.10	13.01	090
21121		A	Reconstruction of chin	7.63	9.73	7.82	0.90	18.26	16.35	090
21122		A	Reconstruction of chin	8.51	NA	8.62	1.07	NA	18.20	090
21123		A	Reconstruction of chin	11.14	NA	10.80	1.40	NA	23.34	090
21125		A	Augmentation, lower jaw bone	10.60	55.22	8.32	0.77	66.59	19.69	090
21127		A	Augmentation, lower jaw bone	11.10	42.80	9.45	1.52	55.42	22.07	090
21137		A	Reduction of forehead	9.81	NA	7.73	1.32	NA	18.86	090
21138		A	Reduction of forehead	12.17	NA	9.53	1.72	NA	23.42	090
21139		A	Reduction of forehead	14.59	NA	11.06	1.18	NA	26.83	090
21141		A	Reconstruct midface, lefort	18.07	NA	13.65	2.33	NA	34.05	090
21142		A	Reconstruct midface, lefort	18.78	NA	12.82	2.37	NA	33.97	090
21143		A	Reconstruct midface, lefort	19.55	NA	14.31	1.65	NA	35.51	090
21145		A	Reconstruct midface, lefort	19.91	NA	13.90	2.81	NA	36.62	090
21146		A	Reconstruct midface, lefort	20.68	NA	15.33	3.06	NA	39.07	090
21147		A	Reconstruct midface, lefort	21.74	NA	15.05	1.83	NA	38.62	090
21150		A	Reconstruct midface, lefort	25.20	NA	16.76	2.53	NA	44.49	090
21151		A	Reconstruct midface, lefort	28.26	NA	22.95	2.28	NA	53.49	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
21154		A	Reconstruct midface, lefort	30.47	NA	23.12	2.46	NA	56.05	090
21155		A	Reconstruct midface, lefort	34.40	NA	23.89	6.61	NA	64.90	090
21159		A	Reconstruct midface, lefort	42.32	NA	29.08	8.13	NA	79.53	090
21160		A	Reconstruct midface, lefort	46.37	NA	27.47	4.09	NA	77.93	090
21172		A	Reconstruct orbit/forehead	27.76	NA	13.75	3.51	NA	45.02	090
21175		A	Reconstruct orbit/forehead	33.12	NA	17.79	4.79	NA	55.70	090
21179		A	Reconstruct entire forehead	22.22	NA	14.13	2.77	NA	39.12	090
21180		A	Reconstruct entire forehead	25.15	NA	15.38	3.45	NA	43.98	090
21181		A	Contour cranial bone lesion	9.89	NA	7.46	1.32	NA	18.67	090
21182		A	Reconstruct cranial bone	32.14	NA	19.11	2.83	NA	54.08	090
21183		A	Reconstruct cranial bone	35.26	NA	20.83	4.44	NA	60.53	090
21184		A	Reconstruct cranial bone	38.18	NA	21.94	5.65	NA	65.77	090
21188		A	Reconstruction of midface	22.43	NA	18.87	1.67	NA	42.97	090
21193		A	Reconst lwr jaw w/o graft	17.12	NA	12.65	2.20	NA	31.97	090
21194		A	Reconst lwr jaw w/graft	19.81	NA	13.75	2.00	NA	35.56	090
21195		A	Reconst lwr jaw w/o fixation	17.21	NA	14.82	1.62	NA	33.65	090
21196		A	Reconst lwr jaw w/fixation	18.88	NA	15.69	2.06	NA	36.63	090
21198		A	Reconstr lwr jaw segment	14.14	NA	12.70	1.44	NA	28.28	090
21199		A	Reconstr lwr jaw w/advance	15.98	NA	9.11	1.42	NA	26.51	090
21206		A	Reconstruct upper jaw bone	14.08	NA	12.63	1.32	NA	28.03	090
21208		A	Augmentation of facial bones	10.21	22.33	9.58	1.09	33.63	20.88	090
21209		A	Reduction of facial bones	6.71	10.80	8.07	0.88	18.39	15.66	090
21210		A	Face bone graft	10.21	24.87	9.35	1.27	36.35	20.83	090
21215		A	Lower jaw bone graft	10.75	41.88	9.36	1.52	54.15	21.63	090
21230		A	Rib cartilage graft	10.75	NA	8.04	1.28	NA	20.07	090
21235		A	Ear cartilage graft	6.71	9.84	6.41	0.61	17.16	13.73	090
21240		A	Reconstruction of jaw joint	14.03	NA	12.05	2.23	NA	28.31	090
21242		A	Reconstruction of jaw joint	12.93	NA	11.51	1.77	NA	26.21	090
21243		A	Reconstruction of jaw joint	20.76	NA	17.43	3.18	NA	41.37	090
21244		A	Reconstruction of lower jaw	11.84	NA	12.09	1.27	NA	25.20	090
21245		A	Reconstruction of jaw	11.84	14.40	9.85	1.19	27.43	22.88	090
21246		A	Reconstruction of jaw	12.45	NA	9.04	1.34	NA	22.83	090
21247		A	Reconstruct lower jaw bone	22.60	NA	17.35	2.80	NA	42.75	090
21248		A	Reconstruction of jaw	11.46	12.13	9.40	1.54	25.13	22.40	090
21249		A	Reconstruction of jaw	17.49	16.72	12.69	2.46	36.67	32.64	090
21255		A	Reconstruct lower jaw bone	16.69	NA	16.13	2.37	NA	35.19	090
21256		A	Reconstruction of orbit	16.17	NA	11.82	1.64	NA	29.63	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
21260		A	Revise eye sockets	16.50	NA	12.76	0.97	NA	30.23	090
21261		A	Revise eye sockets	31.44	NA	24.23	3.39	NA	59.06	090
21263		A	Revise eye sockets	28.38	NA	19.07	2.61	NA	50.06	090
21267		A	Revise eye sockets	18.87	NA	19.77	1.68	NA	40.32	090
21268		A	Revise eye sockets	24.44	NA	20.21	3.62	NA	48.27	090
21270		A	Augmentation, cheek bone	10.21	11.65	7.25	0.72	22.58	18.18	090
21275		A	Revision, orbitofacial bones	11.22	NA	8.16	1.28	NA	20.66	090
21280		A	Revision of eyelid	6.02	NA	5.92	0.42	NA	12.36	090
21282		A	Revision of eyelid	3.48	NA	4.48	0.26	NA	8.22	090
21295		A	Revision of jaw muscle/bone	1.53	NA	2.53	0.16	NA	4.22	090
21296		A	Revision of jaw muscle/bone	4.24	NA	4.91	0.34	NA	9.49	090
21299		C	Cranio/maxillofacial surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21300		A	Treatment of skull fracture	0.72	2.36	0.26	0.12	3.20	1.10	000
21310		A	Treatment of nose fracture	0.58	2.28	0.15	0.06	2.92	0.79	000
21315		A	Treatment of nose fracture	1.51	4.23	1.88	0.14	5.88	3.53	010
21320		A	Treatment of nose fracture	1.85	3.91	1.62	0.18	5.94	3.65	010
21325		A	Treatment of nose fracture	3.76	NA	8.62	0.31	NA	12.69	090
21330		A	Treatment of nose fracture	5.37	NA	9.70	0.58	NA	15.65	090
21335		A	Treatment of nose fracture	8.60	NA	9.62	0.74	NA	18.96	090
21336		A	Treat nasal septal fracture	5.71	NA	9.61	0.56	NA	15.88	090
21337		A	Treat nasal septal fracture	2.70	6.12	3.57	0.28	9.10	6.55	090
21338		A	Treat nasoethmoid fracture	6.45	NA	14.02	0.79	NA	21.26	090
21339		A	Treat nasoethmoid fracture	8.08	NA	13.90	0.95	NA	22.93	090
21340		A	Treatment of nose fracture	10.75	NA	8.40	1.14	NA	20.29	090
21343		A	Treatment of sinus fracture	12.93	NA	15.47	1.49	NA	29.89	090
21344		A	Treatment of sinus fracture	19.69	NA	16.50	2.34	NA	38.53	090
21345		A	Treat nose/jaw fracture	8.15	9.84	7.17	0.92	18.91	16.24	090
21346		A	Treat nose/jaw fracture	10.59	NA	12.20	1.19	NA	23.98	090
21347		A	Treat nose/jaw fracture	12.67	NA	16.19	1.45	NA	30.31	090
21348		A	Treat nose/jaw fracture	16.66	NA	11.11	2.47	NA	30.24	090
21355		A	Treat cheek bone fracture	3.76	6.23	3.48	0.34	10.33	7.58	010
21356		A	Treat cheek bone fracture	4.14	7.12	4.55	0.46	11.72	9.15	010
21360		A	Treat cheek bone fracture	6.45	NA	5.93	0.72	NA	13.10	090
21365		A	Treat cheek bone fracture	14.93	NA	10.83	1.67	NA	27.43	090
21366		A	Treat cheek bone fracture	17.74	NA	11.33	2.48	NA	31.55	090
21385		A	Treat eye socket fracture	9.15	NA	8.28	0.96	NA	18.39	090
21386		A	Treat eye socket fracture	9.15	NA	7.07	0.98	NA	17.20	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
21387		A	Treat eye socket fracture	9.69	NA	8.95	1.06	NA	19.70	090
21390		A	Treat eye socket fracture	10.11	NA	7.80	0.92	NA	18.83	090
21395		A	Treat eye socket fracture	12.66	NA	9.02	1.46	NA	23.14	090
21400		A	Treat eye socket fracture	1.40	2.61	1.87	0.14	4.15	3.41	090
21401		A	Treat eye socket fracture	3.26	7.99	3.49	0.38	11.63	7.13	090
21406		A	Treat eye socket fracture	7.00	NA	6.08	0.72	NA	13.80	090
21407		A	Treat eye socket fracture	8.60	NA	6.86	0.95	NA	16.41	090
21408		A	Treat eye socket fracture	12.36	NA	8.88	1.43	NA	22.67	090
21421		A	Treat mouth roof fracture	5.13	9.33	8.31	0.69	15.15	14.13	090
21422		A	Treat mouth roof fracture	8.31	NA	8.08	0.99	NA	17.38	090
21423		A	Treat mouth roof fracture	10.38	NA	9.32	1.24	NA	20.94	090
21431		A	Treat craniofacial fracture	7.04	NA	9.52	0.70	NA	17.26	090
21432		A	Treat craniofacial fracture	8.60	NA	8.06	0.81	NA	17.47	090
21433		A	Treat craniofacial fracture	25.31	NA	16.40	2.75	NA	44.46	090
21435		A	Treat craniofacial fracture	17.22	NA	12.70	1.96	NA	31.88	090
21436		A	Treat craniofacial fracture	28.00	NA	18.22	3.06	NA	49.28	090
21440		A	Treat dental ridge fracture	2.70	7.10	6.16	0.37	10.17	9.23	090
21445		A	Treat dental ridge fracture	5.37	9.75	8.37	0.76	15.88	14.50	090
21450		A	Treat lower jaw fracture	2.97	7.38	6.87	0.31	10.66	10.15	090
21451		A	Treat lower jaw fracture	4.86	9.35	8.40	0.60	14.81	13.86	090
21452		A	Treat lower jaw fracture	1.98	13.02	4.61	0.27	15.27	6.86	090
21453		A	Treat lower jaw fracture	5.53	10.74	10.73	0.73	17.00	16.99	090
21454		A	Treat lower jaw fracture	6.45	NA	6.26	0.81	NA	13.52	090
21461		A	Treat lower jaw fracture	8.08	24.46	12.66	0.97	33.51	21.71	090
21462		A	Treat lower jaw fracture	9.78	27.61	12.71	1.25	38.64	23.74	090
21465		A	Treat lower jaw fracture	11.89	NA	9.81	1.49	NA	23.19	090
21470		A	Treat lower jaw fracture	15.32	NA	12.02	1.94	NA	29.28	090
21480		A	Reset dislocated jaw	0.61	1.77	0.19	0.06	2.44	0.86	000
21485		A	Reset dislocated jaw	3.98	8.22	7.66	0.50	12.70	12.14	090
21490		A	Repair dislocated jaw	11.84	NA	9.69	1.94	NA	23.47	090
21493		A	Treat hyoid bone fracture	1.27	NA	0.55	0.12	NA	1.94	090
21494		A	Treat hyoid bone fracture	6.27	NA	3.54	0.57	NA	10.38	090
21495		A	Treat hyoid bone fracture	5.68	NA	8.42	0.46	NA	14.56	090
21497		A	Interdental wiring	3.85	8.45	7.64	0.50	12.80	11.99	090
21499		C	Head surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21501		A	Drain neck/chest lesion	3.80	6.42	3.82	0.44	10.66	8.06	090
21502		A	Drain chest lesion	7.11	NA	5.63	0.98	NA	13.72	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
21510		A	Drainage of bone lesion	5.73	NA	5.66	0.77	NA	12.16	090
21550		A	Biopsy of neck/chest	2.06	3.58	1.72	0.17	5.81	3.95	010
21555		A	Remove lesion, neck/chest	4.34	5.51	3.19	0.54	10.39	8.07	090
21556		A	Remove lesion, neck/chest	5.56	NA	4.10	0.66	NA	10.32	090
21557		A	Remove tumor, neck/chest	8.87	NA	5.35	1.08	NA	15.30	090
21600		A	Partial removal of rib	6.88	NA	5.73	0.96	NA	13.57	090
21610		A	Partial removal of rib	14.59	NA	8.86	2.76	NA	26.21	090
21615		A	Removal of rib	9.86	NA	6.68	1.44	NA	17.98	090
21616		A	Removal of rib and nerves	12.02	NA	8.02	1.85	NA	21.89	090
21620		A	Partial removal of sternum	6.78	NA	5.97	0.96	NA	13.71	090
21627		A	Sternal debridement	6.80	NA	6.30	0.99	NA	14.09	090
21630		A	Extensive sternum surgery	17.35	NA	11.84	2.52	NA	31.71	090
21632		A	Extensive sternum surgery	18.11	NA	11.11	2.56	NA	31.78	090
21685		A	Hyoid myotomy & suspension	12.98	NA	9.97	1.06	NA	24.01	090
21700		A	Revision of neck muscle	6.18	NA	4.44	0.45	NA	11.07	090
21705		A	Revision of neck muscle/rib	9.59	NA	5.58	1.43	NA	16.60	090
21720		A	Revision of neck muscle	5.67	2.46	2.46	0.88	9.01	9.01	090
21725		A	Revision of neck muscle	6.98	NA	5.44	1.20	NA	13.62	090
21740		A	Reconstruction of sternum	16.48	NA	8.52	2.35	NA	27.35	090
21742		C	Repair stern/nuss w/o scope	0.00	0.00	0.00	0.00	0.00	0.00	090
21743		C	Repair sternum/nuss w/scope	0.00	0.00	0.00	0.00	0.00	0.00	090
21750		A	Repair of sternum separation	10.75	NA	6.11	1.55	NA	18.41	090
21800		A	Treatment of rib fracture	0.96	NA	1.34	0.09	NA	2.39	090
21805		A	Treatment of rib fracture	2.75	NA	3.20	0.38	NA	6.33	090
21810		A	Treatment of rib fracture(s)	6.85	NA	4.97	0.94	NA	12.76	090
21820		A	Treat sternum fracture	1.28	1.82	1.76	0.15	3.25	3.19	090
21825		A	Treat sternum fracture	7.40	NA	6.39	1.07	NA	14.86	090
21899		C	Neck/chest surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21920		A	Biopsy soft tissue of back	2.06	3.28	1.47	0.15	5.49	3.68	010
21925		A	Biopsy soft tissue of back	4.48	5.17	3.24	0.59	10.24	8.31	090
21930		A	Remove lesion, back or flank	4.99	5.71	3.40	0.64	11.34	9.03	090
21935		A	Remove tumor, back	17.93	NA	9.62	2.39	NA	29.94	090
22100		A	Remove part of neck vertebra	9.72	NA	7.53	2.07	NA	19.32	090
22101		A	Remove part, thorax vertebra	9.80	NA	7.75	1.69	NA	19.24	090
22102		A	Remove part, lumbar vertebra	9.80	NA	8.11	1.68	NA	19.59	090
22103		A	Remove extra spine segment	2.34	NA	1.21	0.41	NA	3.96	ZZZ
22110		A	Remove part of neck vertebra	12.72	NA	9.16	2.70	NA	24.58	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
22112		A	Remove part, thorax vertebra	12.79	NA	9.27	2.44	NA	24.50	090
22114		A	Remove part, lumbar vertebra	12.79	NA	9.25	2.49	NA	24.53	090
22116		A	Remove extra spine segment	2.32	NA	1.17	0.47	NA	3.96	ZZZ
22210		A	Revision of neck spine	23.78	NA	15.41	5.35	NA	44.54	090
22212		A	Revision of thorax spine	19.39	NA	13.27	3.73	NA	36.39	090
22214		A	Revision of lumbar spine	19.42	NA	13.81	3.82	NA	37.05	090
22216		A	Revise, extra spine segment	6.03	NA	3.13	1.28	NA	10.44	ZZZ
22220		A	Revision of neck spine	21.34	NA	13.62	5.02	NA	39.98	090
22222		A	Revision of thorax spine	21.49	NA	11.13	3.43	NA	36.05	090
22224		A	Revision of lumbar spine	21.49	NA	14.22	4.04	NA	39.75	090
22226		A	Revise, extra spine segment	6.03	NA	3.09	1.23	NA	10.35	ZZZ
22305		A	Treat spine process fracture	2.05	2.31	1.92	0.35	4.71	4.32	090
22310		A	Treat spine fracture	2.61	2.80	2.35	0.48	5.89	5.44	090
22315		A	Treat spine fracture	8.83	9.68	7.33	1.79	20.30	17.95	090
22318		A	Treat odontoid fx w/o graft	21.47	NA	13.38	5.14	NA	39.99	090
22319		A	Treat odontoid fx w/graft	23.96	NA	14.71	5.93	NA	44.60	090
22325		A	Treat spine fracture	18.27	NA	12.07	3.76	NA	34.10	090
22326		A	Treat neck spine fracture	19.56	NA	12.70	4.25	NA	36.51	090
22327		A	Treat thorax spine fracture	19.17	NA	12.36	3.88	NA	35.41	090
22328		A	Treat each add spine fx	4.60	NA	2.26	0.93	NA	7.79	ZZZ
22505		A	Manipulation of spine	1.87	NA	0.94	0.30	NA	3.11	010
22520		A	Percut vertebroplasty thor	8.90	61.66	5.10	1.42	71.98	15.42	010
22521		A	Percut vertebroplasty lumb	8.33	55.97	4.95	1.33	65.63	14.61	010
22522		A	Percut vertebroplasty add'l	4.30	NA	1.68	0.69	NA	6.67	ZZZ
22532		A	Lat thorax spine fusion	23.96	NA	14.82	4.07	NA	42.85	090
22533		A	Lat lumbar spine fusion	23.09	NA	13.59	2.93	NA	39.61	090
22534		A	Lat thor/lumb, add'l seg	5.99	NA	3.03	1.18	NA	10.20	ZZZ
22548		A	Neck spine fusion	25.78	NA	15.80	5.54	NA	47.12	090
22554		A	Neck spine fusion	18.59	NA	12.34	4.33	NA	35.26	090
22556		A	Thorax spine fusion	23.42	NA	14.73	4.07	NA	42.22	090
22558		A	Lumbar spine fusion	22.25	NA	13.29	2.93	NA	38.47	090
22585		A	Additional spinal fusion	5.52	NA	2.79	1.18	NA	9.49	ZZZ
22590		A	Spine & skull spinal fusion	20.48	NA	13.32	4.63	NA	38.43	090
22595		A	Neck spinal fusion	19.36	NA	12.83	4.27	NA	36.46	090
22600		A	Neck spine fusion	16.12	NA	11.19	3.63	NA	30.94	090
22610		A	Thorax spine fusion	16.00	NA	11.41	3.43	NA	30.84	090
22612		A	Lumbar spine fusion	20.97	NA	14.20	4.36	NA	39.53	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
22614		A	Spine fusion, extra segment	6.43	NA	3.35	1.36	NA	11.14	ZZZ
22630		A	Lumbar spine fusion	20.81	NA	13.60	4.59	NA	39.00	090
22632		A	Spine fusion, extra segment	5.22	NA	2.66	1.14	NA	9.02	ZZZ
22800		A	Fusion of spine	18.22	NA	12.77	3.65	NA	34.64	090
22802		A	Fusion of spine	30.83	NA	19.59	6.08	NA	56.50	090
22804		A	Fusion of spine	36.22	NA	22.69	6.91	NA	65.82	090
22808		A	Fusion of spine	26.23	NA	16.30	4.78	NA	47.31	090
22810		A	Fusion of spine	30.22	NA	18.36	4.77	NA	53.35	090
22812		A	Fusion of spine	32.65	NA	20.06	5.25	NA	57.96	090
22818		A	Kyphectomy, 1-2 segments	31.78	NA	18.87	6.29	NA	56.94	090
22819		A	Kyphectomy, 3 or more	36.39	NA	20.05	7.59	NA	64.03	090
22830		A	Exploration of spinal fusion	10.83	NA	7.96	2.24	NA	21.03	090
22840		A	Insert spine fixation device	12.52	NA	6.49	2.71	NA	21.72	ZZZ
22841		B	Insert spine fixation device	0.00	0.00	0.00	0.00	0.00	0.00	XXX
22842		A	Insert spine fixation device	12.56	NA	6.50	2.65	NA	21.71	ZZZ
22843		A	Insert spine fixation device	13.44	NA	6.60	2.79	NA	22.83	ZZZ
22844		A	Insert spine fixation device	16.42	NA	8.75	3.13	NA	28.30	ZZZ
22845		A	Insert spine fixation device	11.94	NA	6.07	2.76	NA	20.77	ZZZ
22846		A	Insert spine fixation device	12.40	NA	6.33	2.87	NA	21.60	ZZZ
22847		A	Insert spine fixation device	13.78	NA	7.02	2.96	NA	23.76	ZZZ
22848		A	Insert pelv fixation device	5.99	NA	3.18	1.14	NA	10.31	ZZZ
22849		A	Reinsert spinal fixation	18.48	NA	11.73	3.80	NA	34.01	090
22850		A	Remove spine fixation device	9.51	NA	6.99	2.00	NA	18.50	090
22851		A	Apply spine prosth device	6.70	NA	3.36	1.46	NA	11.52	ZZZ
22852		A	Remove spine fixation device	9.00	NA	6.79	1.85	NA	17.64	090
22855		A	Remove spine fixation device	15.11	NA	9.66	3.40	NA	28.17	090
22899		C	Spine surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
22900		A	Remove abdominal wall lesion	5.79	NA	3.22	0.75	NA	9.76	090
22999		C	Abdomen surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
23000		A	Removal of calcium deposits	4.35	8.53	4.42	0.65	13.53	9.42	090
23020		A	Release shoulder joint	8.92	NA	7.56	1.52	NA	18.00	090
23030		A	Drain shoulder lesion	3.42	7.39	2.90	0.53	11.34	6.85	010
23031		A	Drain shoulder bursa	2.74	7.86	2.72	0.44	11.04	5.90	010
23035		A	Drain shoulder bone lesion	8.60	NA	8.27	1.44	NA	18.31	090
23040		A	Exploratory shoulder surgery	9.19	NA	7.86	1.56	NA	18.61	090
23044		A	Exploratory shoulder surgery	7.11	NA	6.43	1.20	NA	14.74	090
23065		A	Biopsy shoulder tissues	2.27	2.48	1.62	0.20	4.95	4.09	010

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
23066		A	Biopsy shoulder tissues	4.15	7.67	3.98	0.61	12.43	8.74	090
23075		A	Removal of shoulder lesion	2.39	3.66	1.78	0.32	6.37	4.49	010
23076		A	Removal of shoulder lesion	7.62	NA	5.55	1.10	NA	14.27	090
23077		A	Remove tumor of shoulder	16.07	NA	10.21	2.28	NA	28.56	090
23100		A	Biopsy of shoulder joint	6.02	NA	5.65	1.03	NA	12.70	090
23101		A	Shoulder joint surgery	5.57	NA	5.33	0.94	NA	11.84	090
23105		A	Remove shoulder joint lining	8.22	NA	7.12	1.40	NA	16.74	090
23106		A	Incision of collarbone joint	5.95	NA	5.70	0.97	NA	12.62	090
23107		A	Explore treat shoulder joint	8.61	NA	7.39	1.47	NA	17.47	090
23120		A	Partial removal, collar bone	7.10	NA	6.46	1.21	NA	14.77	090
23125		A	Removal of collar bone	9.38	NA	7.56	1.59	NA	18.53	090
23130		A	Remove shoulder bone, part	7.54	NA	7.13	1.29	NA	15.96	090
23140		A	Removal of bone lesion	6.88	NA	5.22	1.04	NA	13.14	090
23145		A	Removal of bone lesion	9.08	NA	7.44	1.49	NA	18.01	090
23146		A	Removal of bone lesion	7.82	NA	7.11	1.35	NA	16.28	090
23150		A	Removal of humerus lesion	8.47	NA	6.92	1.27	NA	16.66	090
23155		A	Removal of humerus lesion	10.33	NA	8.33	1.78	NA	20.44	090
23156		A	Removal of humerus lesion	8.67	NA	7.38	1.49	NA	17.54	090
23170		A	Remove collar bone lesion	6.85	NA	6.02	1.05	NA	13.92	090
23172		A	Remove shoulder blade lesion	6.89	NA	6.28	1.01	NA	14.18	090
23174		A	Remove humerus lesion	9.50	NA	8.36	1.63	NA	19.49	090
23180		A	Remove collar bone lesion	8.52	NA	8.99	1.44	NA	18.95	090
23182		A	Remove shoulder blade lesion	8.14	NA	8.55	1.31	NA	18.00	090
23184		A	Remove humerus lesion	9.37	NA	9.31	1.59	NA	20.27	090
23190		A	Partial removal of scapula	7.23	NA	6.17	1.17	NA	14.57	090
23195		A	Removal of head of humerus	9.80	NA	7.73	1.68	NA	19.21	090
23200		A	Removal of collar bone	12.06	NA	8.72	1.78	NA	22.56	090
23210		A	Removal of shoulder blade	12.47	NA	8.99	1.97	NA	23.43	090
23220		A	Partial removal of humerus	14.54	NA	10.82	2.43	NA	27.79	090
23221		A	Partial removal of humerus	17.71	NA	11.72	3.03	NA	32.46	090
23222		A	Partial removal of humerus	23.88	NA	15.78	3.91	NA	43.57	090
23330		A	Remove shoulder foreign body	1.85	3.68	1.88	0.23	5.76	3.96	010
23331		A	Remove shoulder foreign body	7.37	NA	6.79	1.24	NA	15.40	090
23332		A	Remove shoulder foreign body	11.60	NA	9.32	1.97	NA	22.89	090
23350		A	Injection for shoulder x-ray	1.00	3.46	0.33	0.06	4.52	1.39	000
23395		A	Muscle transfer,shoulder/arm	16.82	NA	12.86	2.80	NA	32.48	090
23397		A	Muscle transfers	16.11	NA	11.37	2.65	NA	30.13	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
23400		A	Fixation of shoulder blade	13.52	NA	10.07	2.27	NA	25.86	090
23405		A	Incision of tendon & muscle	8.36	NA	6.92	1.42	NA	16.70	090
23406		A	Incise tendon(s) & muscle(s)	10.77	NA	8.34	1.82	NA	20.93	090
23410		A	Repair rotator cuff, acute	12.43	NA	9.40	2.11	NA	23.94	090
23412		A	Repair rotator cuff, chronic	13.29	NA	9.89	2.26	NA	25.44	090
23415		A	Release of shoulder ligament	9.96	NA	7.99	1.70	NA	19.65	090
23420		A	Repair of shoulder	13.28	NA	10.84	2.27	NA	26.39	090
23430		A	Repair biceps tendon	9.97	NA	8.10	1.70	NA	19.77	090
23440		A	Remove/transplant tendon	10.46	NA	8.26	1.79	NA	20.51	090
23450		A	Repair shoulder capsule	13.38	NA	9.84	2.29	NA	25.51	090
23455		A	Repair shoulder capsule	14.35	NA	10.44	2.45	NA	27.24	090
23460		A	Repair shoulder capsule	15.35	NA	11.37	2.63	NA	29.35	090
23462		A	Repair shoulder capsule	15.28	NA	10.75	2.57	NA	28.60	090
23465		A	Repair shoulder capsule	15.83	NA	11.18	2.71	NA	29.72	090
23466		A	Repair shoulder capsule	14.20	NA	11.37	2.42	NA	27.99	090
23470		A	Reconstruct shoulder joint	17.12	NA	12.25	2.92	NA	32.29	090
23472		A	Reconstruct shoulder joint	21.07	NA	14.41	3.59	NA	39.07	090
23480		A	Revision of collar bone	11.16	NA	8.77	1.92	NA	21.85	090
23485		A	Revision of collar bone	13.41	NA	9.89	2.30	NA	25.60	090
23490		A	Reinforce clavicle	11.84	NA	8.69	1.46	NA	21.99	090
23491		A	Reinforce shoulder bones	14.19	NA	10.71	2.45	NA	27.35	090
23500		A	Treat clavicle fracture	2.08	2.87	2.52	0.29	5.24	4.89	090
23505		A	Treat clavicle fracture	3.68	4.41	3.84	0.59	8.68	8.11	090
23515		A	Treat clavicle fracture	7.40	NA	6.55	1.27	NA	15.22	090
23520		A	Treat clavicle dislocation	2.16	2.85	2.74	0.32	5.33	5.22	090
23525		A	Treat clavicle dislocation	3.59	4.54	3.94	0.44	8.57	7.97	090
23530		A	Treat clavicle dislocation	7.30	NA	5.93	1.20	NA	14.43	090
23532		A	Treat clavicle dislocation	8.00	NA	6.97	1.38	NA	16.35	090
23540		A	Treat clavicle dislocation	2.23	2.86	2.36	0.27	5.36	4.86	090
23545		A	Treat clavicle dislocation	3.25	4.19	3.36	0.34	7.78	6.95	090
23550		A	Treat clavicle dislocation	7.23	NA	6.37	1.22	NA	14.82	090
23552		A	Treat clavicle dislocation	8.44	NA	7.32	1.45	NA	17.21	090
23570		A	Treat shoulder blade fx	2.23	3.01	2.89	0.35	5.59	5.47	090
23575		A	Treat shoulder blade fx	4.05	4.88	4.31	0.56	9.49	8.92	090
23585		A	Treat scapula fracture	8.95	NA	7.64	1.53	NA	18.12	090
23600		A	Treat humerus fracture	2.93	4.55	3.55	0.46	7.94	6.94	090
23605		A	Treat humerus fracture	4.86	6.15	5.11	0.80	11.81	10.77	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
23615		A	Treat humerus fracture	9.34	NA	8.83	1.60	NA	19.77	090
23616		A	Treat humerus fracture	21.24	NA	14.14	3.63	NA	39.01	090
23620		A	Treat humerus fracture	2.40	3.61	2.98	0.38	6.39	5.76	090
23625		A	Treat humerus fracture	3.92	4.94	4.28	0.62	9.48	8.82	090
23630		A	Treat humerus fracture	7.34	NA	6.63	1.25	NA	15.22	090
23650		A	Treat shoulder dislocation	3.38	3.77	2.76	0.30	7.45	6.44	090
23655		A	Treat shoulder dislocation	4.56	NA	4.17	0.65	NA	9.38	090
23660		A	Treat shoulder dislocation	7.48	NA	6.38	1.27	NA	15.13	090
23665		A	Treat dislocation/fracture	4.46	5.33	4.72	0.69	10.48	9.87	090
23670		A	Treat dislocation/fracture	7.89	NA	6.83	1.34	NA	16.06	090
23675		A	Treat dislocation/fracture	6.04	6.63	5.83	0.96	13.83	12.83	090
23680		A	Treat dislocation/fracture	10.04	NA	8.11	1.70	NA	19.85	090
23700		A	Fixation of shoulder	2.52	NA	2.17	0.43	NA	5.12	010
23800		A	Fusion of shoulder joint	14.14	NA	10.41	2.24	NA	26.79	090
23802		A	Fusion of shoulder joint	16.58	NA	10.17	2.68	NA	29.43	090
23900		A	Amputation of arm & girdle	19.69	NA	11.71	3.11	NA	34.51	090
23920		A	Amputation at shoulder joint	14.59	NA	9.92	2.35	NA	26.86	090
23921		A	Amputation follow-up surgery	5.48	NA	5.08	0.77	NA	11.33	090
23929		C	Shoulder surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
23930		A	Drainage of arm lesion	2.94	6.32	2.31	0.41	9.67	5.66	010
23931		A	Drainage of arm bursa	1.79	5.91	2.17	0.26	7.96	4.22	010
23935		A	Drain arm/elbow bone lesion	6.08	NA	5.91	1.02	NA	13.01	090
24000		A	Exploratory elbow surgery	5.81	NA	5.41	0.95	NA	12.17	090
24006		A	Release elbow joint	9.30	NA	7.75	1.48	NA	18.53	090
24065		A	Biopsy arm/elbow soft tissue	2.08	3.21	1.74	0.17	5.46	3.99	010
24066		A	Biopsy arm/elbow soft tissue	5.20	8.93	4.13	0.76	14.89	10.09	090
24075		A	Remove arm/elbow lesion	3.91	7.35	3.40	0.54	11.80	7.85	090
24076		A	Remove arm/elbow lesion	6.29	NA	4.86	0.92	NA	12.07	090
24077		A	Remove tumor of arm/elbow	11.74	NA	7.74	1.65	NA	21.13	090
24100		A	Biopsy elbow joint lining	4.92	NA	4.52	0.78	NA	10.22	090
24101		A	Explore/treat elbow joint	6.12	NA	5.93	1.03	NA	13.08	090
24102		A	Remove elbow joint lining	8.02	NA	6.86	1.28	NA	16.16	090
24105		A	Removal of elbow bursa	3.60	NA	4.39	0.60	NA	8.59	090
24110		A	Remove humerus lesion	7.38	NA	6.66	1.24	NA	15.28	090
24115		A	Remove/graft bone lesion	9.62	NA	7.21	1.66	NA	18.49	090
24116		A	Remove/graft bone lesion	11.79	NA	9.07	2.03	NA	22.89	090
24120		A	Remove elbow lesion	6.64	NA	5.92	1.09	NA	13.65	090

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CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
24125		A	Remove/graft bone lesion	7.88	NA	6.16	1.06	NA	15.10	090
24126		A	Remove/graft bone lesion	8.30	NA	7.02	1.16	NA	16.48	090
24130		A	Removal of head of radius	6.24	NA	6.02	1.03	NA	13.29	090
24134		A	Removal of arm bone lesion	9.72	NA	8.85	1.62	NA	20.19	090
24136		A	Remove radius bone lesion	7.98	NA	7.22	1.38	NA	16.58	090
24138		A	Remove elbow bone lesion	8.04	NA	7.78	1.32	NA	17.14	090
24140		A	Partial removal of arm bone	9.17	NA	9.10	1.50	NA	19.77	090
24145		A	Partial removal of radius	7.57	NA	8.06	1.23	NA	16.86	090
24147		A	Partial removal of elbow	7.53	NA	8.60	1.27	NA	17.40	090
24149		A	Radical resection of elbow	14.18	NA	11.62	2.30	NA	28.10	090
24150		A	Extensive humerus surgery	13.25	NA	9.99	2.25	NA	25.49	090
24151		A	Extensive humerus surgery	15.56	NA	11.51	2.58	NA	29.65	090
24152		A	Extensive radius surgery	10.04	NA	7.73	1.48	NA	19.25	090
24153		A	Extensive radius surgery	11.52	NA	5.57	0.74	NA	17.83	090
24155		A	Removal of elbow joint	11.71	NA	8.40	1.90	NA	22.01	090
24160		A	Remove elbow joint implant	7.82	NA	6.89	1.27	NA	15.98	090
24164		A	Remove radius head implant	6.22	NA	5.77	1.02	NA	13.01	090
24200		A	Removal of arm foreign body	1.76	3.41	1.63	0.19	5.36	3.58	010
24201		A	Removal of arm foreign body	4.55	9.81	4.23	0.66	15.02	9.44	090
24220		A	Injection for elbow x-ray	1.31	3.63	0.44	0.09	5.03	1.84	000
24300		A	Manipulate elbow w/anesth	3.74	NA	5.71	0.62	NA	10.07	090
24301		A	Muscle/tendon transfer	10.18	NA	8.18	1.58	NA	19.94	090
24305		A	Arm tendon lengthening	7.44	NA	6.71	1.13	NA	15.28	090
24310		A	Revision of arm tendon	5.97	NA	5.58	0.94	NA	12.49	090
24320		A	Repair of arm tendon	10.54	NA	7.53	1.72	NA	19.79	090
24330		A	Revision of arm muscles	9.59	NA	7.88	1.58	NA	19.05	090
24331		A	Revision of arm muscles	10.63	NA	8.67	1.76	NA	21.06	090
24332		A	Tenolysis, triceps	7.44	NA	6.77	1.23	NA	15.44	090
24340		A	Repair of biceps tendon	7.88	NA	6.98	1.33	NA	16.19	090
24341		A	Repair arm tendon/muscle	7.89	NA	7.92	1.33	NA	17.14	090
24342		A	Repair of ruptured tendon	10.60	NA	8.52	1.78	NA	20.90	090
24343		A	Repr elbow lat ligmnt w/tiss	8.64	NA	8.15	1.40	NA	18.19	090
24344		A	Reconstruct elbow lat ligmnt	13.98	NA	11.52	2.33	NA	27.83	090
24345		A	Repr elbw med ligmnt w/tissu	8.64	NA	8.02	1.39	NA	18.05	090
24346		A	Reconstruct elbow med ligmnt	13.98	NA	11.34	2.31	NA	27.63	090
24350		A	Repair of tennis elbow	5.24	NA	5.58	0.86	NA	11.68	090
24351		A	Repair of tennis elbow	5.90	NA	5.92	1.00	NA	12.82	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
24352		A	Repair of tennis elbow	6.42	NA	6.18	1.10	NA	13.70	090
24354		A	Repair of tennis elbow	6.47	NA	6.15	1.07	NA	13.69	090
24356		A	Revision of tennis elbow	6.67	NA	6.31	1.09	NA	14.07	090
24360		A	Reconstruct elbow joint	12.32	NA	9.47	2.01	NA	23.80	090
24361		A	Reconstruct elbow joint	14.06	NA	10.58	2.16	NA	26.80	090
24362		A	Reconstruct elbow joint	14.97	NA	10.04	2.58	NA	27.59	090
24363		A	Replace elbow joint	18.46	NA	13.71	2.96	NA	35.13	090
24365		A	Reconstruct head of radius	8.38	NA	7.20	1.41	NA	16.99	090
24366		A	Reconstruct head of radius	9.12	NA	7.54	1.51	NA	18.17	090
24400		A	Revision of humerus	11.04	NA	8.85	1.86	NA	21.75	090
24410		A	Revision of humerus	14.80	NA	10.31	2.55	NA	27.66	090
24420		A	Revision of humerus	13.42	NA	10.54	2.15	NA	26.11	090
24430		A	Repair of humerus	12.79	NA	9.74	2.17	NA	24.70	090
24435		A	Repair humerus with graft	13.15	NA	10.88	2.22	NA	26.25	090
24470		A	Revision of elbow joint	8.73	NA	7.72	1.48	NA	17.93	090
24495		A	Decompression of forearm	8.11	NA	8.74	1.16	NA	18.01	090
24498		A	Reinforce humerus	11.90	NA	9.26	2.02	NA	23.18	090
24500		A	Treat humerus fracture	3.21	4.85	3.68	0.48	8.54	7.37	090
24505		A	Treat humerus fracture	5.16	6.60	5.39	0.85	12.61	11.40	090
24515		A	Treat humerus fracture	11.63	NA	9.38	1.98	NA	22.99	090
24516		A	Treat humerus fracture	11.63	NA	9.11	1.99	NA	22.73	090
24530		A	Treat humerus fracture	3.49	5.20	4.04	0.55	9.24	8.08	090
24535		A	Treat humerus fracture	6.86	7.84	6.62	1.15	15.85	14.63	090
24538		A	Treat humerus fracture	9.42	NA	8.70	1.57	NA	19.69	090
24545		A	Treat humerus fracture	10.44	NA	8.45	1.79	NA	20.68	090
24546		A	Treat humerus fracture	15.67	NA	11.32	2.67	NA	29.66	090
24560		A	Treat humerus fracture	2.80	4.48	3.19	0.41	7.69	6.40	090
24565		A	Treat humerus fracture	5.55	6.61	5.52	0.90	13.06	11.97	090
24566		A	Treat humerus fracture	7.78	NA	8.16	1.29	NA	17.23	090
24575		A	Treat humerus fracture	10.64	NA	8.40	1.82	NA	20.86	090
24576		A	Treat humerus fracture	2.86	4.76	3.71	0.44	8.06	7.01	090
24577		A	Treat humerus fracture	5.78	6.93	5.84	0.94	13.65	12.56	090
24579		A	Treat humerus fracture	11.58	NA	8.83	1.98	NA	22.39	090
24582		A	Treat humerus fracture	8.54	NA	9.11	1.47	NA	19.12	090
24586		A	Treat elbow fracture	15.19	NA	11.23	2.58	NA	29.00	090
24587		A	Treat elbow fracture	15.14	NA	11.02	2.50	NA	28.66	090
24600		A	Treat elbow dislocation	4.22	4.86	3.50	0.47	9.55	8.19	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
24605		A	Treat elbow dislocation	5.41	NA	5.36	0.87	NA	11.64	090
24615		A	Treat elbow dislocation	9.41	NA	7.82	1.58	NA	18.81	090
24620		A	Treat elbow fracture	6.97	NA	6.25	1.03	NA	14.25	090
24635		A	Treat elbow fracture	13.17	NA	14.05	2.25	NA	29.47	090
24640		A	Treat elbow dislocation	1.20	1.84	0.80	0.12	3.16	2.12	010
24650		A	Treat radius fracture	2.16	3.78	2.75	0.33	6.27	5.24	090
24655		A	Treat radius fracture	4.39	5.95	4.79	0.68	11.02	9.86	090
24665		A	Treat radius fracture	8.13	NA	7.51	1.38	NA	17.02	090
24666		A	Treat radius fracture	9.48	NA	8.07	1.59	NA	19.14	090
24670		A	Treat ulnar fracture	2.54	4.11	3.07	0.39	7.04	6.00	090
24675		A	Treat ulnar fracture	4.71	6.00	4.97	0.77	11.48	10.45	090
24685		A	Treat ulnar fracture	8.79	NA	7.52	1.50	NA	17.81	090
24800		A	Fusion of elbow joint	11.18	NA	8.74	1.62	NA	21.54	090
24802		A	Fusion/graft of elbow joint	13.67	NA	10.38	2.26	NA	26.31	090
24900		A	Amputation of upper arm	9.59	NA	7.06	1.49	NA	18.14	090
24920		A	Amputation of upper arm	9.53	NA	6.94	1.58	NA	18.05	090
24925		A	Amputation follow-up surgery	7.06	NA	6.08	1.14	NA	14.28	090
24930		A	Amputation follow-up surgery	10.23	NA	7.24	1.62	NA	19.09	090
24931		A	Amputate upper arm & implant	12.70	NA	5.72	1.88	NA	20.30	090
24935		A	Revision of amputation	15.54	NA	8.02	2.12	NA	25.68	090
24940		C	Revision of upper arm	0.00	0.00	0.00	0.00	0.00	0.00	090
24999		C	Upper arm/elbow surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
25000		A	Incision of tendon sheath	3.37	NA	6.87	0.53	NA	10.77	090
25001		A	Incise flexor carpi radialis	3.37	NA	4.23	0.52	NA	8.12	090
25020		A	Decompress forearm 1 space	5.91	NA	9.56	0.93	NA	16.40	090
25023		A	Decompress forearm 1 space	12.94	NA	14.94	1.96	NA	29.84	090
25024		A	Decompress forearm 2 spaces	9.49	NA	7.47	1.31	NA	18.27	090
25025		A	Decompress forearm 2 spaces	16.52	NA	9.97	1.72	NA	28.21	090
25028		A	Drainage of forearm lesion	5.24	NA	8.16	0.77	NA	14.17	090
25031		A	Drainage of forearm bursa	4.13	NA	7.92	0.60	NA	12.65	090
25035		A	Treat forearm bone lesion	7.35	NA	13.59	1.20	NA	22.14	090
25040		A	Explore/treat wrist joint	7.17	NA	7.30	1.13	NA	15.60	090
25065		A	Biopsy forearm soft tissues	1.99	3.22	1.90	0.16	5.37	4.05	010
25066		A	Biopsy forearm soft tissues	4.12	NA	7.06	0.62	NA	11.80	090
25075		A	Removal forearm lesion subcu	3.73	NA	5.89	0.51	NA	10.13	090
25076		A	Removal forearm lesion deep	4.91	NA	9.54	0.73	NA	15.18	090
25077		A	Remove tumor, forearm/wrist	9.75	NA	12.08	1.36	NA	23.19	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
25085		A	Incision of wrist capsule	5.49	NA	7.12	0.83	NA	13.44	090
25100		A	Biopsy of wrist joint	3.89	NA	5.27	0.58	NA	9.74	090
25101		A	Explore/treat wrist joint	4.68	NA	5.89	0.75	NA	11.32	090
25105		A	Remove wrist joint lining	5.84	NA	7.30	0.91	NA	14.05	090
25107		A	Remove wrist joint cartilage	6.42	NA	8.34	0.98	NA	15.74	090
25110		A	Remove wrist tendon lesion	3.91	NA	7.05	0.61	NA	11.57	090
25111		A	Remove wrist tendon lesion	3.38	NA	4.70	0.52	NA	8.60	090
25112		A	Reremove wrist tendon lesion	4.52	NA	5.25	0.70	NA	10.47	090
25115		A	Remove wrist/forearm lesion	8.81	NA	14.03	1.30	NA	24.14	090
25116		A	Remove wrist/forearm lesion	7.10	NA	13.14	1.10	NA	21.34	090
25118		A	Excise wrist tendon sheath	4.36	NA	5.74	0.68	NA	10.78	090
25119		A	Partial removal of ulna	6.03	NA	7.60	0.93	NA	14.56	090
25120		A	Removal of forearm lesion	6.09	NA	12.08	0.98	NA	19.15	090
25125		A	Remove/graft forearm lesion	7.47	NA	12.84	1.06	NA	21.37	090
25126		A	Remove/graft forearm lesion	7.54	NA	13.01	1.27	NA	21.82	090
25130		A	Removal of wrist lesion	5.25	NA	6.42	0.80	NA	12.47	090
25135		A	Remove & graft wrist lesion	6.88	NA	7.51	0.99	NA	15.38	090
25136		A	Remove & graft wrist lesion	5.96	NA	6.59	1.03	NA	13.58	090
25145		A	Remove forearm bone lesion	6.36	NA	12.06	1.00	NA	19.42	090
25150		A	Partial removal of ulna	7.08	NA	8.21	1.15	NA	16.44	090
25151		A	Partial removal of radius	7.38	NA	12.72	1.18	NA	21.28	090
25170		A	Extensive forearm surgery	11.07	NA	15.15	1.69	NA	27.91	090
25210		A	Removal of wrist bone	5.94	NA	6.79	0.87	NA	13.60	090
25215		A	Removal of wrist bones	7.88	NA	8.75	1.19	NA	17.82	090
25230		A	Partial removal of radius	5.22	NA	6.14	0.78	NA	12.14	090
25240		A	Partial removal of ulna	5.16	NA	6.95	0.80	NA	12.91	090
25246		A	Injection for wrist x-ray	1.45	3.44	0.48	0.09	4.98	2.02	000
25248		A	Remove forearm foreign body	5.13	NA	8.52	0.69	NA	14.34	090
25250		A	Removal of wrist prosthesis	6.59	NA	6.10	0.98	NA	13.67	090
25251		A	Removal of wrist prosthesis	9.56	NA	7.92	1.25	NA	18.73	090
25259		A	Manipulate wrist w/anesthes	3.74	NA	5.72	0.60	NA	10.06	090
25260		A	Repair forearm tendon/muscle	7.79	NA	13.31	1.17	NA	22.27	090
25263		A	Repair forearm tendon/muscle	7.81	NA	13.26	1.14	NA	22.21	090
25265		A	Repair forearm tendon/muscle	9.87	NA	14.31	1.47	NA	25.65	090
25270		A	Repair forearm tendon/muscle	5.99	NA	12.03	0.93	NA	18.95	090
25272		A	Repair forearm tendon/muscle	7.03	NA	12.79	1.09	NA	20.91	090
25274		A	Repair forearm tendon/muscle	8.74	NA	13.62	1.34	NA	23.70	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
25275		A	Repair forearm tendon sheath	8.49	NA	7.58	1.31	NA	17.38	090
25280		A	Revise wrist/forearm tendon	7.21	NA	12.63	1.06	NA	20.90	090
25290		A	Incise wrist/forearm tendon	5.28	NA	14.99	0.81	NA	21.08	090
25295		A	Release wrist/forearm tendon	6.54	NA	12.15	1.00	NA	19.69	090
25300		A	Fusion of tendons at wrist	8.79	NA	8.45	1.26	NA	18.50	090
25301		A	Fusion of tendons at wrist	8.39	NA	8.06	1.27	NA	17.72	090
25310		A	Transplant forearm tendon	8.13	NA	13.03	1.21	NA	22.37	090
25312		A	Transplant forearm tendon	9.56	NA	13.94	1.41	NA	24.91	090
25315		A	Revise palsy hand tendon(s)	10.18	NA	14.40	1.56	NA	26.14	090
25316		A	Revise palsy hand tendon(s)	12.31	NA	16.22	1.73	NA	30.26	090
25320		A	Repair/revise wrist joint	10.75	NA	11.39	1.58	NA	23.72	090
25332		A	Revise wrist joint	11.39	NA	9.17	1.81	NA	22.37	090
25335		A	Realignment of hand	12.86	NA	11.59	1.90	NA	26.35	090
25337		A	Reconstruct ulna/radioulnar	10.15	NA	11.08	1.58	NA	22.81	090
25350		A	Revision of radius	8.77	NA	13.97	1.43	NA	24.17	090
25355		A	Revision of radius	10.15	NA	14.61	1.72	NA	26.48	090
25360		A	Revision of ulna	8.42	NA	13.87	1.40	NA	23.69	090
25365		A	Revise radius & ulna	12.38	NA	15.64	2.13	NA	30.15	090
25370		A	Revise radius or ulna	13.34	NA	16.07	2.27	NA	31.68	090
25375		A	Revise radius & ulna	13.02	NA	16.42	2.24	NA	31.68	090
25390		A	Shorten radius or ulna	10.38	NA	14.58	1.63	NA	26.59	090
25391		A	Lengthen radius or ulna	13.63	NA	16.55	2.20	NA	32.38	090
25392		A	Shorten radius & ulna	13.93	NA	15.96	2.09	NA	31.98	090
25393		A	Lengthen radius & ulna	15.85	NA	17.58	2.73	NA	36.16	090
25394		A	Repair carpal bone, shorten	10.38	NA	8.06	1.58	NA	20.02	090
25400		A	Repair radius or ulna	10.90	NA	15.19	1.79	NA	27.88	090
25405		A	Repair/graft radius or ulna	14.36	NA	17.27	2.28	NA	33.91	090
25415		A	Repair radius & ulna	13.33	NA	16.51	2.14	NA	31.98	090
25420		A	Repair/graft radius & ulna	16.31	NA	18.27	2.59	NA	37.17	090
25425		A	Repair/graft radius or ulna	13.19	NA	21.39	1.80	NA	36.38	090
25426		A	Repair/graft radius & ulna	15.80	NA	16.55	2.52	NA	34.87	090
25430		A	Vasc graft into carpal bone	9.24	NA	7.34	1.26	NA	17.84	090
25431		A	Repair nonunion carpal bone	10.42	NA	8.40	1.89	NA	20.71	090
25440		A	Repair/graft wrist bone	10.42	NA	9.40	1.60	NA	21.42	090
25441		A	Reconstruct wrist joint	12.88	NA	10.00	2.01	NA	24.89	090
25442		A	Reconstruct wrist joint	10.83	NA	8.88	1.53	NA	21.24	090
25443		A	Reconstruct wrist joint	10.37	NA	8.77	1.36	NA	20.50	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
25444		A	Reconstruct wrist joint	11.13	NA	9.03	1.69	NA	21.85	090
25445		A	Reconstruct wrist joint	9.68	NA	7.99	1.54	NA	19.21	090
25446		A	Wrist replacement	16.53	NA	11.92	2.45	NA	30.90	090
25447		A	Repair wrist joint(s)	10.35	NA	8.65	1.59	NA	20.59	090
25449		A	Remove wrist joint implant	14.47	NA	10.67	2.17	NA	27.31	090
25450		A	Revision of wrist joint	7.86	NA	10.19	1.35	NA	19.40	090
25455		A	Revision of wrist joint	9.48	NA	10.86	0.95	NA	21.29	090
25490		A	Reinforce radius	9.53	NA	13.73	1.43	NA	24.69	090
25491		A	Reinforce ulna	9.95	NA	14.46	1.58	NA	25.99	090
25492		A	Reinforce radius and ulna	12.31	NA	15.30	2.12	NA	29.73	090
25500		A	Treat fracture of radius	2.45	3.57	2.71	0.33	6.35	5.49	090
25505		A	Treat fracture of radius	5.20	6.54	5.42	0.81	12.55	11.43	090
25515		A	Treat fracture of radius	9.17	NA	7.46	1.55	NA	18.18	090
25520		A	Treat fracture of radius	6.25	6.86	6.06	1.02	14.13	13.33	090
25525		A	Treat fracture of radius	12.22	NA	9.99	2.00	NA	24.21	090
25526		A	Treat fracture of radius	12.96	NA	13.50	2.13	NA	28.59	090
25530		A	Treat fracture of ulna	2.09	3.76	2.86	0.32	6.17	5.27	090
25535		A	Treat fracture of ulna	5.13	6.01	5.29	0.84	11.98	11.26	090
25545		A	Treat fracture of ulna	8.89	NA	7.66	1.49	NA	18.04	090
25560		A	Treat fracture radius & ulna	2.44	3.69	2.60	0.33	6.46	5.37	090
25565		A	Treat fracture radius & ulna	5.62	6.70	5.42	0.89	13.21	11.93	090
25574		A	Treat fracture radius & ulna	7.00	NA	7.20	1.20	NA	15.40	090
25575		A	Treat fracture radius/ulna	10.43	NA	9.51	1.76	NA	21.70	090
25600		A	Treat fracture radius/ulna	2.63	4.09	2.97	0.40	7.12	6.00	090
25605		A	Treat fracture radius/ulna	5.80	7.23	6.22	0.95	13.98	12.97	090
25611		A	Treat fracture radius/ulna	7.76	NA	8.96	1.32	NA	18.04	090
25620		A	Treat fracture radius/ulna	8.54	NA	7.26	1.41	NA	17.21	090
25622		A	Treat wrist bone fracture	2.61	4.27	3.10	0.39	7.27	6.10	090
25624		A	Treat wrist bone fracture	4.52	6.30	5.07	0.73	11.55	10.32	090
25628		A	Treat wrist bone fracture	8.42	NA	7.82	1.36	NA	17.60	090
25630		A	Treat wrist bone fracture	2.88	4.18	2.94	0.43	7.49	6.25	090
25635		A	Treat wrist bone fracture	4.38	5.94	3.90	0.71	11.03	8.99	090
25645		A	Treat wrist bone fracture	7.24	NA	6.63	1.19	NA	15.06	090
25650		A	Treat wrist bone fracture	3.05	4.31	3.17	0.43	7.79	6.65	090
25651		A	Pin ulnar styloid fracture	5.35	NA	5.48	0.82	NA	11.65	090
25652		A	Treat fracture ulnar styloid	7.59	NA	7.00	1.20	NA	15.79	090
25660		A	Treat wrist dislocation	4.75	NA	4.71	0.57	NA	10.03	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
25670		A	Treat wrist dislocation	7.91	NA	6.99	1.26	NA	16.16	090
25671		A	Pin radioulnar dislocation	5.99	NA	6.15	0.98	NA	13.12	090
25675		A	Treat wrist dislocation	4.66	5.65	4.65	0.58	10.89	9.89	090
25676		A	Treat wrist dislocation	8.03	NA	7.30	1.33	NA	16.66	090
25680		A	Treat wrist fracture	5.98	NA	4.74	0.74	NA	11.46	090
25685		A	Treat wrist fracture	9.77	NA	7.80	1.56	NA	19.13	090
25690		A	Treat wrist dislocation	5.49	NA	5.50	0.86	NA	11.85	090
25695		A	Treat wrist dislocation	8.33	NA	7.09	1.32	NA	16.74	090
25800		A	Fusion of wrist joint	9.75	NA	9.09	1.54	NA	20.38	090
25805		A	Fusion/graft of wrist joint	11.26	NA	10.25	1.78	NA	23.29	090
25810		A	Fusion/graft of wrist joint	10.55	NA	9.90	1.64	NA	22.09	090
25820		A	Fusion of hand bones	7.44	NA	7.85	1.21	NA	16.50	090
25825		A	Fuse hand bones with graft	9.26	NA	9.23	1.40	NA	19.89	090
25830		A	Fusion, radioulnar jnt/ulna	10.04	NA	14.41	1.54	NA	25.99	090
25900		A	Amputation of forearm	9.00	NA	12.56	1.28	NA	22.84	090
25905		A	Amputation of forearm	9.11	NA	12.29	1.38	NA	22.78	090
25907		A	Amputation follow-up surgery	7.79	NA	11.76	1.10	NA	20.65	090
25909		A	Amputation follow-up surgery	8.95	NA	12.27	1.38	NA	22.60	090
25915		A	Amputation of forearm	17.05	NA	18.88	2.91	NA	38.84	090
25920		A	Amputate hand at wrist	8.67	NA	7.85	1.34	NA	17.86	090
25922		A	Amputate hand at wrist	7.41	NA	7.05	1.12	NA	15.58	090
25924		A	Amputation follow-up surgery	8.45	NA	8.09	1.32	NA	17.86	090
25927		A	Amputation of hand	8.79	NA	11.68	1.26	NA	21.73	090
25929		A	Amputation follow-up surgery	7.58	NA	5.87	1.14	NA	14.59	090
25931		A	Amputation follow-up surgery	7.80	NA	11.46	1.15	NA	20.41	090
25999		C	Forearm or wrist surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
26010		A	Drainage of finger abscess	1.54	5.56	1.63	0.17	7.27	3.34	010
26011		A	Drainage of finger abscess	2.19	8.81	2.32	0.32	11.32	4.83	010
26020		A	Drain hand tendon sheath	4.66	NA	5.35	0.72	NA	10.73	090
26025		A	Drainage of palm bursa	4.81	NA	5.12	0.75	NA	10.68	090
26030		A	Drainage of palm bursa(s)	5.92	NA	5.72	0.91	NA	12.55	090
26034		A	Treat hand bone lesion	6.22	NA	6.35	0.97	NA	13.54	090
26035		A	Decompress fingers/hand	9.50	NA	7.87	1.42	NA	18.79	090
26037		A	Decompress fingers/hand	7.24	NA	6.32	1.12	NA	14.68	090
26040		A	Release palm contracture	3.33	NA	4.05	0.53	NA	7.91	090
26045		A	Release palm contracture	5.55	NA	5.64	0.92	NA	12.11	090
26055		A	Incise finger tendon sheath	2.69	14.35	3.94	0.43	17.47	7.06	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
26060		A	Incision of finger tendon	2.81	NA	3.51	0.44	NA	6.76	090
26070		A	Explore/treat hand joint	3.68	NA	3.36	0.46	NA	7.50	090
26075		A	Explore/treat finger joint	3.78	NA	3.78	0.51	NA	8.07	090
26080		A	Explore/treat finger joint	4.23	NA	4.85	0.64	NA	9.72	090
26100		A	Biopsy hand joint lining	3.66	NA	4.13	0.50	NA	8.29	090
26105		A	Biopsy finger joint lining	3.70	NA	4.23	0.58	NA	8.51	090
26110		A	Biopsy finger joint lining	3.52	NA	4.04	0.53	NA	8.09	090
26115		A	Removal hand lesion subcut	3.85	13.09	4.77	0.58	17.52	9.20	090
26116		A	Removal hand lesion, deep	5.52	NA	6.00	0.83	NA	12.35	090
26117		A	Remove tumor, hand/finger	8.54	NA	7.06	1.24	NA	16.84	090
26121		A	Release palm contracture	7.53	NA	6.96	1.16	NA	15.65	090
26123		A	Release palm contracture	9.28	NA	8.85	1.42	NA	19.55	090
26125		A	Release palm contracture	4.60	NA	2.44	0.70	NA	7.74	ZZZ
26130		A	Remove wrist joint lining	5.41	NA	5.34	0.94	NA	11.69	090
26135		A	Revise finger joint, each	6.95	NA	6.46	1.06	NA	14.47	090
26140		A	Revise finger joint, each	6.16	NA	6.04	0.91	NA	13.11	090
26145		A	Tendon excision, palm/finger	6.31	NA	6.05	0.96	NA	13.32	090
26160		A	Remove tendon sheath lesion	3.15	12.37	4.12	0.48	16.00	7.75	090
26170		A	Removal of palm tendon, each	4.76	NA	4.94	0.70	NA	10.40	090
26180		A	Removal of finger tendon	5.17	NA	5.41	0.78	NA	11.36	090
26185		A	Remove finger bone	5.24	NA	6.03	0.79	NA	12.06	090
26200		A	Remove hand bone lesion	5.50	NA	5.35	0.85	NA	11.70	090
26205		A	Remove/graft bone lesion	7.69	NA	6.89	1.19	NA	15.77	090
26210		A	Removal of finger lesion	5.14	NA	5.42	0.77	NA	11.33	090
26215		A	Remove/graft finger lesion	7.09	NA	6.31	0.97	NA	14.37	090
26230		A	Partial removal of hand bone	6.32	NA	5.91	0.99	NA	13.22	090
26235		A	Partial removal, finger bone	6.18	NA	5.81	0.94	NA	12.93	090
26236		A	Partial removal, finger bone	5.31	NA	5.32	0.79	NA	11.42	090
26250		A	Extensive hand surgery	7.54	NA	6.43	1.07	NA	15.04	090
26255		A	Extensive hand surgery	12.41	NA	9.37	1.66	NA	23.44	090
26260		A	Extensive finger surgery	7.02	NA	6.18	0.98	NA	14.18	090
26261		A	Extensive finger surgery	9.08	NA	6.17	1.13	NA	16.38	090
26262		A	Partial removal of finger	5.66	NA	5.33	0.88	NA	11.87	090
26320		A	Removal of implant from hand	3.97	NA	4.31	0.58	NA	8.86	090
26340		A	Manipulate finger w/anesth	2.50	NA	4.88	0.38	NA	7.76	090
26350		A	Repair finger/hand tendon	5.98	NA	14.61	0.91	NA	21.50	090
26352		A	Repair/graft hand tendon	7.67	NA	15.36	1.12	NA	24.15	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
26356		A	Repair finger/hand tendon	8.06	NA	18.37	1.20	NA	27.63	090
26357		A	Repair finger/hand tendon	8.57	NA	15.63	1.32	NA	25.52	090
26358		A	Repair/graft hand tendon	9.13	NA	16.64	1.37	NA	27.14	090
26370		A	Repair finger/hand tendon	7.10	NA	15.11	1.10	NA	23.31	090
26372		A	Repair/graft hand tendon	8.75	NA	16.53	1.39	NA	26.67	090
26373		A	Repair finger/hand tendon	8.15	NA	16.04	1.23	NA	25.42	090
26390		A	Revise hand/finger tendon	9.18	NA	13.28	1.39	NA	23.85	090
26392		A	Repair/graft hand tendon	10.24	NA	16.72	1.52	NA	28.48	090
26410		A	Repair hand tendon	4.62	NA	11.94	0.71	NA	17.27	090
26412		A	Repair/graft hand tendon	6.30	NA	13.27	0.96	NA	20.53	090
26415		A	Excision, hand/finger tendon	8.33	NA	11.78	0.97	NA	21.08	090
26416		A	Graft hand or finger tendon	9.36	NA	14.59	0.79	NA	24.74	090
26418		A	Repair finger tendon	4.24	NA	12.32	0.64	NA	17.20	090
26420		A	Repair/graft finger tendon	6.76	NA	13.63	1.06	NA	21.45	090
26426		A	Repair finger/hand tendon	6.14	NA	13.16	0.93	NA	20.23	090
26428		A	Repair/graft finger tendon	7.20	NA	13.86	1.08	NA	22.14	090
26432		A	Repair finger tendon	4.01	NA	10.26	0.62	NA	14.89	090
26433		A	Repair finger tendon	4.55	NA	10.79	0.71	NA	16.05	090
26434		A	Repair/graft finger tendon	6.08	NA	11.54	0.93	NA	18.55	090
26437		A	Realignment of tendons	5.81	NA	11.57	0.89	NA	18.27	090
26440		A	Release palm/finger tendon	5.01	NA	13.43	0.74	NA	19.18	090
26442		A	Release palm & finger tendon	8.15	NA	15.94	1.18	NA	25.27	090
26445		A	Release hand/finger tendon	4.30	NA	13.14	0.64	NA	18.08	090
26449		A	Release forearm/hand tendon	6.99	NA	15.77	1.05	NA	23.81	090
26450		A	Incision of palm tendon	3.66	NA	7.33	0.58	NA	11.57	090
26455		A	Incision of finger tendon	3.63	NA	7.28	0.57	NA	11.48	090
26460		A	Incise hand/finger tendon	3.45	NA	7.14	0.54	NA	11.13	090
26471		A	Fusion of finger tendons	5.72	NA	11.24	0.87	NA	17.83	090
26474		A	Fusion of finger tendons	5.31	NA	11.39	0.75	NA	17.45	090
26476		A	Tendon lengthening	5.17	NA	10.93	0.77	NA	16.87	090
26477		A	Tendon shortening	5.14	NA	11.06	0.80	NA	17.00	090
26478		A	Lengthening of hand tendon	5.79	NA	11.84	0.89	NA	18.52	090
26479		A	Shortening of hand tendon	5.73	NA	11.56	0.91	NA	18.20	090
26480		A	Transplant hand tendon	6.68	NA	15.04	1.01	NA	22.73	090
26483		A	Transplant/graft hand tendon	8.28	NA	15.50	1.26	NA	25.04	090
26485		A	Transplant palm tendon	7.69	NA	15.36	1.13	NA	24.18	090
26489		A	Transplant/graft palm tendon	9.54	NA	12.06	1.19	NA	22.79	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
26490		A	Revise thumb tendon	8.40	NA	12.82	1.20	NA	22.42	090
26492		A	Tendon transfer with graft	9.61	NA	13.60	1.40	NA	24.61	090
26494		A	Hand tendon/muscle transfer	8.46	NA	12.97	1.28	NA	22.71	090
26496		A	Revise thumb tendon	9.58	NA	13.23	1.44	NA	24.25	090
26497		A	Finger tendon transfer	9.56	NA	13.57	1.39	NA	24.52	090
26498		A	Finger tendon transfer	13.98	NA	16.16	2.09	NA	32.23	090
26499		A	Revision of finger	8.97	NA	13.04	1.34	NA	23.35	090
26500		A	Hand tendon reconstruction	5.95	NA	11.44	0.89	NA	18.28	090
26502		A	Hand tendon reconstruction	7.13	NA	12.02	1.12	NA	20.27	090
26504		A	Hand tendon reconstruction	7.46	NA	12.58	1.24	NA	21.28	090
26508		A	Release thumb contracture	6.00	NA	11.68	0.96	NA	18.64	090
26510		A	Thumb tendon transfer	5.42	NA	11.34	0.79	NA	17.55	090
26516		A	Fusion of knuckle joint	7.14	NA	12.23	1.08	NA	20.45	090
26517		A	Fusion of knuckle joints	8.82	NA	13.50	1.40	NA	23.72	090
26518		A	Fusion of knuckle joints	9.01	NA	13.39	1.31	NA	23.71	090
26520		A	Release knuckle contracture	5.29	NA	13.89	0.79	NA	19.97	090
26525		A	Release finger contracture	5.32	NA	13.97	0.80	NA	20.09	090
26530		A	Revise knuckle joint	6.68	NA	6.14	1.03	NA	13.85	090
26531		A	Revise knuckle with implant	7.90	NA	7.12	1.17	NA	16.19	090
26535		A	Revise finger joint	5.23	NA	3.74	0.71	NA	9.68	090
26536		A	Revise/implant finger joint	6.36	NA	9.65	0.94	NA	16.95	090
26540		A	Repair hand joint	6.42	NA	11.87	0.98	NA	19.27	090
26541		A	Repair hand joint with graft	8.61	NA	13.39	1.27	NA	23.27	090
26542		A	Repair hand joint with graft	6.77	NA	12.03	1.02	NA	19.82	090
26545		A	Reconstruct finger joint	6.91	NA	12.13	1.04	NA	20.08	090
26546		A	Repair nonunion hand	8.91	NA	15.03	1.43	NA	25.37	090
26548		A	Reconstruct finger joint	8.02	NA	12.85	1.18	NA	22.05	090
26550		A	Construct thumb replacement	21.21	NA	17.58	2.43	NA	41.22	090
26551		A	Great toe-hand transfer	46.51	NA	32.44	7.92	NA	86.87	090
26553		A	Single transfer, toe-hand	46.20	NA	22.68	2.40	NA	71.28	090
26554		A	Double transfer, toe-hand	54.87	NA	37.53	9.36	NA	101.76	090
26555		A	Positional change of finger	16.61	NA	18.18	2.46	NA	37.25	090
26556		A	Toe joint transfer	47.19	NA	33.32	2.55	NA	83.06	090
26560		A	Repair of web finger	5.37	NA	9.80	0.84	NA	16.01	090
26561		A	Repair of web finger	10.90	NA	12.34	1.45	NA	24.69	090
25562		A	Repair of web finger	14.98	NA	17.14	2.22	NA	34.34	090
26565		A	Correct metacarpal flaw	6.73	NA	12.01	0.99	NA	19.73	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
26567		A	Correct finger deformity	6.81	NA	11.95	1.03	NA	19.79	090
26568		A	Lengthen metacarpal/finger	9.07	NA	15.43	1.49	NA	25.99	090
26580		A	Repair hand deformity	18.15	NA	13.64	2.27	NA	34.06	090
26587		A	Reconstruct extra finger	14.03	NA	9.21	1.52	NA	24.76	090
26590		A	Repair finger deformity	17.93	NA	13.94	2.74	NA	34.61	090
26591		A	Repair muscles of hand	3.25	NA	9.62	0.47	NA	13.34	090
26593		A	Release muscles of hand	5.30	NA	11.13	0.78	NA	17.21	090
26596		A	Excision constricting tissue	8.94	NA	8.82	1.38	NA	19.14	090
26600		A	Treat metacarpal fracture	1.96	3.61	2.65	0.29	5.86	4.90	090
26605		A	Treat metacarpal fracture	2.85	4.56	3.65	0.45	7.86	6.95	090
26607		A	Treat metacarpal fracture	5.35	NA	6.27	0.85	NA	12.47	090
26608		A	Treat metacarpal fracture	5.35	NA	6.25	0.87	NA	12.47	090
26615		A	Treat metacarpal fracture	5.32	NA	5.30	0.85	NA	11.47	090
26641		A	Treat thumb dislocation	3.93	4.57	3.53	0.40	8.90	7.86	090
26645		A	Treat thumb fracture	4.40	5.17	4.19	0.63	10.20	9.22	090
26650		A	Treat thumb fracture	5.71	NA	6.69	0.93	NA	13.33	090
26665		A	Treat thumb fracture	7.59	NA	6.61	0.88	NA	15.08	090
26670		A	Treat hand dislocation	3.68	4.26	2.94	0.38	8.32	7.00	090
26675		A	Treat hand dislocation	4.63	5.47	4.47	0.75	10.85	9.85	090
26676		A	Pin hand dislocation	5.51	NA	6.69	0.88	NA	13.08	090
26685		A	Treat hand dislocation	6.97	NA	6.14	1.07	NA	14.18	090
26686		A	Treat hand dislocation	7.93	NA	6.90	1.23	NA	16.06	090
26700		A	Treat knuckle dislocation	3.68	3.76	2.86	0.35	7.79	6.89	090
26705		A	Treat knuckle dislocation	4.18	5.33	4.30	0.61	10.12	9.09	090
26706		A	Pin knuckle dislocation	5.11	NA	5.09	0.78	NA	10.98	090
26715		A	Treat knuckle dislocation	5.73	NA	5.51	0.91	NA	12.15	090
26720		A	Treat finger fracture, each	1.66	2.78	2.05	0.22	4.66	3.93	090
26725		A	Treat finger fracture, each	3.33	4.77	3.50	0.49	8.59	7.32	090
26727		A	Treat finger fracture, each	5.22	NA	6.23	0.83	NA	12.28	090
26735		A	Treat finger fracture, each	5.97	NA	5.55	0.93	NA	12.45	090
26740		A	Treat finger fracture, each	1.94	3.13	2.70	0.29	5.36	4.93	090
26742		A	Treat finger fracture, each	3.84	4.99	3.88	0.56	9.39	8.28	090
26746		A	Treat finger fracture, each	5.80	NA	5.56	0.90	NA	12.26	090
26750		A	Treat finger fracture, each	1.70	2.48	2.01	0.21	4.39	3.92	090
26755		A	Treat finger fracture, each	3.10	4.42	3.00	0.40	7.92	6.50	090
26756		A	Pin finger fracture, each	4.38	NA	5.72	0.70	NA	10.80	090
26765		A	Treat finger fracture, each	4.16	NA	4.39	0.63	NA	9.18	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
26770		A	Treat finger dislocation	3.02	3.43	2.41	0.28	6.73	5.71	090
26775		A	Treat finger dislocation	3.70	5.19	3.81	0.52	9.41	8.03	090
26776		A	Pin finger dislocation	4.79	NA	6.00	0.76	NA	11.55	090
26785		A	Treat finger dislocation	4.20	NA	4.53	0.65	NA	9.38	090
26820		A	Thumb fusion with graft	8.25	NA	13.25	1.26	NA	22.76	090
26841		A	Fusion of thumb	7.12	NA	13.23	1.17	NA	21.52	090
26842		A	Thumb fusion with graft	8.23	NA	13.37	1.32	NA	22.92	090
26843		A	Fusion of hand joint	7.60	NA	12.35	1.15	NA	21.10	090
26844		A	Fusion/graft of hand joint	8.72	NA	13.36	1.32	NA	23.40	090
26850		A	Fusion of knuckle	6.96	NA	12.20	1.05	NA	20.21	090
26852		A	Fusion of knuckle with graft	8.45	NA	12.89	1.21	NA	22.55	090
26860		A	Fusion of finger joint	4.68	NA	11.19	0.72	NA	16.59	090
26861		A	Fusion of finger jnt, add-on	1.74	NA	0.93	0.26	NA	2.93	ZZZ
26862		A	Fusion/graft of finger joint	7.36	NA	12.34	1.09	NA	20.79	090
26863		A	Fuse/graft added joint	3.89	NA	2.11	0.56	NA	6.56	ZZZ
26910		A	Amputate metacarpal bone	7.59	NA	11.22	1.15	NA	19.96	090
26951		A	Amputation of finger/thumb	4.58	NA	10.15	0.70	NA	15.43	090
26952		A	Amputation of finger/thumb	6.30	NA	11.66	0.93	NA	18.89	090
26989		C	Hand/finger surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
26990		A	Drainage of pelvis lesion	7.47	NA	7.21	1.17	NA	15.85	090
26991		A	Drainage of pelvis bursa	6.67	11.16	5.43	1.08	18.91	13.18	090
26992		A	Drainage of bone lesion	13.00	NA	10.38	2.13	NA	25.51	090
27000		A	Incision of hip tendon	5.61	NA	5.28	0.96	NA	11.85	090
27001		A	Incision of hip tendon	6.93	NA	6.09	1.22	NA	14.24	090
27003		A	Incision of hip tendon	7.33	NA	6.48	1.10	NA	14.91	090
27005		A	Incision of hip tendon	9.65	NA	7.82	1.66	NA	19.13	090
27006		A	Incision of hip tendons	9.67	NA	7.98	1.67	NA	19.32	090
27025		A	Incision of hip/thigh fascia	11.14	NA	8.55	1.79	NA	21.48	090
27030		A	Drainage of hip joint	12.99	NA	9.64	2.22	NA	24.85	090
27033		A	Exploration of hip joint	13.37	NA	9.92	2.29	NA	25.58	090
27035		A	Denervation of hip joint	16.66	NA	11.23	2.10	NA	29.99	090
27036		A	Excision of hip joint/muscle	12.86	NA	10.00	2.21	NA	25.07	090
27040		A	Biopsy of soft tissues	2.87	5.23	2.01	0.27	8.37	5.15	010
27041		A	Biopsy of soft tissues	9.88	NA	6.64	1.30	NA	17.82	090
27047		A	Remove hip/pelvis lesion	7.44	7.11	4.77	1.00	15.55	13.21	090
27048		A	Remove hip/pelvis lesion	6.24	NA	4.80	0.90	NA	11.94	090
27049		A	Remove tumor, hip/pelvis	13.64	NA	8.40	2.01	NA	24.05	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
27050		A	Biopsy of sacroiliac joint	4.35	NA	4.42	0.60	NA	9.37	090
27052		A	Biopsy of hip joint	6.22	NA	5.88	1.05	NA	13.15	090
27054		A	Removal of hip joint lining	8.53	NA	7.34	1.46	NA	17.33	090
27060		A	Removal of ischial bursa	5.42	NA	4.37	0.79	NA	10.58	090
27062		A	Remove femur lesion/bursa	5.36	NA	5.19	0.92	NA	11.47	090
27065		A	Removal of hip bone lesion	5.89	NA	5.44	0.95	NA	12.28	090
27066		A	Removal of hip bone lesion	10.31	NA	8.44	1.73	NA	20.48	090
27067		A	Remove/graft hip bone lesion	13.81	NA	10.66	1.82	NA	26.29	090
27070		A	Partial removal of hip bone	10.70	NA	9.13	1.71	NA	21.54	090
27071		A	Partial removal of hip bone	11.44	NA	10.12	1.89	NA	23.45	090
27075		A	Extensive hip surgery	34.95	NA	19.20	5.50	NA	59.65	090
27076		A	Extensive hip surgery	22.09	NA	14.51	3.59	NA	40.19	090
27077		A	Extensive hip surgery	39.94	NA	22.66	6.07	NA	68.67	090
27078		A	Extensive hip surgery	13.42	NA	9.94	2.20	NA	25.56	090
27079		A	Extensive hip surgery	13.73	NA	9.54	1.89	NA	25.16	090
27080		A	Removal of tail bone	6.38	NA	4.83	0.92	NA	12.13	090
27086		A	Remove hip foreign body	1.87	4.55	1.82	0.23	6.65	3.92	010
27087		A	Remove hip foreign body	8.53	NA	6.66	1.30	NA	16.49	090
27090		A	Removal of hip prosthesis	11.13	NA	8.78	1.91	NA	21.82	090
27091		A	Removal of hip prosthesis	22.11	NA	13.99	3.78	NA	39.88	090
27093		A	Injection for hip x-ray	1.30	4.46	0.48	0.12	5.88	1.90	000
27095		A	Injection for hip x-ray	1.50	5.72	0.52	0.14	7.36	2.16	000
27096		A	Inject sacroiliac joint	1.40	4.35	0.33	0.10	5.85	1.83	000
27097		A	Revision of hip tendon	8.79	NA	6.41	1.55	NA	16.75	090
27098		A	Transfer tendon to pelvis	8.82	NA	7.02	0.95	NA	16.79	090
27100		A	Transfer of abdominal muscle	11.06	NA	8.66	1.78	NA	21.50	090
27105		A	Transfer of spinal muscle	11.75	NA	9.16	1.70	NA	22.61	090
27110		A	Transfer of iliopsoas muscle	13.24	NA	9.11	2.08	NA	24.43	090
27111		A	Transfer of iliopsoas muscle	12.13	NA	9.13	1.92	NA	23.18	090
27120		A	Reconstruction of hip socket	17.98	NA	11.84	2.97	NA	32.79	090
27122		A	Reconstruction of hip socket	14.96	NA	11.04	2.56	NA	28.56	090
27125		A	Partial hip replacement	14.67	NA	10.62	2.50	NA	27.79	090
27130		A	Total hip arthroplasty	20.09	NA	13.30	3.45	NA	36.84	090
27132		A	Total hip arthroplasty	23.27	NA	15.63	3.99	NA	42.89	090
27134		A	Revise hip joint replacement	28.48	NA	17.79	4.88	NA	51.15	090
27137		A	Revise hip joint replacement	21.14	NA	13.93	3.63	NA	38.70	090
27138		A	Revise hip joint replacement	22.14	NA	14.39	3.79	NA	40.32	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
27140		A	Transplant femur ridge	12.22	NA	9.41	2.05	NA	23.68	090
27146		A	Incision of hip bone	17.40	NA	12.13	2.95	NA	32.48	090
27147		A	Revision of hip bone	20.55	NA	13.25	3.54	NA	37.34	090
27151		A	Incision of hip bones	22.48	NA	7.95	3.88	NA	34.31	090
27156		A	Revision of hip bones	24.59	NA	16.06	4.11	NA	44.76	090
27158		A	Revision of pelvis	19.71	NA	10.97	3.13	NA	33.81	090
27161		A	Incision of neck of femur	16.68	NA	12.10	2.87	NA	31.65	090
27165		A	Incision/fixation of femur	17.88	NA	12.91	3.07	NA	33.86	090
27170		A	Repair/graft femur head/neck	16.05	NA	11.30	2.76	NA	30.11	090
27175		A	Treat slipped epiphysis	8.45	NA	6.67	1.46	NA	16.58	090
27176		A	Treat slipped epiphysis	12.03	NA	9.01	2.20	NA	23.24	090
27177		A	Treat slipped epiphysis	15.06	NA	10.69	2.60	NA	28.55	090
27178		A	Treat slipped epiphysis	11.97	NA	8.42	2.06	NA	22.45	090
27179		A	Revise head/neck of femur	12.96	NA	9.99	2.23	NA	25.18	090
27181		A	Treat slipped epiphysis	14.66	NA	10.20	1.56	NA	26.42	090
27185		A	Revision of femur epiphysis	9.17	NA	7.52	2.37	NA	19.06	090
27187		A	Reinforce hip bones	13.52	NA	10.32	2.34	NA	26.18	090
27193		A	Treat pelvic ring fracture	5.55	5.09	5.09	0.93	11.57	11.57	090
27194		A	Treat pelvic ring fracture	9.64	NA	7.65	1.62	NA	18.91	090
27200		A	Treat tail bone fracture	1.84	2.22	2.15	0.26	4.32	4.25	090
27202		A	Treat tail bone fracture	7.03	NA	16.86	1.06	NA	24.95	090
27215		A	Treat pelvic fracture(s)	10.03	NA	7.08	1.93	NA	19.04	090
27216		A	Treat pelvic ring fracture	15.17	NA	9.59	2.66	NA	27.42	090
27217		A	Treat pelvic ring fracture	14.09	NA	10.14	2.35	NA	26.58	090
27218		A	Treat pelvic ring fracture	20.12	NA	11.40	3.45	NA	34.97	090
27220		A	Treat hip socket fracture	6.17	5.72	5.63	1.04	12.93	12.84	090
27222		A	Treat hip socket fracture	12.68	NA	9.97	2.10	NA	24.75	090
27226		A	Treat hip wall fracture	14.89	NA	7.81	2.45	NA	25.15	090
27227		A	Treat hip fracture(s)	23.41	NA	15.40	3.98	NA	42.79	090
27228		A	Treat hip fracture(s)	27.12	NA	17.62	4.61	NA	49.35	090
27230		A	Treat thigh fracture	5.49	5.51	5.10	0.90	11.90	11.49	090
27232		A	Treat thigh fracture	10.66	NA	7.17	1.68	NA	19.51	090
27235		A	Treat thigh fracture	12.14	NA	9.45	2.08	NA	23.67	090
27236		A	Treat thigh fracture	15.58	NA	11.05	2.66	NA	29.29	090
27238		A	Treat thigh fracture	5.51	NA	5.14	0.87	NA	11.52	090
27240		A	Treat thigh fracture	12.48	NA	9.47	2.06	NA	24.01	090
27244		A	Treat thigh fracture	15.92	NA	11.30	2.72	NA	29.94	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
27245		A	Treat thigh fracture	20.28	NA	13.74	3.47	NA	37.49	090
27246		A	Treat thigh fracture	4.70	4.46	4.42	0.80	9.96	9.92	090
27248		A	Treat thigh fracture	10.43	NA	8.21	1.78	NA	20.42	090
27250		A	Treat hip dislocation	6.94	NA	4.62	0.61	NA	12.17	090
27252		A	Treat hip dislocation	10.37	NA	7.43	1.60	NA	19.40	090
27253		A	Treat hip dislocation	12.90	NA	9.78	2.20	NA	24.88	090
27254		A	Treat hip dislocation	18.23	NA	12.02	3.09	NA	33.34	090
27256		A	Treat hip dislocation	4.11	3.52	2.08	0.44	8.07	6.63	010
27257		A	Treat hip dislocation	5.21	NA	2.81	0.68	NA	8.70	010
27258		A	Treat hip dislocation	15.41	NA	10.87	2.59	NA	28.87	090
27259		A	Treat hip dislocation	21.52	NA	14.12	3.71	NA	39.35	090
27265		A	Treat hip dislocation	5.04	NA	4.79	0.61	NA	10.44	090
27266		A	Treat hip dislocation	7.48	NA	6.34	1.27	NA	15.09	090
27275		A	Manipulation of hip joint	2.27	NA	2.10	0.38	NA	4.75	010
27280		A	Fusion of sacroiliac joint	13.37	NA	10.26	2.38	NA	26.01	090
27282		A	Fusion of pubic bones	11.32	NA	8.00	1.85	NA	21.17	090
27284		A	Fusion of hip joint	23.41	NA	14.76	3.89	NA	42.06	090
27286		A	Fusion of hip joint	23.41	NA	15.79	3.09	NA	42.29	090
27290		A	Amputation of leg at hip	23.25	NA	14.06	3.32	NA	40.63	090
27295		A	Amputation of leg at hip	18.62	NA	11.31	2.88	NA	32.81	090
27299		C	Pelvis/hip joint surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
27301		A	Drain thigh/knee lesion	6.48	10.07	5.14	1.00	17.55	12.62	090
27303		A	Drainage of bone lesion	8.27	NA	6.98	1.40	NA	16.65	090
27305		A	Incise thigh tendon & fascia	5.91	NA	5.18	0.98	NA	12.07	090
27306		A	Incision of thigh tendon	4.61	NA	4.72	0.83	NA	10.16	090
27307		A	Incision of thigh tendons	5.79	NA	5.38	1.03	NA	12.20	090
27310		A	Exploration of knee joint	9.26	NA	7.58	1.58	NA	18.42	090
27315		A	Partial removal, thigh nerve	6.96	NA	4.95	1.09	NA	13.00	090
27320		A	Partial removal, thigh nerve	6.29	NA	5.23	1.05	NA	12.57	090
27323		A	Biopsy, thigh soft tissues	2.28	3.51	1.88	0.24	6.03	4.40	010
27324		A	Biopsy, thigh soft tissues	4.89	NA	4.18	0.73	NA	9.80	090
27327		A	Removal of thigh lesion	4.46	5.99	3.72	0.62	11.07	8.80	090
27328		A	Removal of thigh lesion	5.56	NA	4.37	0.83	NA	10.76	090
27329		A	Remove tumor, thigh/knee	14.12	NA	9.02	2.09	NA	25.23	090
27330		A	Biopsy, knee joint lining	4.96	NA	4.57	0.82	NA	10.35	090
27331		A	Explore/treat knee joint	5.87	NA	5.52	1.00	NA	12.39	090
27332		A	Removal of knee cartilage	8.26	NA	7.12	1.42	NA	16.80	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
27333		A	Removal of knee cartilage	7.29	NA	6.67	1.26	NA	15.22	090
27334		A	Remove knee joint lining	8.69	NA	7.41	1.49	NA	17.59	090
27335		A	Remove knee joint lining	9.99	NA	8.22	1.72	NA	19.93	090
27340		A	Removal of kneecap bursa	4.17	NA	4.56	0.71	NA	9.44	090
27345		A	Removal of knee cyst	5.91	NA	5.62	0.99	NA	12.52	090
27347		A	Remove knee cyst	5.77	NA	5.42	0.97	NA	12.16	090
27350		A	Removal of kneecap	8.16	NA	7.24	1.40	NA	16.80	090
27355		A	Remove femur lesion	7.64	NA	6.77	1.31	NA	15.72	090
27356		A	Remove femur lesion/graft	9.47	NA	7.85	1.60	NA	18.92	090
27357		A	Remove femur lesion/graft	10.51	NA	8.70	1.92	NA	21.13	090
27358		A	Remove femur lesion/fixation	4.73	NA	2.52	0.82	NA	8.07	ZZZ
27360		A	Partial removal, leg bone(s)	10.48	NA	9.55	1.75	NA	21.78	090
27365		A	Extensive leg surgery	16.25	NA	11.68	2.73	NA	30.66	090
27370		A	Injection for knee x-ray	0.96	3.72	0.32	0.08	4.76	1.36	000
27372		A	Removal of foreign body	5.06	10.05	4.69	0.79	15.90	10.54	090
27380		A	Repair of kneecap tendon	7.15	NA	7.28	1.23	NA	15.66	090
27381		A	Repair/graft kneecap tendon	10.32	NA	9.09	1.76	NA	21.17	090
27385		A	Repair of thigh muscle	7.75	NA	7.63	1.34	NA	16.72	090
27386		A	Repair/graft of thigh muscle	10.54	NA	9.51	1.81	NA	21.86	090
27390		A	Incision of thigh tendon	5.32	NA	5.11	0.91	NA	11.34	090
27391		A	Incision of thigh tendons	7.19	NA	6.56	1.20	NA	14.95	090
27392		A	Incision of thigh tendons	9.19	NA	7.59	1.56	NA	18.34	090
27393		A	Lengthening of thigh tendon	6.38	NA	5.83	1.06	NA	13.27	090
27394		A	Lengthening of thigh tendons	8.49	NA	7.22	1.45	NA	17.16	090
27395		A	Lengthening of thigh tendons	11.71	NA	9.32	2.02	NA	23.05	090
27396		A	Transplant of thigh tendon	7.85	NA	7.00	1.32	NA	16.17	090
27397		A	Transplants of thigh tendons	11.26	NA	9.04	1.81	NA	22.11	090
27400		A	Revise thigh muscles/tendons	9.01	NA	7.25	1.31	NA	17.57	090
27403		A	Repair of knee cartilage	8.32	NA	7.18	1.43	NA	16.93	090
27405		A	Repair of knee ligament	8.64	NA	7.49	1.49	NA	17.62	090
27407		A	Repair of knee ligament	10.26	NA	8.32	1.71	NA	20.29	090
27409		A	Repair of knee ligaments	12.88	NA	9.95	2.22	NA	25.05	090
27412		A	Autochondrocyte implant knee	23.23	NA	14.80	4.33	NA	42.36	090
27415		A	Osteochondral knee allograft	18.49	NA	12.55	4.33	NA	35.37	090
27418		A	Repair degenerated kneecap	10.83	NA	8.90	1.87	NA	21.60	090
27420		A	Revision of unstable kneecap	9.82	NA	8.11	1.67	NA	19.60	090
27422		A	Revision of unstable kneecap	9.77	NA	8.12	1.68	NA	19.57	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
27424		A	Revision/removal of kneecap	9.80	NA	8.09	1.68	NA	19.57	090
27425		A	Lat retinacular release open	5.21	NA	5.52	0.90	NA	11.63	090
27427		A	Reconstruction, knee	9.35	NA	7.80	1.58	NA	18.73	090
27428		A	Reconstruction, knee	13.98	NA	11.24	2.38	NA	27.60	090
27429		A	Reconstruction, knee	15.50	NA	12.41	2.67	NA	30.58	090
27430		A	Revision of thigh muscles	9.66	NA	8.00	1.66	NA	19.32	090
27435		A	Incision of knee joint	9.48	NA	8.48	1.67	NA	19.63	090
27437		A	Revise kneecap	8.45	NA	7.24	1.48	NA	17.17	090
27438		A	Revise kneecap with implant	11.21	NA	8.54	1.93	NA	21.68	090
27440		A	Revision of knee joint	10.41	NA	5.99	1.80	NA	18.20	090
27441		A	Revision of knee joint	10.80	NA	6.71	1.84	NA	19.35	090
27442		A	Revision of knee joint	11.87	NA	8.91	2.07	NA	22.85	090
27443		A	Revision of knee joint	10.91	NA	8.72	1.87	NA	21.50	090
27445		A	Revision of knee joint	17.65	NA	12.35	3.05	NA	33.05	090
27446		A	Revision of knee joint	15.82	NA	11.27	2.76	NA	29.85	090
27447		A	Total knee arthroplasty	21.45	NA	14.60	3.74	NA	39.79	090
27448		A	Incision of thigh	11.04	NA	8.60	1.90	NA	21.54	090
27450		A	Incision of thigh	13.96	NA	10.58	2.38	NA	26.92	090
27454		A	Realignment of thigh bone	17.53	NA	12.50	3.05	NA	33.08	090
27455		A	Realignment of knee	12.80	NA	9.88	2.22	NA	24.90	090
27457		A	Realignment of knee	13.43	NA	9.92	2.32	NA	25.67	090
27465		A	Shortening of thigh bone	13.85	NA	10.22	2.45	NA	26.52	090
27466		A	Lengthening of thigh bone	16.31	NA	11.83	2.74	NA	30.88	090
27468		A	Shorten/lengthen thighs	18.94	NA	12.35	3.27	NA	34.56	090
27470		A	Repair of thigh	16.05	NA	11.79	2.74	NA	30.58	090
27472		A	Repair/graft of thigh	17.69	NA	12.68	3.02	NA	33.39	090
27475		A	Surgery to stop leg growth	8.63	NA	7.21	1.36	NA	17.20	090
27477		A	Surgery to stop leg growth	9.84	NA	7.73	1.71	NA	19.28	090
27479		A	Surgery to stop leg growth	12.78	NA	9.64	2.75	NA	25.17	090
27485		A	Surgery to stop leg growth	8.83	NA	7.40	1.52	NA	17.75	090
27486		A	Revise/replace knee joint	19.24	NA	13.49	3.32	NA	36.05	090
27487		A	Revise/replace knee joint	25.23	NA	16.55	4.33	NA	46.11	090
27488		A	Removal of knee prosthesis	15.72	NA	11.70	2.70	NA	30.12	090
27495		A	Reinforce thigh	15.53	NA	11.41	2.66	NA	29.60	090
27496		A	Decompression of thigh/knee	6.10	NA	5.60	0.97	NA	12.67	090
27497		A	Decompression of thigh/knee	7.16	NA	5.43	1.14	NA	13.73	090
27498		A	Decompression of thigh/knee	7.98	NA	5.95	1.24	NA	15.17	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
27499		A	Decompression of thigh/knee	8.99	NA	6.82	1.46	NA	17.27	090
27500		A	Treatment of thigh fracture	5.91	6.12	4.99	0.96	12.99	11.86	090
27501		A	Treatment of thigh fracture	5.91	5.79	5.38	1.01	12.71	12.30	090
27502		A	Treatment of thigh fracture	10.56	NA	8.11	1.72	NA	20.39	090
27503		A	Treatment of thigh fracture	10.56	NA	8.29	1.80	NA	20.65	090
27506		A	Treatment of thigh fracture	17.42	NA	12.78	2.95	NA	33.15	090
27507		A	Treatment of thigh fracture	13.97	NA	9.84	2.36	NA	26.17	090
27508		A	Treatment of thigh fracture	5.82	6.46	5.48	0.95	13.23	12.25	090
27509		A	Treatment of thigh fracture	7.70	NA	7.96	1.33	NA	16.99	090
27510		A	Treatment of thigh fracture	9.12	NA	7.33	1.49	NA	17.94	090
27511		A	Treatment of thigh fracture	13.62	NA	11.20	2.33	NA	27.15	090
27513		A	Treatment of thigh fracture	17.89	NA	13.88	3.07	NA	34.84	090
27514		A	Treatment of thigh fracture	17.27	NA	13.35	2.95	NA	33.57	090
27516		A	Treat thigh fx growth plate	5.36	6.35	5.51	0.78	12.49	11.65	090
27517		A	Treat thigh fx growth plate	8.77	NA	7.45	1.21	NA	17.43	090
27519		A	Treat thigh fx growth plate	15.00	NA	11.59	2.53	NA	29.12	090
27520		A	Treat kneecap fracture	2.86	4.54	3.44	0.45	7.85	6.75	090
27524		A	Treat kneecap fracture	9.99	NA	8.23	1.71	NA	19.93	090
27530		A	Treat knee fracture	3.77	5.31	4.42	0.62	9.70	8.81	090
27532		A	Treat knee fracture	7.29	7.36	6.45	1.24	15.89	14.98	090
27535		A	Treat knee fracture	11.48	NA	10.11	1.97	NA	23.56	090
27536		A	Treat knee fracture	15.63	NA	11.61	2.68	NA	29.92	090
27538		A	Treat knee fracture(s)	4.86	6.13	5.19	0.81	11.80	10.86	090
27540		A	Treat knee fracture	13.08	NA	9.51	2.22	NA	24.81	090
27550		A	Treat knee dislocation	5.75	6.01	4.93	0.72	12.48	11.40	090
27552		A	Treat knee dislocation	7.89	NA	6.95	1.33	NA	16.17	090
27556		A	Treat knee dislocation	14.39	NA	11.65	2.46	NA	28.50	090
27557		A	Treat knee dislocation	16.74	NA	13.12	2.89	NA	32.75	090
27558		A	Treat knee dislocation	17.69	NA	13.04	3.05	NA	33.78	090
27560		A	Treat kneecap dislocation	3.81	4.84	3.18	0.40	9.05	7.39	090
27562		A	Treat kneecap dislocation	5.78	NA	4.77	0.92	NA	11.47	090
27566		A	Treat kneecap dislocation	12.21	NA	9.32	2.10	NA	23.63	090
27570		A	Fixation of knee joint	1.74	NA	1.77	0.30	NA	3.81	010
27580		A	Fusion of knee	19.34	NA	14.80	3.27	NA	37.41	090
27590		A	Amputate leg at thigh	12.01	NA	6.67	1.72	NA	20.40	090
27591		A	Amputate leg at thigh	12.66	NA	8.64	1.95	NA	23.25	090
27592		A	Amputate leg at thigh	10.00	NA	6.17	1.44	NA	17.61	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
27594		A	Amputation follow-up surgery	6.91	NA	5.17	1.01	NA	13.09	090
27596		A	Amputation follow-up surgery	10.58	NA	6.81	1.55	NA	18.94	090
27598		A	Amputate lower leg at knee	10.51	NA	7.02	1.61	NA	19.14	090
27599		C	Leg surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
27600		A	Decompression of lower leg	5.64	NA	4.53	0.84	NA	11.01	090
27601		A	Decompression of lower leg	5.63	NA	4.85	0.80	NA	11.28	090
27602		A	Decompression of lower leg	7.34	NA	5.13	1.08	NA	13.55	090
27603		A	Drain lower leg lesion	4.93	7.49	4.16	0.71	13.13	9.80	090
27604		A	Drain lower leg bursa	4.46	6.08	3.96	0.68	11.22	9.10	090
27605		A	Incision of achilles tendon	2.87	7.68	2.32	0.41	10.96	5.60	010
27606		A	Incision of achilles tendon	4.13	NA	3.36	0.68	NA	8.17	010
27607		A	Treat lower leg bone lesion	7.96	NA	6.17	1.29	NA	15.42	090
27610		A	Explore/treat ankle joint	8.33	NA	7.00	1.37	NA	16.70	090
27612		A	Exploration of ankle joint	7.32	NA	6.09	1.12	NA	14.53	090
27613		A	Biopsy lower leg soft tissue	2.17	3.23	1.80	0.21	5.61	4.18	010
27614		A	Biopsy lower leg soft tissue	5.65	7.13	4.44	0.77	13.55	10.86	090
27615		A	Remove tumor, lower leg	12.54	NA	9.39	1.77	NA	23.70	090
27618		A	Remove lower leg lesion	5.08	6.01	3.99	0.69	11.78	9.76	090
27619		A	Remove lower leg lesion	8.39	9.51	5.95	1.23	19.13	15.57	090
27620		A	Explore/treat ankle joint	5.97	NA	5.46	0.95	NA	12.38	090
27625		A	Remove ankle joint lining	8.29	NA	6.46	1.28	NA	16.03	090
27626		A	Remove ankle joint lining	8.90	NA	6.92	1.47	NA	17.29	090
27630		A	Removal of tendon lesion	4.79	7.56	4.38	0.73	13.08	9.90	090
27635		A	Remove lower leg bone lesion	7.77	NA	6.74	1.29	NA	15.80	090
27637		A	Remove/graft leg bone lesion	9.84	NA	8.29	1.64	NA	19.77	090
27638		A	Remove/graft leg bone lesion	10.55	NA	8.29	1.79	NA	20.63	090
27640		A	Partial removal of tibia	11.35	NA	10.31	1.84	NA	23.50	090
27641		A	Partial removal of fibula	9.23	NA	8.34	1.45	NA	19.02	090
27645		A	Extensive lower leg surgery	14.15	NA	12.05	2.35	NA	28.55	090
27646		A	Extensive lower leg surgery	12.64	NA	11.03	2.01	NA	25.68	090
27647		A	Extensive ankle/heel surgery	12.22	NA	7.61	1.74	NA	21.57	090
27648		A	Injection for ankle x-ray	0.96	3.52	0.33	0.08	4.56	1.37	000
27650		A	Repair achilles tendon	9.68	NA	7.51	1.57	NA	18.76	090
27652		A	Repair/graft achilles tendon	10.31	NA	8.03	1.68	NA	20.02	090
27654		A	Repair of achilles tendon	10.00	NA	7.14	1.56	NA	18.70	090
27656		A	Repair leg fascia defect	4.56	8.53	3.77	0.64	13.73	8.97	090
27658		A	Repair of leg tendon, each	4.97	NA	4.56	0.78	NA	10.31	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
27659		A	Repair of leg tendon, each	6.80	NA	5.64	1.08	NA	13.52	090
27664		A	Repair of leg tendon, each	4.58	NA	4.55	0.75	NA	9.88	090
27665		A	Repair of leg tendon, each	5.39	NA	4.97	0.88	NA	11.24	090
27675		A	Repair lower leg tendons	7.17	NA	5.73	1.11	NA	14.01	090
27676		A	Repair lower leg tendons	8.41	NA	6.75	1.37	NA	16.53	090
27680		A	Release of lower leg tendon	5.73	NA	5.11	0.93	NA	11.77	090
27681		A	Release of lower leg tendons	6.81	NA	5.91	1.14	NA	13.86	090
27685		A	Revision of lower leg tendon	6.49	7.29	5.46	0.97	14.75	12.92	090
27686		A	Revise lower leg tendons	7.45	NA	6.49	1.24	NA	15.18	090
27687		A	Revision of calf tendon	6.23	NA	5.31	1.00	NA	12.54	090
27690		A	Revise lower leg tendon	8.70	NA	6.35	1.32	NA	16.37	090
27691		A	Revise lower leg tendon	9.95	NA	7.76	1.63	NA	19.34	090
27692		A	Revise additional leg tendon	1.87	NA	0.93	0.32	NA	3.12	ZZZ
27695		A	Repair of ankle ligament	6.50	NA	5.87	1.04	NA	13.41	090
27696		A	Repair of ankle ligaments	8.26	NA	6.43	1.28	NA	15.97	090
27698		A	Repair of ankle ligament	9.35	NA	6.94	1.47	NA	17.76	090
27700		A	Revision of ankle joint	9.28	NA	5.68	1.31	NA	16.27	090
27702		A	Reconstruct ankle joint	13.65	NA	10.46	2.35	NA	26.46	090
27703		A	Reconstruction, ankle joint	15.85	NA	11.23	2.72	NA	29.80	090
27704		A	Removal of ankle implant	7.61	NA	5.59	1.26	NA	14.46	090
27705		A	Incision of tibia	10.36	NA	8.17	1.74	NA	20.27	090
27707		A	Incision of fibula	4.36	NA	4.94	0.74	NA	10.04	090
27709		A	Incision of tibia & fibula	9.94	NA	8.13	1.69	NA	19.76	090
27712		A	Realignment of lower leg	14.23	NA	10.74	2.45	NA	27.42	090
27715		A	Revision of lower leg	14.37	NA	10.77	2.44	NA	27.58	090
27720		A	Repair of tibia	11.77	NA	9.40	2.01	NA	23.18	090
27722		A	Repair/graft of tibia	11.80	NA	9.13	2.00	NA	22.93	090
27724		A	Repair/graft of tibia	18.17	NA	12.36	3.12	NA	33.65	090
27725		A	Repair of lower leg	15.57	NA	11.91	2.62	NA	30.10	090
27727		A	Repair of lower leg	13.99	NA	10.34	2.41	NA	26.74	090
27730		A	Repair of tibia epiphysis	7.40	NA	6.42	1.70	NA	15.52	090
27732		A	Repair of fibula epiphysis	5.31	NA	4.93	0.77	NA	11.01	090
27734		A	Repair lower leg epiphyses	8.47	NA	6.28	1.35	NA	16.10	090
27740		A	Repair of leg epiphyses	9.29	NA	7.99	1.60	NA	18.88	090
27742		A	Repair of leg epiphyses	10.28	5.56	5.56	1.77	17.61	17.61	090
27745		A	Reinforce tibia	10.05	NA	8.17	1.70	NA	19.92	090
27750		A	Treatment of tibia fracture	3.19	4.76	3.85	0.51	8.46	7.55	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
27752		A	Treatment of tibia fracture	5.83	6.65	5.67	0.98	13.46	12.48	090
27756		A	Treatment of tibia fracture	6.77	NA	6.46	1.15	NA	14.38	090
27758		A	Treatment of tibia fracture	11.65	NA	9.18	2.00	NA	22.83	090
27759		A	Treatment of tibia fracture	13.74	NA	10.31	2.35	NA	26.40	090
27760		A	Treatment of ankle fracture	3.01	4.68	3.59	0.45	8.14	7.05	090
27762		A	Treatment of ankle fracture	5.24	6.33	5.27	0.81	12.38	11.32	090
27766		A	Treatment of ankle fracture	8.35	NA	7.22	1.42	NA	16.99	090
27780		A	Treatment of fibula fracture	2.65	4.18	3.21	0.40	7.23	6.26	090
27781		A	Treatment of fibula fracture	4.39	5.49	4.64	0.71	10.59	9.74	090
27784		A	Treatment of fibula fracture	7.10	NA	6.47	1.21	NA	14.78	090
27786		A	Treatment of ankle fracture	2.84	4.46	3.33	0.43	7.73	6.60	090
27788		A	Treatment of ankle fracture	4.44	5.64	4.65	0.71	10.79	9.80	090
27792		A	Treatment of ankle fracture	7.65	NA	6.96	1.30	NA	15.91	090
27808		A	Treatment of ankle fracture	2.83	4.80	3.70	0.45	8.08	6.98	090
27810		A	Treatment of ankle fracture	5.12	6.24	5.15	0.80	12.16	11.07	090
27814		A	Treatment of ankle fracture	10.66	NA	8.56	1.82	NA	21.04	090
27816		A	Treatment of ankle fracture	2.89	4.38	3.41	0.41	7.68	6.71	090
27818		A	Treatment of ankle fracture	5.49	6.37	5.17	0.79	12.65	11.45	090
27822		A	Treatment of ankle fracture	10.98	NA	10.65	1.87	NA	23.50	090
27823		A	Treatment of ankle fracture	12.98	NA	11.47	2.21	NA	26.66	090
27824		A	Treat lower leg fracture	2.89	4.06	3.56	0.43	7.38	6.88	090
27825		A	Treat lower leg fracture	6.18	6.60	5.38	1.00	13.78	12.56	090
27826		A	Treat lower leg fracture	8.53	NA	8.82	1.46	NA	18.81	090
27827		A	Treat lower leg fracture	14.04	NA	12.76	2.39	NA	29.19	090
27828		A	Treat lower leg fracture	16.21	NA	13.93	2.76	NA	32.90	090
27829		A	Treat lower leg joint	5.48	NA	6.78	0.94	NA	13.20	090
27830		A	Treat lower leg dislocation	3.78	4.39	3.85	0.52	8.69	8.15	090
27831		A	Treat lower leg dislocation	4.55	NA	4.46	0.73	NA	9.74	090
27832		A	Treat lower leg dislocation	6.48	NA	6.17	0.97	NA	13.62	090
27840		A	Treat ankle dislocation	4.57	NA	3.76	0.45	NA	8.78	090
27842		A	Treat ankle dislocation	6.20	NA	5.12	0.97	NA	12.29	090
27846		A	Treat ankle dislocation	9.78	NA	7.93	1.63	NA	19.34	090
27848		A	Treat ankle dislocation	11.18	NA	9.71	1.88	NA	22.77	090
27860		A	Fixation of ankle joint	2.34	NA	1.98	0.38	NA	4.70	010
27870		A	Fusion of ankle joint, open	13.89	NA	10.52	2.34	NA	26.75	090
27871		A	Fusion of tibiofibular joint	9.16	NA	7.58	1.56	NA	18.30	090
27880		A	Amputation of lower leg	11.83	NA	7.13	1.73	NA	20.69	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
27881		A	Amputation of lower leg	12.32	NA	8.84	1.95	NA	23.11	090
27882		A	Amputation of lower leg	8.93	NA	6.48	1.28	NA	16.69	090
27884		A	Amputation follow-up surgery	8.20	NA	5.75	1.20	NA	15.15	090
27886		A	Amputation follow-up surgery	9.31	NA	6.51	1.38	NA	17.20	090
27888		A	Amputation of foot at ankle	9.66	NA	7.50	1.50	NA	18.66	090
27889		A	Amputation of foot at ankle	9.97	NA	6.47	1.44	NA	17.88	090
27892		A	Decompression of leg	7.38	NA	5.59	1.08	NA	14.05	090
27893		A	Decompression of leg	7.34	NA	5.46	1.09	NA	13.89	090
27894		A	Decompression of leg	10.47	NA	7.77	1.61	NA	19.85	090
27899		C	Leg/ankle surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
28001		A	Drainage of bursa of foot	2.73	2.98	1.95	0.34	6.05	5.02	010
28002		A	Treatment of foot infection	4.61	4.99	3.77	0.62	10.22	9.00	010
28003		A	Treatment of foot infection	8.40	6.23	5.22	1.13	15.76	14.75	090
28005		A	Treat foot bone lesion	8.67	NA	6.04	1.17	NA	15.88	090
28008		A	Incision of foot fascia	4.44	4.55	3.20	0.58	9.57	8.22	090
28010		A	Incision of toe tendon	2.84	2.37	2.37	0.37	5.58	5.58	090
28011		A	Incision of toe tendons	4.13	NA	3.30	0.59	NA	8.02	090
28020		A	Exploration of foot joint	5.00	6.01	4.13	0.72	11.73	9.85	090
28022		A	Exploration of foot joint	4.66	5.19	3.85	0.63	10.48	9.14	090
28024		A	Exploration of toe joint	4.37	5.21	3.92	0.57	10.15	8.86	090
28030		A	Removal of foot nerve	6.14	NA	3.65	0.76	NA	10.55	090
28035		A	Decompression of tibia nerve	5.08	5.85	4.09	0.70	11.63	9.87	090
28043		A	Excision of foot lesion	3.53	3.81	3.17	0.46	7.80	7.16	090
28045		A	Excision of foot lesion	4.71	5.37	3.60	0.63	10.71	8.94	090
28046		A	Resection of tumor, foot	10.16	8.76	6.47	1.35	20.27	17.98	090
28050		A	Biopsy of foot joint lining	4.24	4.89	3.59	0.60	9.73	8.43	090
28052		A	Biopsy of foot joint lining	3.93	4.91	3.43	0.53	9.37	7.89	090
28054		A	Biopsy of toe joint lining	3.44	4.72	3.23	0.46	8.62	7.13	090
28060		A	Partial removal, foot fascia	5.22	5.47	3.87	0.70	11.39	9.79	090
28062		A	Removal of foot fascia	6.51	6.51	4.01	0.84	13.86	11.36	090
28070		A	Removal of foot joint lining	5.09	5.21	3.81	0.73	11.03	9.63	090
28072		A	Removal of foot joint lining	4.57	5.52	4.30	0.67	10.76	9.54	090
28080		A	Removal of foot lesion	3.57	5.11	3.68	0.47	9.15	7.72	090
28086		A	Excise foot tendon sheath	4.77	7.98	4.68	0.75	13.50	10.20	090
28088		A	Excise foot tendon sheath	3.85	5.75	3.89	0.60	10.20	8.34	090
28090		A	Removal of foot lesion	4.40	5.14	3.45	0.59	10.13	8.44	090
28092		A	Removal of toe lesions	3.63	5.21	3.52	0.49	9.33	7.64	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
28100		A	Removal of ankle/heel lesion	5.65	7.96	4.69	0.80	14.41	11.14	090
28102		A	Remove/graft foot lesion	7.72	NA	5.94	1.15	NA	14.81	090
28103		A	Remove/graft foot lesion	6.49	NA	4.61	0.91	NA	12.01	090
28104		A	Removal of foot lesion	5.11	5.48	3.92	0.70	11.29	9.73	090
28106		A	Remove/graft foot lesion	7.15	NA	4.43	0.97	NA	12.55	090
28107		A	Remove/graft foot lesion	5.55	6.52	4.20	0.74	12.81	10.49	090
28108		A	Removal of toe lesions	4.15	4.59	3.25	0.53	9.27	7.93	090
28110		A	Part removal of metatarsal	4.07	5.21	3.22	0.54	9.82	7.83	090
28111		A	Part removal of metatarsal	5.00	6.27	3.65	0.68	11.95	9.33	090
28112		A	Part removal of metatarsal	4.48	5.80	3.57	0.62	10.90	8.67	090
28113		A	Part removal of metatarsal	4.78	6.05	4.31	0.63	11.46	9.72	090
28114		A	Removal of metatarsal heads	9.78	11.62	8.37	1.43	22.83	19.58	090
28116		A	Revision of foot	7.74	6.79	5.17	1.04	15.57	13.95	090
28118		A	Removal of heel bone	5.95	6.24	4.34	0.84	13.03	11.13	090
28119		A	Removal of heel spur	5.38	5.42	3.72	0.70	11.50	9.80	090
28120		A	Part removal of ankle/heel	5.39	7.28	4.41	0.77	13.44	10.57	090
28122		A	Partial removal of foot bone	7.28	6.83	5.26	0.98	15.09	13.52	090
28124		A	Partial removal of toe	4.80	4.99	3.65	0.60	10.39	9.05	090
28126		A	Partial removal of toe	3.51	4.21	2.99	0.45	8.17	6.95	090
28130		A	Removal of ankle bone	8.10	NA	6.71	1.25	NA	16.06	090
28140		A	Removal of metatarsal	6.90	7.22	4.76	0.92	15.04	12.58	090
28150		A	Removal of toe	4.08	4.83	3.28	0.53	9.44	7.89	090
28153		A	Partial removal of toe	3.65	4.31	2.68	0.47	8.43	6.80	090
28160		A	Partial removal of toe	3.73	4.56	3.33	0.49	8.78	7.55	090
28171		A	Extensive foot surgery	9.59	NA	5.42	1.33	NA	16.34	090
28173		A	Extensive foot surgery	8.79	7.59	5.19	1.13	17.51	15.11	090
28175		A	Extensive foot surgery	6.04	5.70	3.70	0.74	12.48	10.48	090
28190		A	Removal of foot foreign body	1.96	3.39	1.48	0.22	5.57	3.66	010
28192		A	Removal of foot foreign body	4.63	5.47	3.64	0.59	10.69	8.86	090
28193		A	Removal of foot foreign body	5.72	5.60	3.92	0.72	12.04	10.36	090
28200		A	Repair of foot tendon	4.59	5.09	3.55	0.61	10.29	8.75	090
28202		A	Repair/graft of foot tendon	6.83	7.21	4.49	0.91	14.95	12.23	090
28208		A	Repair of foot tendon	4.36	4.81	3.30	0.58	9.75	8.24	090
28210		A	Repair/graft of foot tendon	6.34	6.21	4.02	0.82	13.37	11.18	090
28220		A	Release of foot tendon	4.52	4.67	3.42	0.57	9.76	8.51	090
28222		A	Release of foot tendons	5.61	5.23	4.12	0.70	11.54	10.43	090
28225		A	Release of foot tendon	3.65	4.28	2.90	0.47	8.40	7.02	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
28226		A	Release of foot tendons	4.52	4.79	3.74	0.58	9.89	8.84	090
28230		A	Incision of foot tendon(s)	4.23	4.67	3.67	0.56	9.46	8.46	090
28232		A	Incision of toe tendon	3.38	4.52	3.31	0.45	8.35	7.14	090
28234		A	Incision of foot tendon	3.36	4.67	3.35	0.44	8.47	7.15	090
28238		A	Revision of foot tendon	7.72	7.24	4.93	1.06	16.02	13.71	090
28240		A	Release of big toe	4.35	4.63	3.48	0.58	9.56	8.41	090
28250		A	Revision of foot fascia	5.91	5.62	4.13	0.83	12.36	10.87	090
28260		A	Release of midfoot joint	7.95	6.32	4.99	1.14	15.41	14.08	090
28261		A	Revision of foot tendon	11.71	8.61	7.30	1.57	21.89	20.58	090
28262		A	Revision of foot and ankle	15.81	13.55	10.91	2.57	31.93	29.29	090
28264		A	Release of midfoot joint	10.33	7.73	7.28	1.54	19.60	19.15	090
28270		A	Release of foot contracture	4.75	4.89	3.73	0.62	10.26	9.10	090
28272		A	Release of toe joint, each	3.79	4.18	2.85	0.47	8.44	7.11	090
28280		A	Fusion of toes	5.18	6.24	4.48	0.73	12.15	10.39	090
28285		A	Repair of hammertoe	4.58	4.86	3.42	0.60	10.04	8.60	090
28286		A	Repair of hammertoe	4.55	4.79	3.25	0.58	9.92	8.38	090
28288		A	Partial removal of foot bone	4.73	5.93	4.88	0.65	11.31	10.26	090
28289		A	Repair hallux rigidus	7.03	7.98	5.76	1.02	16.03	13.81	090
28290		A	Correction of bunion	5.65	6.25	4.72	0.82	12.72	11.19	090
28292		A	Correction of bunion	7.03	7.46	5.53	0.92	15.41	13.48	090
28293		A	Correction of bunion	9.14	10.74	6.10	1.14	21.02	16.38	090
28294		A	Correction of bunion	8.55	7.43	4.71	1.10	17.08	14.36	090
28296		A	Correction of bunion	9.17	8.15	5.41	1.20	18.52	15.78	090
28297		A	Correction of bunion	9.17	8.94	6.25	1.32	19.43	16.74	090
28298		A	Correction of bunion	7.93	7.21	5.00	1.05	16.19	13.98	090
28299		A	Correction of bunion	10.56	8.76	6.06	1.38	20.70	18.00	090
28300		A	Incision of heel bone	9.53	NA	7.03	1.53	NA	18.09	090
28302		A	Incision of ankle bone	9.54	NA	6.88	1.42	NA	17.84	090
28304		A	Incision of midfoot bones	9.15	7.94	5.73	1.27	18.36	16.15	090
28305		A	Incise/graft midfoot bones	10.48	NA	6.72	1.27	NA	18.47	090
28306		A	Incision of metatarsal	5.85	6.83	4.17	0.84	13.52	10.86	090
28307		A	Incision of metatarsal	6.32	11.02	5.28	0.91	18.25	12.51	090
28308		A	Incision of metatarsal	5.28	5.74	3.68	0.70	11.72	9.66	090
28309		A	Incision of metatarsals	12.76	NA	7.95	2.02	NA	22.73	090
28310		A	Revision of big toe	5.42	5.74	3.55	0.70	11.86	9.67	090
28312		A	Revision of toe	4.54	5.43	3.63	0.63	10.60	8.80	090
28313		A	Repair deformity of toe	5.00	5.27	4.83	0.73	11.00	10.56	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
28315		A	Removal of sesamoid bone	4.85	4.89	3.33	0.63	10.37	8.81	090
28320		A	Repair of foot bones	9.17	NA	6.71	1.42	NA	17.30	090
28322		A	Repair of metatarsals	8.33	9.17	6.33	1.26	18.76	15.92	090
28340		A	Resect enlarged toe tissue	6.97	6.44	4.24	0.85	14.26	12.06	090
28341		A	Resect enlarged toe	8.40	6.93	4.81	1.05	16.38	14.26	090
28344		A	Repair extra toe(s)	4.25	5.74	3.63	0.52	10.51	8.40	090
28345		A	Repair webbed toe(s)	5.91	6.19	4.68	0.81	12.91	11.40	090
28360		A	Reconstruct cleft foot	13.32	NA	10.49	2.27	NA	26.08	090
28400		A	Treatment of heel fracture	2.16	3.63	3.05	0.33	6.12	5.54	090
28405		A	Treatment of heel fracture	4.56	4.83	4.62	0.72	10.11	9.90	090
28406		A	Treatment of heel fracture	6.30	NA	6.79	1.09	NA	14.18	090
28415		A	Treat heel fracture	15.95	NA	13.28	2.63	NA	31.86	090
28420		A	Treat/graft heel fracture	16.62	NA	12.91	2.75	NA	32.28	090
28430		A	Treatment of ankle fracture	2.09	3.39	2.56	0.30	5.78	4.95	090
28435		A	Treatment of ankle fracture	3.39	3.88	3.74	0.53	7.80	7.66	090
28436		A	Treatment of ankle fracture	4.70	NA	5.91	0.78	NA	11.39	090
28445		A	Treat ankle fracture	15.60	NA	11.03	2.55	NA	29.18	090
28450		A	Treat midfoot fracture, each	1.90	3.11	2.47	0.28	5.29	4.65	090
28455		A	Treat midfoot fracture, each	3.09	3.42	3.42	0.43	6.94	6.94	090
28456		A	Treat midfoot fracture	2.68	NA	4.15	0.44	NA	7.27	090
28465		A	Treat midfoot fracture, each	7.00	NA	6.31	1.08	NA	14.39	090
28470		A	Treat metatarsal fracture	1.99	3.12	2.44	0.29	5.40	4.72	090
28475		A	Treat metatarsal fracture	2.97	3.33	3.21	0.43	6.73	6.61	090
28476		A	Treat metatarsal fracture	3.37	NA	4.98	0.54	NA	8.89	090
28485		A	Treat metatarsal fracture	5.70	NA	5.44	0.83	NA	11.97	090
28490		A	Treat big toe fracture	1.09	2.01	1.64	0.14	3.24	2.87	090
28495		A	Treat big toe fracture	1.58	2.17	2.06	0.20	3.95	3.84	090
28496		A	Treat big toe fracture	2.33	8.25	3.19	0.36	10.94	5.88	090
28505		A	Treat big toe fracture	3.80	8.10	3.90	0.55	12.45	8.25	090
28510		A	Treatment of toe fracture	1.09	1.53	1.53	0.13	2.75	2.75	090
28515		A	Treatment of toe fracture	1.46	1.89	1.89	0.18	3.53	3.53	090
28525		A	Treat toe fracture	3.32	7.51	3.43	0.47	11.30	7.22	090
28530		A	Treat sesamoid bone fracture	1.06	1.44	1.44	0.14	2.64	2.64	090
28531		A	Treat sesamoid bone fracture	2.35	7.26	2.06	0.34	9.95	4.75	090
28540		A	Treat foot dislocation	2.04	2.40	2.40	0.25	4.69	4.69	090
28545		A	Treat foot dislocation	2.45	2.34	2.34	0.37	5.16	5.16	090
28546		A	Treat foot dislocation	3.20	6.91	4.38	0.52	10.63	8.10	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
28555		A	Repair foot dislocation	6.29	9.90	5.67	1.04	17.23	13.00	090
28570		A	Treat foot dislocation	1.66	2.42	2.33	0.22	4.30	4.21	090
28575		A	Treat foot dislocation	3.31	3.72	3.72	0.56	7.59	7.59	090
28576		A	Treat foot dislocation	4.16	NA	4.17	0.69	NA	9.02	090
28585		A	Repair foot dislocation	7.98	7.32	5.83	1.23	16.53	15.04	090
28600		A	Treat foot dislocation	1.89	2.81	2.68	0.27	4.97	4.84	090
28605		A	Treat foot dislocation	2.71	3.12	3.12	0.40	6.23	6.23	090
28606		A	Treat foot dislocation	4.89	NA	4.69	0.82	NA	10.40	090
28615		A	Repair foot dislocation	7.76	NA	8.04	1.29	NA	17.09	090
28630		A	Treat toe dislocation	1.70	1.57	1.00	0.19	3.46	2.89	010
28635		A	Treat toe dislocation	1.91	2.02	1.53	0.26	4.19	3.70	010
28636		A	Treat toe dislocation	2.77	3.87	2.62	0.43	7.07	5.82	010
28645		A	Repair toe dislocation	4.21	4.95	3.27	0.58	9.74	8.06	090
28660		A	Treat toe dislocation	1.23	1.26	0.79	0.13	2.62	2.15	010
28665		A	Treat toe dislocation	1.92	NA	1.43	0.25	NA	3.60	010
28666		A	Treat toe dislocation	2.66	5.88	2.58	0.43	8.97	5.67	010
28675		A	Repair of toe dislocation	2.92	7.14	3.35	0.45	10.51	6.72	090
28705		A	Fusion of foot bones	18.77	NA	12.43	3.05	NA	34.25	090
28715		A	Fusion of foot bones	13.08	NA	9.75	2.14	NA	24.97	090
28725		A	Fusion of foot bones	11.59	NA	8.24	1.85	NA	21.68	090
28730		A	Fusion of foot bones	10.74	NA	8.48	1.68	NA	20.90	090
28735		A	Fusion of foot bones	10.83	NA	7.82	1.67	NA	20.32	090
28737		A	Revision of foot bones	9.63	NA	6.80	1.46	NA	17.89	090
28740		A	Fusion of foot bones	8.01	10.86	6.46	1.22	20.09	15.69	090
28750		A	Fusion of big toe joint	7.29	11.91	6.66	1.11	20.31	15.06	090
28755		A	Fusion of big toe joint	4.73	6.10	3.75	0.65	11.48	9.13	090
28760		A	Fusion of big toe joint	7.74	7.97	5.51	1.06	16.77	14.31	090
28800		A	Amputation of midfoot	8.20	NA	5.79	1.15	NA	15.14	090
28805		A	Amputation thru metatarsal	8.38	NA	5.64	1.17	NA	15.19	090
28810		A	Amputation toe & metatarsal	6.20	NA	4.47	0.86	NA	11.53	090
28820		A	Amputation of toe	4.40	7.55	3.78	0.61	12.56	8.79	090
28825		A	Partial amputation of toe	3.58	6.99	3.48	0.50	11.07	7.56	090
28899		C	Foot/toes surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
29000		A	Application of body cast	2.25	2.96	1.73	0.40	5.61	4.38	000
29010		A	Application of body cast	2.06	3.28	1.77	0.45	5.79	4.28	000
29015		A	Application of body cast	2.41	2.97	1.60	0.29	5.67	4.30	000
29020		A	Application of body cast	2.11	3.18	1.41	0.28	5.57	3.80	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
29025		A	Application of body cast	2.40	3.14	1.85	0.44	5.98	4.69	000
29035		A	Application of body cast	1.77	3.61	1.58	0.28	5.66	3.63	000
29040		A	Application of body cast	2.22	2.46	1.51	0.36	5.04	4.09	000
29044		A	Application of body cast	2.12	3.97	1.90	0.35	6.44	4.37	000
29046		A	Application of body cast	2.41	3.23	2.09	0.41	6.05	4.91	000
29049		A	Application of figure eight	0.89	1.30	0.53	0.12	2.31	1.54	000
29055		A	Application of shoulder cast	1.78	2.98	1.47	0.28	5.04	3.53	000
29058		A	Application of shoulder cast	1.31	1.56	0.72	0.16	3.03	2.19	000
29065		A	Application of long arm cast	0.87	1.33	0.75	0.14	2.34	1.76	000
29075		A	Application of forearm cast	0.77	1.26	0.68	0.12	2.15	1.57	000
29085		A	Apply hand/wrist cast	0.87	1.28	0.63	0.13	2.28	1.63	000
29086		A	Apply finger cast	0.62	0.96	0.49	0.07	1.65	1.18	000
29105		A	Apply long arm splint	0.87	1.23	0.51	0.12	2.22	1.50	000
29125		A	Apply forearm splint	0.59	1.02	0.39	0.07	1.68	1.05	000
29126		A	Apply forearm splint	0.77	1.21	0.46	0.06	2.04	1.29	000
29130		A	Application of finger splint	0.50	0.47	0.17	0.06	1.03	0.73	000
29131		A	Application of finger splint	0.55	0.74	0.24	0.04	1.33	0.83	000
29200		A	Strapping of chest	0.65	0.72	0.34	0.04	1.41	1.03	000
29220		A	Strapping of low back	0.64	0.72	0.39	0.04	1.40	1.07	000
29240		A	Strapping of shoulder	0.71	0.85	0.36	0.05	1.61	1.12	000
29260		A	Strapping of elbow or wrist	0.55	0.74	0.32	0.05	1.34	0.92	000
29280		A	Strapping of hand or finger	0.51	0.80	0.32	0.03	1.34	0.86	000
29305		A	Application of hip cast	2.03	3.34	1.76	0.33	5.70	4.12	000
29325		A	Application of hip casts	2.32	3.53	1.95	0.38	6.23	4.65	000
29345		A	Application of long leg cast	1.40	1.76	1.06	0.23	3.39	2.69	000
29355		A	Application of long leg cast	1.53	1.71	1.12	0.24	3.48	2.89	000
29358		A	Apply long leg cast brace	1.43	2.06	1.09	0.24	3.73	2.76	000
29365		A	Application of long leg cast	1.18	1.66	0.95	0.20	3.04	2.33	000
29405		A	Apply short leg cast	0.86	1.22	0.71	0.14	2.22	1.71	000
29425		A	Apply short leg cast	1.01	1.23	0.74	0.15	2.39	1.90	000
29435		A	Apply short leg cast	1.18	1.56	0.93	0.20	2.94	2.31	000
29440		A	Addition of walker to cast	0.57	0.69	0.27	0.08	1.34	0.92	000
29445		A	Apply rigid leg cast	1.78	1.80	0.96	0.26	3.84	3.00	000
29450		A	Application of leg cast	2.08	1.47	1.09	0.27	3.82	3.44	000
29505		A	Application, long leg splint	0.69	1.18	0.45	0.07	1.94	1.21	000
29515		A	Application lower leg splint	0.73	0.87	0.46	0.09	1.69	1.28	000
29520		A	Strapping of hip	0.54	0.85	0.47	0.03	1.42	1.04	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
29530		A	Strapping of knee	0.57	0.79	0.33	0.04	1.40	0.94	000
29540		A	Strapping of ankle and/or ft	0.51	0.42	0.31	0.06	0.99	0.88	000
29550		A	Strapping of toes	0.47	0.42	0.28	0.06	0.95	0.81	000
29580		A	Application of paste boot	0.57	0.65	0.35	0.07	1.29	0.99	000
29590		A	Application of foot splint	0.76	0.51	0.29	0.09	1.36	1.14	000
29700		A	Removal/revision of cast	0.57	0.89	0.28	0.07	1.53	0.92	000
29705		A	Removal/revision of cast	0.76	0.82	0.38	0.12	1.70	1.26	000
29710		A	Removal/revision of cast	1.34	1.53	0.70	0.19	3.06	2.23	000
29715		A	Removal/revision of cast	0.94	1.17	0.40	0.10	2.21	1.44	000
29720		A	Repair of body cast	0.68	1.16	0.39	0.11	1.95	1.18	000
29730		A	Windowing of cast	0.75	0.81	0.35	0.12	1.68	1.22	000
29740		A	Wedging of cast	1.12	1.15	0.49	0.17	2.44	1.78	000
29750		A	Wedging of clubfoot cast	1.26	1.06	0.58	0.20	2.52	2.04	000
29799		C	Casting/strapping procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
29800		A	Jaw arthroscopy/surgery	6.42	NA	6.97	0.98	NA	14.37	090
29804		A	Jaw arthroscopy/surgery	8.13	NA	7.62	1.38	NA	17.13	090
29805		A	Shoulder arthroscopy, dx	5.88	NA	5.67	1.00	NA	12.55	090
29806		A	Shoulder arthroscopy/surgery	14.35	NA	11.16	2.45	NA	27.96	090
29807		A	Shoulder arthroscopy/surgery	13.88	NA	10.99	2.36	NA	27.23	090
29819		A	Shoulder arthroscopy/surgery	7.61	NA	6.79	1.29	NA	15.69	090
29820		A	Shoulder arthroscopy/surgery	7.06	NA	6.22	1.20	NA	14.48	090
29821		A	Shoulder arthroscopy/surgery	7.71	NA	6.80	1.30	NA	15.81	090
29822		A	Shoulder arthroscopy/surgery	7.42	NA	6.69	1.27	NA	15.38	090
29823		A	Shoulder arthroscopy/surgery	8.16	NA	7.22	1.39	NA	16.77	090
29824		A	Shoulder arthroscopy/surgery	8.24	NA	7.53	1.41	NA	17.18	090
29825		A	Shoulder arthroscopy/surgery	7.61	NA	6.76	1.29	NA	15.66	090
29826		A	Shoulder arthroscopy/surgery	8.98	NA	7.53	1.54	NA	18.05	090
29827		A	Arthroscop rotator cuff repr	15.34	NA	11.53	2.63	NA	29.50	090
29830		A	Elbow arthroscopy	5.75	NA	5.34	0.96	NA	12.05	090
29834		A	Elbow arthroscopy/surgery	6.27	NA	5.83	1.06	NA	13.16	090
29835		A	Elbow arthroscopy/surgery	6.47	NA	5.88	1.11	NA	13.46	090
29836		A	Elbow arthroscopy/surgery	7.54	NA	6.79	1.21	NA	15.54	090
29837		A	Elbow arthroscopy/surgery	6.86	NA	6.13	1.18	NA	14.17	090
29838		A	Elbow arthroscopy/surgery	7.70	NA	6.89	1.27	NA	15.86	090
29840		A	Wrist arthroscopy	5.53	NA	5.32	0.83	NA	11.68	090
29843		A	Wrist arthroscopy/surgery	6.00	NA	5.62	0.92	NA	12.54	090
29844		A	Wrist arthroscopy/surgery	6.36	NA	5.82	1.04	NA	13.22	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
29845		A	Wrist arthroscopy/surgery	7.51	NA	6.47	0.99	NA	14.97	090
29846		A	Wrist arthroscopy/surgery	6.74	NA	6.05	1.06	NA	13.85	090
29847		A	Wrist arthroscopy/surgery	7.07	NA	6.19	1.08	NA	14.34	090
29848		A	Wrist endoscopy/surgery	5.43	NA	5.60	0.87	NA	11.90	090
29850		A	Knee arthroscopy/surgery	8.18	NA	5.04	1.17	NA	14.39	090
29851		A	Knee arthroscopy/surgery	13.08	NA	9.79	2.32	NA	25.19	090
29855		A	Tibial arthroscopy/surgery	10.60	NA	8.76	1.82	NA	21.18	090
29856		A	Tibial arthroscopy/surgery	14.12	NA	10.67	2.38	NA	27.17	090
29860		A	Hip arthroscopy, dx	8.04	NA	6.95	1.35	NA	16.34	090
29861		A	Hip arthroscopy/surgery	9.14	NA	7.34	1.55	NA	18.03	090
29862		A	Hip arthroscopy/surgery	9.89	NA	8.56	1.61	NA	20.06	090
29863		A	Hip arthroscopy/surgery	9.89	NA	8.51	1.42	NA	19.82	090
29866		A	Autgrft implnt, knee w/scope	13.88	NA	11.35	2.38	NA	27.61	090
29867		A	Allgrft implnt, knee w/scope	17.00	NA	13.22	2.76	NA	32.98	090
29868		A	Meniscal trnspl, knee w/scpe	23.59	NA	16.79	4.33	NA	44.71	090
29870		A	Knee arthroscopy, dx	5.06	NA	4.89	0.83	NA	10.78	090
29871		A	Knee arthroscopy/drainage	6.54	NA	5.87	1.12	NA	13.53	090
29873		A	Knee arthroscopy/surgery	5.99	NA	6.57	1.03	NA	13.59	090
29874		A	Knee arthroscopy/surgery	7.04	NA	6.07	1.07	NA	14.18	090
29875		A	Knee arthroscopy/surgery	6.30	NA	5.85	1.08	NA	13.23	090
29876		A	Knee arthroscopy/surgery	7.91	NA	7.02	1.36	NA	16.29	090
29877		A	Knee arthroscopy/surgery	7.34	NA	6.74	1.26	NA	15.34	090
29879		A	Knee arthroscopy/surgery	8.03	NA	7.12	1.38	NA	16.53	090
29880		A	Knee arthroscopy/surgery	8.49	NA	7.36	1.46	NA	17.31	090
29881		A	Knee arthroscopy/surgery	7.75	NA	6.96	1.33	NA	16.04	090
29882		A	Knee arthroscopy/surgery	8.64	NA	7.24	1.48	NA	17.36	090
29883		A	Knee arthroscopy/surgery	11.03	NA	9.06	1.89	NA	21.98	090
29884		A	Knee arthroscopy/surgery	7.32	NA	6.70	1.26	NA	15.28	090
29885		A	Knee arthroscopy/surgery	9.08	NA	7.97	1.56	NA	18.61	090
29886		A	Knee arthroscopy/surgery	7.53	NA	6.85	1.29	NA	15.67	090
29887		A	Knee arthroscopy/surgery	9.03	NA	7.93	1.55	NA	18.51	090
29888		A	Knee arthroscopy/surgery	13.88	NA	10.20	2.38	NA	26.46	090
29889		A	Knee arthroscopy/surgery	15.98	NA	12.43	2.73	NA	31.14	090
29891		A	Ankle arthroscopy/surgery	8.39	NA	7.51	1.38	NA	17.28	090
29892		A	Ankle arthroscopy/surgery	8.99	NA	7.74	1.41	NA	18.14	090
29893		A	Scope, plantar fasciotomy	5.21	6.28	3.99	0.65	12.14	9.85	090
29894		A	Ankle arthroscopy/surgery	7.20	NA	5.47	1.14	NA	13.81	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
29895		A	Ankle arthroscopy/surgery	6.98	NA	5.47	1.10	NA	13.55	090
29897		A	Ankle arthroscopy/surgery	7.17	NA	5.88	1.17	NA	14.22	090
29898		A	Ankle arthroscopy/surgery	8.31	NA	6.19	1.27	NA	15.77	090
29899		A	Ankle arthroscopy/surgery	13.89	NA	10.54	2.36	NA	26.79	090
29900		A	Mcp joint arthroscopy, dx	5.41	NA	5.86	0.93	NA	12.20	090
29901		A	Mcp joint arthroscopy, surg	6.12	NA	6.26	1.06	NA	13.44	090
29902		A	Mcp joint arthroscopy, surg	6.69	NA	6.54	1.12	NA	14.35	090
29999		C	Arthroscopy of joint	0.00	0.00	0.00	0.00	0.00	0.00	YYY
30000		A	Drainage of nose lesion	1.43	4.07	1.39	0.12	5.62	2.94	010
30020		A	Drainage of nose lesion	1.43	3.27	1.47	0.12	4.82	3.02	010
30100		A	Intranasal biopsy	0.94	1.97	0.82	0.07	2.98	1.83	000
30110		A	Removal of nose polyp(s)	1.63	3.24	1.57	0.14	5.01	3.34	010
30115		A	Removal of nose polyp(s)	4.34	NA	5.76	0.41	NA	10.51	090
30117		A	Removal of intranasal lesion	3.16	13.14	4.63	0.26	16.56	8.05	090
30118		A	Removal of intranasal lesion	9.68	NA	9.19	0.82	NA	19.69	090
30120		A	Revision of nose	5.26	6.49	6.00	0.52	12.27	11.78	090
30124		A	Removal of nose lesion	3.10	NA	3.61	0.25	NA	6.96	090
30125		A	Removal of nose lesion	7.15	NA	8.32	0.65	NA	16.12	090
30130		A	Removal of turbinate bones	3.37	NA	5.59	0.32	NA	9.28	090
30140		A	Removal of turbinate bones	3.42	NA	6.19	0.36	NA	9.97	090
30150		A	Partial removal of nose	9.13	NA	11.01	0.90	NA	21.04	090
30160		A	Removal of nose	9.57	NA	10.21	0.91	NA	20.69	090
30200		A	Injection treatment of nose	0.78	1.62	0.74	0.06	2.46	1.58	000
30210		A	Nasal sinus therapy	1.08	2.10	1.31	0.09	3.27	2.48	010
30220		A	Insert nasal septal button	1.54	4.23	1.53	0.13	5.90	3.20	010
30300		A	Remove nasal foreign body	1.04	4.63	1.91	0.08	5.75	3.03	010
30310		A	Remove nasal foreign body	1.96	NA	3.10	0.17	NA	5.23	010
30320		A	Remove nasal foreign body	4.51	NA	7.04	0.39	NA	11.94	090
30400		R	Reconstruction of nose	9.82	NA	15.49	1.03	NA	26.34	090
30410		R	Reconstruction of nose	12.96	NA	18.37	1.41	NA	32.74	090
30420		R	Reconstruction of nose	15.86	NA	17.91	1.46	NA	35.23	090
30430		R	Revision of nose	7.20	NA	16.01	0.77	NA	23.98	090
30435		R	Revision of nose	11.69	NA	19.35	1.19	NA	32.23	090
30450		R	Revision of nose	18.62	NA	21.89	1.93	NA	42.44	090
30460		A	Revision of nose	9.95	NA	9.94	1.03	NA	20.92	090
30462		A	Revision of nose	19.54	NA	20.24	2.51	NA	42.29	090
30465		A	Repair nasal stenosis	11.62	NA	11.97	1.05	NA	24.64	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
30520		A	Repair of nasal septum	5.69	NA	6.66	0.47	NA	12.82	090
30540		A	Repair nasal defect	7.74	NA	9.27	0.68	NA	17.69	090
30545		A	Repair nasal defect	11.36	NA	11.90	1.68	NA	24.94	090
30560		A	Release of nasal adhesions	1.26	4.77	2.13	0.10	6.13	3.49	010
30580		A	Repair upper jaw fistula	6.68	7.77	5.79	0.89	15.34	13.36	090
30600		A	Repair mouth/nose fistula	6.01	7.52	5.02	0.68	14.21	11.71	090
30620		A	Intranasal reconstruction	5.96	NA	8.83	0.57	NA	15.36	090
30630		A	Repair nasal septum defect	7.11	NA	7.95	0.61	NA	15.67	090
30801		A	Cauterization, inner nose	1.09	4.13	1.92	0.09	5.31	3.10	010
30802		A	Cauterization, inner nose	2.03	4.61	2.36	0.17	6.81	4.56	010
30901		A	Control of nosebleed	1.21	1.36	0.32	0.11	2.68	1.64	000
30903		A	Control of nosebleed	1.54	2.71	0.50	0.13	4.38	2.17	000
30905		A	Control of nosebleed	1.97	3.51	0.76	0.17	5.65	2.90	000
30906		A	Repeat control of nosebleed	2.45	3.89	1.20	0.20	6.54	3.85	000
30915		A	Ligation, nasal sinus artery	7.19	NA	6.69	0.59	NA	14.47	090
30920		A	Ligation, upper jaw artery	9.82	NA	8.97	0.80	NA	19.59	090
30930		A	Therapy, fracture of nose	1.26	NA	1.62	0.12	NA	3.00	010
30999		C	Nasal surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
31000		A	Irrigation, maxillary sinus	1.15	2.84	1.40	0.09	4.08	2.64	010
31002		A	Irrigation, sphenoid sinus	1.91	NA	3.24	0.16	NA	5.31	010
31020		A	Exploration, maxillary sinus	2.94	8.53	5.18	0.29	11.76	8.41	090
31030		A	Exploration, maxillary sinus	5.91	11.50	6.66	0.58	17.99	13.15	090
31032		A	Explore sinus, remove polyps	6.56	NA	7.23	0.60	NA	14.39	090
31040		A	Exploration behind upper jaw	9.41	NA	9.82	0.85	NA	20.08	090
31050		A	Exploration, sphenoid sinus	5.27	NA	6.35	0.53	NA	12.15	090
31051		A	Sphenoid sinus surgery	7.10	NA	8.24	0.64	NA	15.98	090
31070		A	Exploration of frontal sinus	4.27	NA	5.93	0.40	NA	10.60	090
31075		A	Exploration of frontal sinus	9.15	NA	9.73	0.80	NA	19.68	090
31080		A	Removal of frontal sinus	11.40	NA	13.53	1.15	NA	26.08	090
31081		A	Removal of frontal sinus	12.73	NA	14.00	2.44	NA	29.17	090
31084		A	Removal of frontal sinus	13.49	NA	13.50	1.25	NA	28.24	090
31085		A	Removal of frontal sinus	14.18	NA	13.96	1.68	NA	29.82	090
31086		A	Removal of frontal sinus	12.84	NA	13.28	1.09	NA	27.21	090
31087		A	Removal of frontal sinus	13.08	NA	12.53	1.49	NA	27.10	090
31090		A	Exploration of sinuses	9.52	NA	12.55	0.93	NA	23.00	090
31200		A	Removal of ethmoid sinus	4.96	NA	9.21	0.30	NA	14.47	090
31201		A	Removal of ethmoid sinus	8.36	NA	9.17	0.82	NA	18.35	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
31205		A	Removal of ethmoid sinus	10.22	NA	11.88	0.68	NA	22.78	090
31225		A	Removal of upper jaw	19.20	NA	17.82	1.69	NA	38.71	090
31230		A	Removal of upper jaw	21.91	NA	19.36	1.81	NA	43.08	090
31231		A	Nasal endoscopy, dx	1.10	3.38	0.88	0.09	4.57	2.07	000
31233		A	Nasal/sinus endoscopy, dx	2.18	4.30	1.48	0.20	6.68	3.86	000
31235		A	Nasal/sinus endoscopy, dx	2.64	4.91	1.72	0.26	7.81	4.62	000
31237		A	Nasal/sinus endoscopy, surg	2.98	5.19	1.88	0.28	8.45	5.14	000
31238		A	Nasal/sinus endoscopy, surg	3.26	5.23	2.09	0.27	8.76	5.62	000
31239		A	Nasal/sinus endoscopy, surg	8.69	NA	8.00	0.62	NA	17.31	010
31240		A	Nasal/sinus endoscopy, surg	2.61	NA	1.73	0.24	NA	4.58	000
31254		A	Revision of ethmoid sinus	4.64	NA	2.85	0.45	NA	7.94	000
31255		A	Removal of ethmoid sinus	6.95	NA	4.11	0.73	NA	11.79	000
31256		A	Exploration maxillary sinus	3.29	NA	2.11	0.34	NA	5.74	000
31267		A	Endoscopy, maxillary sinus	5.45	NA	3.29	0.55	NA	9.29	000
31276		A	Sinus endoscopy, surgical	8.84	NA	5.12	0.91	NA	14.87	000
31287		A	Nasal/sinus endoscopy, surg	3.91	NA	2.45	0.39	NA	6.75	000
31288		A	Nasal/sinus endoscopy, surg	4.57	NA	2.81	0.46	NA	7.84	000
31290		A	Nasal/sinus endoscopy, surg	17.21	NA	12.05	1.49	NA	30.75	010
31291		A	Nasal/sinus endoscopy, surg	18.16	NA	12.47	1.67	NA	32.30	010
31292		A	Nasal/sinus endoscopy, surg	14.74	NA	10.61	1.21	NA	26.56	010
31293		A	Nasal/sinus endoscopy, surg	16.19	NA	11.38	1.31	NA	28.88	010
31294		A	Nasal/sinus endoscopy, surg	19.03	NA	12.87	1.52	NA	33.42	010
31299		C	Sinus surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
31300		A	Removal of larynx lesion	14.27	NA	14.98	1.18	NA	30.43	090
31320		A	Diagnostic incision, larynx	5.25	NA	10.30	0.46	NA	16.01	090
31360		A	Removal of larynx	17.05	NA	16.72	1.40	NA	35.17	090
31365		A	Removal of larynx	24.12	NA	20.36	2.02	NA	46.50	090
31367		A	Partial removal of larynx	21.83	NA	21.89	1.81	NA	45.53	090
31368		A	Partial removal of larynx	27.05	NA	25.49	2.23	NA	54.77	090
31370		A	Partial removal of larynx	21.35	NA	22.26	1.81	NA	45.42	090
31375		A	Partial removal of larynx	20.18	NA	20.38	1.61	NA	42.17	090
31380		A	Partial removal of larynx	20.18	NA	20.60	1.69	NA	42.47	090
31382		A	Partial removal of larynx	20.49	NA	21.61	1.71	NA	43.81	090
31390		A	Removal of larynx & pharynx	27.49	NA	24.38	2.35	NA	54.22	090
31395		A	Reconstruct larynx & pharynx	31.04	NA	28.30	2.52	NA	61.86	090
31400		A	Revision of larynx	10.29	NA	13.77	0.85	NA	24.91	090
31420		A	Removal of epiglottis	10.20	NA	9.54	0.84	NA	20.58	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
31500		A	Insert emergency airway	2.33	NA	0.55	0.19	NA	3.07	000
31502		A	Change of windpipe airway	0.65	0.31	0.28	0.05	1.01	0.98	000
31505		A	Diagnostic laryngoscopy	0.61	1.45	0.61	0.05	2.11	1.27	000
31510		A	Laryngoscopy with biopsy	1.92	3.30	1.25	0.16	5.38	3.33	000
31511		A	Remove foreign body, larynx	2.16	3.12	1.06	0.19	5.47	3.41	000
31512		A	Removal of larynx lesion	2.07	3.20	1.36	0.18	5.45	3.61	000
31513		A	Injection into vocal cord	2.10	NA	1.46	0.17	NA	3.73	000
31515		A	Laryngoscopy for aspiration	1.80	3.54	1.06	0.14	5.48	3.00	000
31520		A	Diagnostic laryngoscopy	2.56	NA	1.56	0.20	NA	4.32	000
31525		A	Diagnostic laryngoscopy	2.63	3.64	1.66	0.21	6.48	4.50	000
31526		A	Diagnostic laryngoscopy	2.57	NA	1.72	0.21	NA	4.50	000
31527		A	Laryngoscopy for treatment	3.27	NA	1.87	0.26	NA	5.40	000
31528		A	Laryngoscopy and dilation	2.37	NA	1.46	0.20	NA	4.03	000
31529		A	Laryngoscopy and dilation	2.68	NA	1.71	0.22	NA	4.61	000
31530		A	Operative laryngoscopy	3.38	NA	1.95	0.29	NA	5.62	000
31531		A	Operative laryngoscopy	3.58	NA	2.27	0.29	NA	6.14	000
31535		A	Operative laryngoscopy	3.16	NA	1.99	0.26	NA	5.41	000
31536		A	Operative laryngoscopy	3.55	NA	2.25	0.29	NA	6.09	000
31540		A	Operative laryngoscopy	4.12	NA	2.54	0.34	NA	7.00	000
31541		A	Operative laryngoscopy	4.52	NA	2.78	0.37	NA	7.67	000
31545		A	Remove vc lesion w/scope	6.30	NA	3.47	0.37	NA	10.14	000
31546		A	Remove vc lesion scope/graft	9.73	NA	4.97	0.78	NA	15.48	000
31560		A	Operative laryngoscopy	5.45	NA	3.15	0.43	NA	9.03	000
31561		A	Operative laryngoscopy	5.99	NA	3.37	0.48	NA	9.84	000
31570		A	Laryngoscopy with injection	3.86	5.67	2.38	0.31	9.84	6.55	000
31571		A	Laryngoscopy with injection	4.26	NA	2.60	0.34	NA	7.20	000
31575		A	Diagnostic laryngoscopy	1.10	1.90	0.89	0.09	3.09	2.08	000
31576		A	Laryngoscopy with biopsy	1.97	3.66	1.29	0.15	5.78	3.41	000
31577		A	Remove foreign body, larynx	2.47	3.76	1.53	0.21	6.44	4.21	000
31578		A	Removal of larynx lesion	2.84	4.28	1.52	0.23	7.35	4.59	000
31579		A	Diagnostic laryngoscopy	2.26	3.78	1.48	0.19	6.23	3.93	000
31580		A	Revision of larynx	12.36	NA	15.91	1.02	NA	29.29	090
31582		A	Revision of larynx	21.59	NA	25.80	1.74	NA	49.13	090
31584		A	Treat larynx fracture	19.61	NA	18.15	1.70	NA	39.46	090
31585		A	Treat larynx fracture	4.63	NA	6.69	0.37	NA	11.69	090
31586		A	Treat larynx fracture	8.02	NA	10.86	0.66	NA	19.54	090
31587		A	Revision of larynx	11.97	NA	9.26	1.03	NA	22.26	090

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CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
31588		A	Revision of larynx	13.09	NA	13.61	1.06	NA	27.76	090
31590		A	Reinnervate larynx	6.96	NA	15.53	0.80	NA	23.29	090
31595		A	Larynx nerve surgery	8.33	NA	10.55	0.69	NA	19.57	090
31599		C	Larynx surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
31600		A	Incision of windpipe	7.17	NA	3.19	0.80	NA	11.16	000
31601		A	Incision of windpipe	4.44	NA	2.40	0.40	NA	7.24	000
31603		A	Incision of windpipe	4.14	NA	1.71	0.44	NA	6.29	000
31605		A	Incision of windpipe	3.57	NA	1.19	0.38	NA	5.14	000
31610		A	Incision of windpipe	8.75	NA	8.26	0.80	NA	17.81	090
31611		A	Surgery/speech prosthesis	5.63	NA	7.06	0.47	NA	13.16	090
31612		A	Puncture/clear windpipe	0.91	1.10	0.35	0.08	2.09	1.34	000
31613		A	Repair windpipe opening	4.58	NA	5.99	0.44	NA	11.01	090
31614		A	Repair windpipe opening	7.11	NA	8.71	0.62	NA	16.44	090
31615		A	Visualization of windpipe	2.09	2.59	1.20	0.17	4.85	3.46	000
31620		A	Endobronchial us add-on	1.40	5.64	0.55	0.11	7.15	2.06	ZZZ
31622		A	Dx bronchoscope/wash	2.78	5.65	1.06	0.20	8.63	4.04	000
31623		A	Dx bronchoscope/brush	2.88	6.42	1.05	0.16	9.46	4.09	000
31624		A	Dx bronchoscope/lavage	2.88	5.77	1.05	0.16	8.81	4.09	000
31625		A	Bronchoscopy w/biopsy(s)	3.36	5.81	1.21	0.20	9.37	4.77	000
31628		A	Bronchoscopy/lung bx, each	3.80	7.02	1.30	0.19	11.01	5.29	000
31629		A	Bronchoscopy/needle bx, each	4.09	14.25	1.40	0.17	18.51	5.66	000
31630		A	Bronchoscopy dilate/fx repr	3.81	NA	1.72	0.34	NA	5.87	000
31631		A	Bronchoscopy, dilate w/stent	4.36	NA	1.76	0.36	NA	6.48	000
31632		A	Bronchoscopy/lung bx, add'l	1.03	0.81	0.31	0.19	2.03	1.53	ZZZ
31633		A	Bronchoscopy/needle bx add'l	1.32	0.92	0.40	0.17	2.41	1.89	ZZZ
31635		A	Bronchoscopy w/fb removal	3.67	6.11	1.43	0.26	10.04	5.36	000
31636		A	Bronchoscopy, bronch stents	4.30	NA	1.76	0.31	NA	6.37	000
31637		A	Bronchoscopy, stent add-on	1.58	NA	0.56	0.13	NA	2.27	ZZZ
31638		A	Bronchoscopy, revise stent	4.88	NA	1.97	0.22	NA	7.07	000
31640		A	Bronchoscopy w/tumor excise	4.93	NA	2.07	0.46	NA	7.46	000
31641		A	Bronchoscopy, treat blockage	5.02	NA	1.88	0.38	NA	7.28	000
31643		A	Diag bronchoscope/catheter	3.49	NA	1.23	0.20	NA	4.92	000
31645		A	Bronchoscopy, clear airways	3.16	5.14	1.12	0.19	8.49	4.47	000
31646		A	Bronchoscopy, reclear airway	2.72	4.86	1.00	0.16	7.74	3.88	000
31656		A	Bronchoscopy, inj for x-ray	2.17	7.29	0.83	0.16	9.62	3.16	000
31700		A	Insertion of airway catheter	1.34	2.15	0.68	0.10	3.59	2.12	000
31708		A	Instill airway contrast dye	1.41	2.03	0.46	0.07	3.51	1.94	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
31710		A	Insertion of airway catheter	1.30	NA	0.41	0.13	NA	1.84	000
31715		A	Injection for bronchus x-ray	1.11	NA	0.34	0.07	NA	1.52	000
31717		A	Bronchial brush biopsy	2.12	8.25	0.79	0.14	10.51	3.05	000
31720		A	Clearance of airways	1.06	0.33	0.33	0.07	1.46	1.46	000
31725		A	Clearance of airways	1.96	0.65	0.58	0.15	2.76	2.69	000
31730		A	Intro, windpipe wire/tube	2.85	2.19	1.00	0.23	5.27	4.08	000
31750		A	Repair of windpipe	13.00	NA	17.55	1.12	NA	31.67	090
31755		A	Repair of windpipe	15.91	NA	24.52	1.31	NA	41.74	090
31760		A	Repair of windpipe	22.32	NA	10.71	2.78	NA	35.81	090
31766		A	Reconstruction of windpipe	30.38	NA	13.65	4.49	NA	48.52	090
31770		A	Repair/graft of bronchus	22.48	NA	10.24	2.80	NA	35.52	090
31775		A	Reconstruct bronchus	23.50	NA	11.79	2.98	NA	38.27	090
31780		A	Reconstruct windpipe	17.69	NA	11.05	1.65	NA	30.39	090
31781		A	Reconstruct windpipe	23.49	NA	12.12	2.21	NA	37.82	090
31785		A	Remove windpipe lesion	17.20	NA	10.18	1.59	NA	28.97	090
31786		A	Remove windpipe lesion	23.94	NA	13.09	3.26	NA	40.29	090
31800		A	Repair of windpipe injury	7.42	NA	9.24	0.78	NA	17.44	090
31805		A	Repair of windpipe injury	13.11	NA	7.21	1.81	NA	22.13	090
31820		A	Closure of windpipe lesion	4.48	5.66	3.65	0.39	10.53	8.52	090
31825		A	Repair of windpipe defect	6.80	7.66	5.37	0.56	15.02	12.73	090
31830		A	Revise windpipe scar	4.49	5.76	3.98	0.44	10.69	8.91	090
31899		C	Airways surgical procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
32000		A	Drainage of chest	1.54	3.05	0.48	0.09	4.68	2.11	000
32002		A	Treatment of collapsed lung	2.19	3.21	1.06	0.14	5.54	3.39	000
32005		A	Treat lung lining chemically	2.19	6.45	0.70	0.22	8.86	3.11	000
32019		A	Insert pleural catheter	4.17	19.96	1.65	0.42	24.55	6.24	000
32020		A	Insertion of chest tube	3.97	NA	1.35	0.42	NA	5.74	000
32035		A	Exploration of chest	8.66	NA	5.85	1.22	NA	15.73	090
32036		A	Exploration of chest	9.67	NA	6.43	1.38	NA	17.48	090
32095		A	Biopsy through chest wall	8.35	NA	5.36	1.17	NA	14.88	090
32100		A	Exploration/biopsy of chest	15.22	NA	7.82	2.16	NA	25.20	090
32110		A	Explore/repair chest	22.97	NA	10.73	3.13	NA	36.83	090
32120		A	Re-exploration of chest	11.52	NA	7.07	1.61	NA	20.20	090
32124		A	Explore chest free adhesions	12.70	NA	7.21	1.85	NA	21.76	090
32140		A	Removal of lung lesion(s)	13.91	NA	7.68	1.95	NA	23.54	090
32141		A	Remove/treat lung lesions	13.98	NA	7.55	1.98	NA	23.51	090
32150		A	Removal of lung lesion(s)	14.13	NA	7.60	1.96	NA	23.69	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
32151		A	Remove lung foreign body	14.19	NA	8.00	1.92	NA	24.11	090
32160		A	Open chest heart massage	9.29	NA	5.26	1.25	NA	15.80	090
32200		A	Drain, open, lung lesion	15.27	NA	8.61	1.93	NA	25.81	090
32201		A	Drain, percut, lung lesion	3.99	20.70	1.30	0.24	24.93	5.53	000
32215		A	Treat chest lining	11.31	NA	6.90	1.56	NA	19.77	090
32220		A	Release of lung	23.96	NA	12.95	3.41	NA	40.32	090
32225		A	Partial release of lung	13.94	NA	7.65	1.97	NA	23.56	090
32310		A	Removal of chest lining	13.42	NA	7.39	1.92	NA	22.73	090
32320		A	Free/remove chest lining	23.96	NA	12.15	3.39	NA	39.50	090
32400		A	Needle biopsy chest lining	1.76	2.12	0.55	0.10	3.98	2.41	000
32402		A	Open biopsy chest lining	7.55	NA	5.11	1.04	NA	13.70	090
32405		A	Biopsy, lung or mediastinum	1.93	0.67	0.63	0.11	2.71	2.67	000
32420		A	Puncture/clear lung	2.18	NA	0.68	0.14	NA	3.00	000
32440		A	Removal of lung	24.96	NA	12.89	3.56	NA	41.41	090
32442		A	Sleeve pneumonectomy	26.20	NA	14.76	3.81	NA	44.77	090
32445		A	Removal of lung	25.05	NA	14.06	3.62	NA	42.73	090
32480		A	Partial removal of lung	23.71	NA	12.06	3.38	NA	39.15	090
32482		A	Bilobectomy	24.96	NA	12.91	3.53	NA	41.40	090
32484		A	Segmentectomy	20.66	NA	11.38	2.94	NA	34.98	090
32486		A	Sleeve lobectomy	23.88	NA	13.24	3.48	NA	40.60	090
32488		A	Completion pneumonectomy	25.67	NA	13.78	3.66	NA	43.11	090
32491		R	Lung volume reduction	21.22	NA	12.62	2.94	NA	36.78	090
32500		A	Partial removal of lung	21.97	NA	12.35	3.14	NA	37.46	090
32501		A	Repair bronchus add-on	4.68	NA	1.54	0.65	NA	6.87	ZZZ
32520		A	Remove lung & revise chest	21.65	NA	11.31	3.04	NA	36.00	090
32522		A	Remove lung & revise chest	24.16	NA	12.12	3.28	NA	39.56	090
32525		A	Remove lung & revise chest	26.46	NA	12.80	3.72	NA	42.98	090
32540		A	Removal of lung lesion	14.62	NA	9.63	2.04	NA	26.29	090
32601		A	Thoracoscopy, diagnostic	5.45	NA	2.35	0.78	NA	8.58	000
32602		A	Thoracoscopy, diagnostic	5.95	NA	2.52	0.84	NA	9.31	000
32603		A	Thoracoscopy, diagnostic	7.80	NA	3.03	1.11	NA	11.94	000
32604		A	Thoracoscopy, diagnostic	8.77	NA	3.45	1.23	NA	13.45	000
32605		A	Thoracoscopy, diagnostic	6.92	NA	2.90	0.97	NA	10.79	000
32606		A	Thoracoscopy, diagnostic	8.39	NA	3.33	1.20	NA	12.92	000
32650		A	Thoracoscopy, surgical	10.73	NA	6.76	1.50	NA	18.99	090
32651		A	Thoracoscopy, surgical	12.89	NA	7.23	1.82	NA	21.94	090
32652		A	Thoracoscopy, surgical	18.63	NA	10.14	2.60	NA	31.37	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
32653		A	Thoracoscopy, surgical	12.85	NA	6.97	1.79	NA	21.61	090
32654		A	Thoracoscopy, surgical	12.42	NA	7.53	1.62	NA	21.57	090
32655		A	Thoracoscopy, surgical	13.08	NA	7.24	1.82	NA	22.14	090
32656		A	Thoracoscopy, surgical	12.89	NA	7.94	1.82	NA	22.65	090
32657		A	Thoracoscopy, surgical	13.63	NA	7.68	1.94	NA	23.25	090
32658		A	Thoracoscopy, surgical	11.61	NA	7.35	1.62	NA	20.58	090
32659		A	Thoracoscopy, surgical	11.57	NA	7.45	1.61	NA	20.63	090
32660		A	Thoracoscopy, surgical	17.40	NA	9.48	2.06	NA	28.94	090
32661		A	Thoracoscopy, surgical	13.23	NA	7.79	1.82	NA	22.84	090
32662		A	Thoracoscopy, surgical	16.42	NA	8.82	2.16	NA	27.40	090
32663		A	Thoracoscopy, surgical	18.44	NA	10.76	2.66	NA	31.86	090
32664		A	Thoracoscopy, surgical	14.18	NA	7.63	2.33	NA	24.14	090
32665		A	Thoracoscopy, surgical	15.52	NA	8.13	2.13	NA	25.78	090
32800		A	Repair lung hernia	13.67	NA	7.41	1.86	NA	22.94	090
32810		A	Close chest after drainage	13.03	NA	7.52	1.87	NA	22.42	090
32815		A	Close bronchial fistula	23.12	NA	10.97	3.23	NA	37.32	090
32820		A	Reconstruct injured chest	21.45	NA	12.16	2.51	NA	36.12	090
32850		X	Donor pneumonectomy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32851		A	Lung transplant, single	38.57	NA	27.66	5.35	NA	71.58	090
32852		A	Lung transplant with bypass	41.74	NA	33.16	5.96	NA	80.86	090
32853		A	Lung transplant, double	47.74	NA	31.75	6.85	NA	86.34	090
32854		A	Lung transplant with bypass	50.90	NA	34.73	7.16	NA	92.79	090
32855		C	Prepare donor lung, single	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32856		C	Prepare donor lung, double	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32900		A	Removal of rib(s)	20.24	NA	9.88	2.89	NA	33.01	090
32905		A	Revise & repair chest wall	20.72	NA	10.13	3.03	NA	33.88	090
32906		A	Revise & repair chest wall	26.73	NA	12.06	3.82	NA	42.61	090
32940		A	Revision of lung	19.40	NA	9.47	2.75	NA	31.62	090
32960		A	Therapeutic pneumothorax	1.84	1.73	0.56	0.16	3.73	2.56	000
32997		A	Total lung lavage	5.99	NA	1.91	0.54	NA	8.44	000
32999		C	Chest surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
33010		A	Drainage of heart sac	2.24	NA	0.78	0.15	NA	3.17	000
33011		A	Repeat drainage of heart sac	2.24	NA	0.81	0.17	NA	3.22	000
33015		A	Incision of heart sac	6.79	NA	4.95	0.64	NA	12.38	090
33020		A	Incision of heart sac	12.59	NA	6.78	1.74	NA	21.11	090
33025		A	Incision of heart sac	12.07	NA	6.35	1.72	NA	20.14	090
33030		A	Partial removal of heart sac	18.68	NA	9.52	2.73	NA	30.93	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
33031		A	Partial removal of heart sac	21.76	NA	10.03	3.10	NA	34.89	090
33050		A	Removal of heart sac lesion	14.34	NA	7.84	2.08	NA	24.26	090
33120		A	Removal of heart lesion	24.52	NA	11.58	3.57	NA	39.67	090
33130		A	Removal of heart lesion	21.36	NA	10.11	2.87	NA	34.34	090
33140		A	Heart revascularize (tmr)	19.97	NA	10.88	2.81	NA	33.66	090
33141		A	Heart tmr w/other procedure	4.83	NA	1.58	0.69	NA	7.10	ZZZ
33200		A	Insertion of heart pacemaker	12.46	NA	6.84	1.67	NA	20.97	090
33201		A	Insertion of heart pacemaker	10.16	NA	6.58	1.34	NA	18.08	090
33206		A	Insertion of heart pacemaker	6.66	NA	4.46	0.52	NA	11.64	090
33207		A	Insertion of heart pacemaker	8.03	NA	4.66	0.61	NA	13.30	090
33208		A	Insertion of heart pacemaker	8.12	NA	4.77	0.59	NA	13.48	090
33210		A	Insertion of heart electrode	3.30	NA	1.25	0.19	NA	4.74	000
33211		A	Insertion of heart electrode	3.39	NA	1.31	0.23	NA	4.93	000
33212		A	Insertion of pulse generator	5.51	NA	3.36	0.46	NA	9.33	090
33213		A	Insertion of pulse generator	6.36	NA	3.72	0.48	NA	10.56	090
33214		A	Upgrade of pacemaker system	7.74	NA	4.89	0.58	NA	13.21	090
33215		A	Reposition pacing-defib lead	4.75	NA	3.18	0.37	NA	8.30	090
33216		A	Insert lead pace-defib, one	5.77	NA	4.20	0.40	NA	10.37	090
33217		A	Insert lead pace-defib, dual	5.74	NA	4.23	0.41	NA	10.38	090
33218		A	Repair lead pace-defib, one	5.43	NA	4.30	0.39	NA	10.12	090
33220		A	Repair lead pace-defib, dual	5.51	NA	4.27	0.39	NA	10.17	090
33222		A	Revise pocket, pacemaker	4.95	NA	4.29	0.42	NA	9.66	090
33223		A	Revise pocket, pacing-defib	6.45	NA	4.59	0.45	NA	11.49	090
33224		A	Insert pacing lead & connect	9.04	NA	4.00	0.57	NA	13.61	000
33225		A	L ventric pacing lead add-on	8.33	NA	3.25	0.48	NA	12.06	ZZZ
33226		A	Reposition l ventric lead	8.68	NA	3.82	0.61	NA	13.11	000
33233		A	Removal of pacemaker system	3.29	NA	3.27	0.23	NA	6.79	090
33234		A	Removal of pacemaker system	7.81	NA	4.91	0.58	NA	13.30	090
33235		A	Removal pacemaker electrode	9.39	NA	6.81	0.75	NA	16.95	090
33236		A	Remove electrode/thoracotomy	12.58	NA	7.43	1.66	NA	21.67	090
33237		A	Remove electrode/thoracotomy	13.69	NA	7.78	1.56	NA	23.03	090
33238		A	Remove electrode/thoracotomy	15.20	NA	8.20	1.95	NA	25.35	090
33240		A	Insert pulse generator	7.59	NA	4.58	0.48	NA	12.65	090
33241		A	Remove pulse generator	3.24	NA	2.96	0.21	NA	6.41	090
33243		A	Remove eltrd/thoracotomy	22.61	NA	11.46	2.10	NA	36.17	090
33244		A	Remove eltrd, transven	13.74	NA	8.89	1.00	NA	23.63	090
33245		A	Insert epic eltrd pace-defib	14.28	NA	7.90	1.98	NA	24.16	090

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CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
33246		A	Insert epic eltrd/generator	20.68	NA	10.28	2.59	NA	33.55	090
33249		A	Eltrd/insert pace-defib	14.21	NA	8.36	0.83	NA	23.40	090
33250		A	Ablate heart dysrhythm focus	21.82	NA	11.02	3.06	NA	35.90	090
33251		A	Ablate heart dysrhythm focus	24.84	NA	11.66	3.49	NA	39.99	090
33253		A	Reconstruct atria	31.01	NA	13.82	4.45	NA	49.28	090
33261		A	Ablate heart dysrhythm focus	24.84	NA	11.77	3.38	NA	39.99	090
33282		A	Implant pat-active ht record	4.16	NA	4.02	0.25	NA	8.43	090
33284		A	Remove pat-active ht record	2.50	NA	3.53	0.15	NA	6.18	090
33300		A	Repair of heart wound	17.89	NA	9.23	2.56	NA	29.68	090
33305		A	Repair of heart wound	21.41	NA	10.61	3.07	NA	35.09	090
33310		A	Exploratory heart surgery	18.48	NA	9.58	2.56	NA	30.62	090
33315		A	Exploratory heart surgery	22.34	NA	10.88	3.23	NA	36.45	090
33320		A	Repair major blood vessel(s)	16.76	NA	8.22	2.03	NA	27.01	090
33321		A	Repair major vessel	20.17	NA	9.78	2.87	NA	32.82	090
33322		A	Repair major blood vessel(s)	20.59	NA	10.36	2.80	NA	33.75	090
33330		A	Insert major vessel graft	21.40	NA	10.26	2.73	NA	34.39	090
33332		A	Insert major vessel graft	23.92	NA	10.51	2.99	NA	37.42	090
33335		A	Insert major vessel graft	29.96	NA	13.33	4.19	NA	47.48	090
33400		A	Repair of aortic valve	28.46	NA	15.66	4.04	NA	48.16	090
33401		A	Valvuloplasty, open	23.87	NA	13.50	3.53	NA	40.90	090
33403		A	Valvuloplasty, w/cp bypass	24.85	NA	14.30	3.51	NA	42.66	090
33404		A	Prepare heart-aorta conduit	28.50	NA	14.54	4.29	NA	47.33	090
33405		A	Replacement of aortic valve	34.95	NA	18.29	5.09	NA	58.33	090
33406		A	Replacement of aortic valve	37.44	NA	19.12	5.38	NA	61.94	090
33410		A	Replacement of aortic valve	32.41	NA	16.58	4.61	NA	53.60	090
33411		A	Replacement of aortic valve	36.20	NA	18.74	5.29	NA	60.23	090
33412		A	Replacement of aortic valve	41.94	NA	20.40	6.29	NA	68.63	090
33413		A	Replacement of aortic valve	43.43	NA	20.81	6.46	NA	70.70	090
33414		A	Repair of aortic valve	30.30	NA	14.13	4.45	NA	48.88	090
33415		A	Revision, subvalvular tissue	27.11	NA	12.02	3.80	NA	42.93	090
33416		A	Revise ventricle muscle	30.30	NA	13.50	4.46	NA	48.26	090
33417		A	Repair of aortic valve	28.49	NA	13.61	4.05	NA	46.15	090
33420		A	Revision of mitral valve	22.67	NA	9.56	1.82	NA	34.05	090
33422		A	Revision of mitral valve	25.90	NA	13.65	3.76	NA	43.31	090
33425		A	Repair of mitral valve	26.96	NA	13.05	3.91	NA	43.92	090
33426		A	Repair of mitral valve	32.95	NA	17.13	4.77	NA	54.85	090
33427		A	Repair of mitral valve	39.94	NA	19.36	5.82	NA	65.12	090

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CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
33430		A	Replacement of mitral valve	33.45	NA	17.29	4.85	NA	55.59	090
33460		A	Revision of tricuspid valve	23.56	NA	11.30	3.39	NA	38.25	090
33463		A	Valvuloplasty, tricuspid	25.58	NA	12.91	3.71	NA	42.20	090
33464		A	Valvuloplasty, tricuspid	27.29	NA	13.52	3.96	NA	44.77	090
33465		A	Replace tricuspid valve	28.75	NA	12.96	4.18	NA	45.89	090
33468		A	Revision of tricuspid valve	30.07	NA	13.65	4.03	NA	47.75	090
33470		A	Revision of pulmonary valve	20.78	NA	10.69	1.03	NA	32.50	090
33471		A	Valvotomy, pulmonary valve	22.22	NA	9.75	3.35	NA	35.32	090
33472		A	Revision of pulmonary valve	22.22	NA	11.86	3.52	NA	37.60	090
33474		A	Revision of pulmonary valve	23.01	NA	10.88	3.18	NA	37.07	090
33475		A	Replacement, pulmonary valve	32.95	NA	15.37	4.76	NA	53.08	090
33476		A	Revision of heart chamber	25.73	NA	11.96	2.39	NA	40.08	090
33478		A	Revision of heart chamber	26.70	NA	13.05	3.85	NA	43.60	090
33496		A	Repair, prosth valve clot	27.21	NA	12.74	4.01	NA	43.96	090
33500		A	Repair heart vessel fistula	25.51	NA	11.46	3.66	NA	40.63	090
33501		A	Repair heart vessel fistula	17.75	NA	8.28	1.84	NA	27.87	090
33502		A	Coronary artery correction	21.01	NA	11.07	2.96	NA	35.04	090
33503		A	Coronary artery graft	21.75	NA	9.73	1.86	NA	33.34	090
33504		A	Coronary artery graft	24.62	NA	11.81	3.32	NA	39.75	090
33505		A	Repair artery w/tunnel	26.80	NA	12.90	2.17	NA	41.87	090
33506		A	Repair artery, translocation	35.45	NA	14.56	4.62	NA	54.63	090
33508		A	Endoscopic vein harvest	0.31	NA	0.10	0.04	NA	0.45	ZZZ
33510		A	CABG, vein, single	28.96	NA	16.33	4.19	NA	49.48	090
33511		A	CABG, vein, two	29.96	NA	17.07	4.36	NA	51.39	090
33512		A	CABG, vein, three	31.75	NA	17.60	4.59	NA	53.94	090
33513		A	CABG, vein, four	31.95	NA	17.78	4.63	NA	54.36	090
33514		A	CABG, vein, five	32.70	NA	18.05	4.68	NA	55.43	090
33516		A	Cabg, vein, six or more	34.95	NA	18.80	5.02	NA	58.77	090
33517		A	CABG, artery-vein, single	2.57	NA	0.84	0.37	NA	3.78	ZZZ
33518		A	CABG, artery-vein, two	4.84	NA	1.58	0.70	NA	7.12	ZZZ
33519		A	CABG, artery-vein, three	7.11	NA	2.32	1.03	NA	10.46	ZZZ
33521		A	CABG, artery-vein, four	9.39	NA	3.07	1.35	NA	13.81	ZZZ
33522		A	CABG, artery-vein, five	11.65	NA	3.81	1.69	NA	17.15	ZZZ
33523		A	Cabg, art-vein, six or more	13.93	NA	4.53	2.06	NA	20.52	ZZZ
33530		A	Coronary artery, bypass/reop	5.85	NA	1.91	0.85	NA	8.61	ZZZ
33533		A	CABG, arterial, single	29.96	NA	16.46	4.33	NA	50.75	090
33534		A	CABG, arterial, two	32.15	NA	17.71	4.53	NA	54.39	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
33535		A	CABG, arterial, three	34.45	NA	18.13	4.94	NA	57.52	090
33536		A	Cabg, arterial, four or more	37.44	NA	18.29	5.27	NA	61.00	090
33542		A	Removal of heart lesion	28.81	NA	12.99	4.18	NA	45.98	090
33545		A	Repair of heart damage	36.72	NA	15.62	5.13	NA	57.47	090
33572		A	Open coronary endarterectomy	4.44	NA	1.45	0.64	NA	6.53	ZZZ
33600		A	Closure of valve	29.47	NA	12.51	4.38	NA	46.36	090
33602		A	Closure of valve	28.50	NA	12.44	3.78	NA	44.72	090
33606		A	Anastomosis/artery-aorta	30.69	NA	13.67	4.37	NA	48.73	090
33608		A	Repair anomaly w/conduit	31.04	NA	14.10	4.69	NA	49.83	090
33610		A	Repair by enlargement	30.56	NA	13.60	4.52	NA	48.68	090
33611		A	Repair double ventricle	33.95	NA	14.13	4.33	NA	52.41	090
33612		A	Repair double ventricle	34.95	NA	15.15	5.23	NA	55.33	090
33615		A	Repair, modified fontan	33.95	NA	13.14	4.26	NA	51.35	090
33617		A	Repair single ventricle	36.94	NA	15.99	5.59	NA	58.52	090
33619		A	Repair single ventricle	44.93	NA	20.80	6.39	NA	72.12	090
33641		A	Repair heart septum defect	21.36	NA	9.57	3.10	NA	34.03	090
33645		A	Revision of heart veins	24.78	NA	11.77	3.63	NA	40.18	090
33647		A	Repair heart septum defects	28.69	NA	13.77	3.22	NA	45.68	090
33660		A	Repair of heart defects	29.96	NA	13.48	4.45	NA	47.89	090
33665		A	Repair of heart defects	28.56	NA	13.83	3.96	NA	46.35	090
33670		A	Repair of heart chambers	34.95	NA	13.17	4.61	NA	52.73	090
33681		A	Repair heart septum defect	30.56	NA	14.68	4.39	NA	49.63	090
33684		A	Repair heart septum defect	29.61	NA	13.62	3.46	NA	46.69	090
33688		A	Repair heart septum defect	30.57	NA	10.47	4.69	NA	45.73	090
33690		A	Reinforce pulmonary artery	19.52	NA	10.16	1.94	NA	31.62	090
33692		A	Repair of heart defects	30.70	NA	13.92	4.55	NA	49.17	090
33694		A	Repair of heart defects	33.95	NA	14.22	5.21	NA	53.38	090
33697		A	Repair of heart defects	35.95	NA	14.87	4.05	NA	54.87	090
33702		A	Repair of heart defects	26.50	NA	12.56	3.64	NA	42.70	090
33710		A	Repair of heart defects	29.67	NA	13.96	4.38	NA	48.01	090
33720		A	Repair of heart defect	26.52	NA	12.28	3.76	NA	42.56	090
33722		A	Repair of heart defect	28.37	NA	13.85	1.30	NA	43.52	090
33730		A	Repair heart-vein defect(s)	34.20	NA	14.12	4.96	NA	53.28	090
33732		A	Repair heart-vein defect	28.12	NA	13.38	3.64	NA	45.14	090
33735		A	Revision of heart chamber	21.36	NA	8.95	1.89	NA	32.20	090
33736		A	Revision of heart chamber	23.48	NA	11.85	3.05	NA	38.38	090
33737		A	Revision of heart chamber	21.73	NA	10.93	3.21	NA	35.87	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
33750		A	Major vessel shunt	21.38	NA	10.21	1.16	NA	32.75	090
33755		A	Major vessel shunt	21.76	NA	8.80	3.22	NA	33.78	090
33762		A	Major vessel shunt	21.76	NA	10.15	3.10	NA	35.01	090
33764		A	Major vessel shunt & graft	21.76	NA	10.22	2.97	NA	34.95	090
33766		A	Major vessel shunt	22.73	NA	11.67	3.67	NA	38.07	090
33767		A	Major vessel shunt	24.46	NA	11.72	3.79	NA	39.97	090
33770		A	Repair great vessels defect	36.94	NA	14.68	5.67	NA	57.29	090
33771		A	Repair great vessels defect	34.60	NA	12.38	5.63	NA	52.61	090
33774		A	Repair great vessels defect	30.93	NA	14.66	4.75	NA	50.34	090
33775		A	Repair great vessels defect	32.15	NA	14.99	4.94	NA	52.08	090
33776		A	Repair great vessels defect	33.99	NA	15.80	5.02	NA	54.81	090
33777		A	Repair great vessels defect	33.41	NA	15.61	5.44	NA	54.46	090
33778		A	Repair great vessels defect	39.94	NA	16.89	6.13	NA	62.96	090
33779		A	Repair great vessels defect	36.16	NA	15.37	2.89	NA	54.42	090
33780		A	Repair great vessels defect	41.69	NA	19.08	3.64	NA	64.41	090
33781		A	Repair great vessels defect	36.40	NA	13.33	5.92	NA	55.65	090
33786		A	Repair arterial trunk	38.94	NA	16.71	5.66	NA	61.31	090
33788		A	Revision of pulmonary artery	26.58	NA	11.95	4.00	NA	42.53	090
33800		A	Aortic suspension	16.22	NA	8.11	2.43	NA	26.76	090
33802		A	Repair vessel defect	17.63	NA	9.22	2.24	NA	29.09	090
33803		A	Repair vessel defect	19.57	NA	9.76	3.17	NA	32.50	090
33813		A	Repair septal defect	20.62	NA	10.91	3.09	NA	34.62	090
33814		A	Repair septal defect	25.73	NA	12.64	3.80	NA	42.17	090
33820		A	Revise major vessel	16.27	NA	8.36	2.38	NA	27.01	090
33822		A	Revise major vessel	17.29	NA	8.95	2.66	NA	28.90	090
33824		A	Revise major vessel	19.49	NA	9.98	2.86	NA	32.33	090
33840		A	Remove aorta constriction	20.60	NA	10.29	2.14	NA	33.03	090
33845		A	Remove aorta constriction	22.09	NA	11.35	3.18	NA	36.62	090
33851		A	Remove aorta constriction	21.24	NA	10.68	3.14	NA	35.06	090
33852		A	Repair septal defect	23.67	NA	11.36	2.13	NA	37.16	090
33853		A	Repair septal defect	31.67	NA	14.82	4.42	NA	50.91	090
33860		A	Ascending aortic graft	37.94	NA	16.45	5.53	NA	59.92	090
33861		A	Ascending aortic graft	41.94	NA	17.71	6.07	NA	65.72	090
33863		A	Ascending aortic graft	44.93	NA	18.69	6.47	NA	70.09	090
33870		A	Transverse aortic arch graft	43.93	NA	18.38	6.28	NA	68.59	090
33875		A	Thoracic aortic graft	33.01	NA	14.09	4.73	NA	51.83	090
33877		A	Thoracoabdominal graft	42.54	NA	16.31	5.77	NA	64.62	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
33910		A	Remove lung artery emboli	24.55	NA	11.43	3.62	NA	39.60	090
33915		A	Remove lung artery emboli	20.99	NA	9.63	1.66	NA	32.28	090
33916		A	Surgery of great vessel	25.79	NA	11.34	3.64	NA	40.77	090
33917		A	Repair pulmonary artery	24.46	NA	12.18	3.66	NA	40.30	090
33918		A	Repair pulmonary atresia	26.41	NA	12.07	4.12	NA	42.60	090
33919		A	Repair pulmonary atresia	39.94	NA	17.51	5.90	NA	63.35	090
33920		A	Repair pulmonary atresia	31.90	NA	13.82	4.35	NA	50.07	090
33922		A	Transect pulmonary artery	23.48	NA	10.90	3.06	NA	37.44	090
33924		A	Remove pulmonary shunt	5.49	NA	1.84	0.82	NA	8.15	ZZZ
33930		X	Removal of donor heart/lung	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33933		C	Prepare donor heart/lung	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33935		R	Transplantation, heart/lung	60.87	NA	28.77	8.95	NA	98.59	090
33940		X	Removal of donor heart	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33944		C	Prepare donor heart	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33945		R	Transplantation of heart	42.04	NA	21.39	6.08	NA	69.51	090
33960		A	External circulation assist	19.33	NA	4.91	2.60	NA	26.84	000
33961		A	External circulation assist	10.91	NA	3.61	0.90	NA	15.42	ZZZ
33967		A	Insert ia percut device	4.84	NA	1.84	0.35	NA	7.03	000
33968		A	Remove aortic assist device	0.64	NA	0.23	0.07	NA	0.94	000
33970		A	Aortic circulation assist	6.74	NA	2.28	0.82	NA	9.84	000
33971		A	Aortic circulation assist	9.68	NA	6.00	1.21	NA	16.89	090
33973		A	Insert balloon device	9.75	NA	3.31	1.22	NA	14.28	000
33974		A	Remove intra-aortic balloon	14.39	NA	7.88	1.68	NA	23.95	090
33975		A	Implant ventricular device	20.97	NA	6.28	2.99	NA	30.24	XXX
33976		A	Implant ventricular device	22.97	NA	7.55	3.20	NA	33.72	XXX
33977		A	Remove ventricular device	19.26	NA	11.07	2.77	NA	33.10	090
33978		A	Remove ventricular device	21.70	NA	11.75	3.20	NA	36.65	090
33979		A	Insert intracorporeal device	45.93	NA	14.92	6.80	NA	67.65	XXX
33980		A	Remove intracorporeal device	56.17	NA	25.24	8.35	NA	89.76	090
33999		C	Cardiac surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
34001		A	Removal of artery clot	12.89	NA	6.71	1.77	NA	21.37	090
34051		A	Removal of artery clot	15.19	NA	7.78	2.18	NA	25.15	090
34101		A	Removal of artery clot	9.99	NA	5.35	1.38	NA	16.72	090
34111		A	Removal of arm artery clot	9.99	NA	5.35	1.35	NA	16.69	090
34151		A	Removal of artery clot	24.96	NA	10.40	3.47	NA	38.83	090
34201		A	Removal of artery clot	10.01	NA	5.41	1.42	NA	16.84	090
34203		A	Removal of leg artery clot	16.46	NA	8.06	2.31	NA	26.85	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
34401		A	Removal of vein clot	24.96	NA	10.66	2.94	NA	38.56	090
34421		A	Removal of vein clot	11.98	NA	6.29	1.54	NA	19.81	090
34451		A	Removal of vein clot	26.96	NA	11.44	3.70	NA	42.10	090
34471		A	Removal of vein clot	10.16	NA	5.30	1.14	NA	16.60	090
34490		A	Removal of vein clot	9.85	NA	5.42	1.33	NA	16.60	090
34501		A	Repair valve, femoral vein	15.98	NA	8.49	2.19	NA	26.66	090
34502		A	Reconstruct vena cava	26.91	NA	12.29	3.57	NA	42.77	090
34510		A	Transposition of vein valve	18.92	NA	9.41	2.27	NA	30.60	090
34520		A	Cross-over vein graft	17.92	NA	8.45	2.18	NA	28.55	090
34530		A	Leg vein fusion	16.62	NA	8.61	1.71	NA	26.94	090
34800		A	Endovas aaa repr w/sm tube	20.72	NA	9.16	2.30	NA	32.18	090
34802		A	Endovas aaa repr w/2-p part	22.97	NA	9.78	2.25	NA	35.00	090
34803		A	Endovas aaa repr w/3-p part	24.00	NA	10.21	1.99	NA	36.20	090
34804		A	Endovas aaa repr w/1-p part	22.97	NA	9.80	2.23	NA	35.00	090
34805		A	Endovas aaa repr w/long tube	21.85	NA	9.64	1.99	NA	33.48	090
34808		A	Endovas iliac a device addon	4.12	NA	1.37	0.53	NA	6.02	ZZZ
34812		A	Xpose for endoprosth, femorl	6.74	NA	2.23	1.15	NA	10.12	000
34813		A	Femoral endovas graft add-on	4.79	NA	1.57	0.64	NA	7.00	ZZZ
34820		A	Xpose for endoprosth, iliac	9.74	NA	3.23	1.41	NA	14.38	000
34825		A	Endovasc extend prosth, init	11.98	NA	6.14	1.26	NA	19.38	090
34826		A	Endovasc exten prosth, add'l	4.12	NA	1.37	0.43	NA	5.92	ZZZ
34830		A	Open aortic tube prosth repr	32.54	NA	13.69	4.52	NA	50.75	090
34831		A	Open aortoiliac prosth repr	35.29	NA	11.73	4.59	NA	51.61	090
34832		A	Open aortofemor prosth repr	35.29	NA	14.62	4.69	NA	54.60	090
34833		A	Xpose for endoprosth, iliac	11.98	NA	4.43	1.63	NA	18.04	000
34834		A	Xpose, endoprosth, brachial	5.34	NA	2.19	0.75	NA	8.28	000
34900		A	Endovasc iliac repr w/graft	16.36	NA	7.58	1.90	NA	25.84	090
35001		A	Repair defect of artery	19.61	NA	9.55	2.73	NA	31.89	090
35002		A	Repair artery rupture, neck	20.97	NA	9.69	3.00	NA	33.66	090
35005		A	Repair defect of artery	18.09	NA	8.84	1.75	NA	28.68	090
35011		A	Repair defect of artery	17.97	NA	7.98	2.48	NA	28.43	090
35013		A	Repair artery rupture, arm	21.97	NA	9.67	3.04	NA	34.68	090
35021		A	Repair defect of artery	19.62	NA	9.41	2.76	NA	31.79	090
35022		A	Repair artery rupture, chest	23.15	NA	9.85	3.13	NA	36.13	090
35045		A	Repair defect of arm artery	17.54	NA	7.50	2.41	NA	27.45	090
35081		A	Repair defect of artery	27.97	NA	11.46	3.91	NA	43.34	090
35082		A	Repair artery rupture, aorta	38.44	NA	15.29	5.32	NA	59.05	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
35091		A	Repair defect of artery	35.35	NA	13.56	5.04	NA	53.95	090
35092		A	Repair artery rupture, aorta	44.93	NA	17.63	6.22	NA	68.78	090
35102		A	Repair defect of artery	30.71	NA	12.35	4.39	NA	47.45	090
35103		A	Repair artery rupture, groin	40.44	NA	15.84	5.69	NA	61.97	090
35111		A	Repair defect of artery	24.96	NA	10.46	3.36	NA	38.78	090
35112		A	Repair artery rupture,spleen	29.96	NA	11.96	4.04	NA	45.96	090
35121		A	Repair defect of artery	29.96	NA	12.36	4.21	NA	46.53	090
35122		A	Repair artery rupture, belly	34.95	NA	13.80	4.69	NA	53.44	090
35131		A	Repair defect of artery	24.96	NA	10.74	3.70	NA	39.40	090
35132		A	Repair artery rupture, groin	29.96	NA	12.37	4.27	NA	46.60	090
35141		A	Repair defect of artery	19.97	NA	8.91	2.82	NA	31.70	090
35142		A	Repair artery rupture, thigh	23.27	NA	10.36	3.28	NA	36.91	090
35151		A	Repair defect of artery	22.61	NA	9.98	3.18	NA	35.77	090
35152		A	Repair artery rupture, knee	25.58	NA	11.37	3.55	NA	40.50	090
35180		A	Repair blood vessel lesion	13.60	NA	6.94	1.00	NA	21.54	090
35182		A	Repair blood vessel lesion	29.96	NA	12.79	4.31	NA	47.06	090
35184		A	Repair blood vessel lesion	17.97	NA	8.29	2.49	NA	28.75	090
35188		A	Repair blood vessel lesion	14.26	NA	7.63	2.13	NA	24.02	090
35189		A	Repair blood vessel lesion	27.96	NA	11.95	3.92	NA	43.83	090
35190		A	Repair blood vessel lesion	12.73	NA	6.47	1.76	NA	20.96	090
35201		A	Repair blood vessel lesion	16.12	NA	7.99	2.26	NA	26.37	090
35206		A	Repair blood vessel lesion	13.23	NA	6.55	1.84	NA	21.62	090
35207		A	Repair blood vessel lesion	10.13	NA	7.35	1.44	NA	18.92	090
35211		A	Repair blood vessel lesion	22.09	NA	10.61	3.15	NA	35.85	090
35216		A	Repair blood vessel lesion	18.72	NA	8.97	2.61	NA	30.30	090
35221		A	Repair blood vessel lesion	24.35	NA	9.93	3.27	NA	37.55	090
35226		A	Repair blood vessel lesion	14.48	NA	7.43	1.98	NA	23.89	090
35231		A	Repair blood vessel lesion	19.97	NA	9.76	2.78	NA	32.51	090
35236		A	Repair blood vessel lesion	17.08	NA	7.88	2.40	NA	27.36	090
35241		A	Repair blood vessel lesion	23.09	NA	11.12	3.46	NA	37.67	090
35246		A	Repair blood vessel lesion	26.41	NA	11.42	3.69	NA	41.52	090
35251		A	Repair blood vessel lesion	30.15	NA	11.79	4.05	NA	45.99	090
35256		A	Repair blood vessel lesion	18.33	NA	8.35	2.59	NA	29.27	090
35261		A	Repair blood vessel lesion	17.77	NA	8.01	2.54	NA	28.32	090
35266		A	Repair blood vessel lesion	14.89	NA	7.00	2.05	NA	23.94	090
35271		A	Repair blood vessel lesion	22.09	NA	10.51	3.12	NA	35.72	090
35276		A	Repair blood vessel lesion	24.21	NA	11.20	3.36	NA	38.77	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
35261		A	Repair blood vessel lesion	27.96	NA	11.70	3.89	NA	43.55	090
35286		A	Repair blood vessel lesion	16.14	NA	8.05	2.30	NA	26.49	090
35301		A	Rechanneling of artery	18.67	NA	8.43	2.68	NA	29.78	090
35311		A	Rechanneling of artery	26.96	NA	11.74	3.38	NA	42.08	090
35321		A	Rechanneling of artery	15.98	NA	7.38	2.22	NA	25.58	090
35331		A	Rechanneling of artery	26.16	NA	11.23	3.72	NA	41.11	090
35341		A	Rechanneling of artery	25.07	NA	10.86	3.71	NA	39.64	090
35351		A	Rechanneling of artery	22.97	NA	9.59	3.30	NA	35.86	090
35355		A	Rechanneling of artery	18.47	NA	8.08	2.63	NA	29.18	090
35361		A	Rechanneling of artery	28.16	NA	11.70	3.96	NA	43.82	090
35363		A	Rechanneling of artery	30.15	NA	12.58	4.27	NA	47.00	090
35371		A	Rechanneling of artery	14.70	NA	6.95	2.08	NA	23.73	090
35372		A	Rechanneling of artery	17.97	NA	8.04	2.59	NA	28.60	090
35381		A	Rechanneling of artery	15.79	NA	7.81	2.18	NA	25.78	090
35390		A	Reoperation, carotid add-on	3.19	NA	1.06	0.45	NA	4.70	ZZZ
35400		A	Angioscopy	3.00	NA	1.11	0.42	NA	4.53	ZZZ
35450		A	Repair arterial blockage	10.05	NA	3.56	1.24	NA	14.85	000
35452		A	Repair arterial blockage	6.90	NA	2.60	0.90	NA	10.40	000
35454		A	Repair arterial blockage	6.03	NA	2.31	0.84	NA	9.18	000
35456		A	Repair arterial blockage	7.34	NA	2.76	1.01	NA	11.11	000
35458		A	Repair arterial blockage	9.48	NA	3.47	1.23	NA	14.18	000
35459		A	Repair arterial blockage	8.62	NA	3.17	1.17	NA	12.96	000
35460		A	Repair venous blockage	6.03	NA	2.27	0.82	NA	9.12	000
35470		A	Repair arterial blockage	8.62	88.86	3.35	0.72	98.20	12.69	000
35471		A	Repair arterial blockage	10.05	100.26	3.95	0.71	111.02	14.71	000
35472		A	Repair arterial blockage	6.90	64.35	2.74	0.60	71.85	10.24	000
35473		A	Repair arterial blockage	6.03	59.84	2.42	0.52	66.39	8.97	000
35474		A	Repair arterial blockage	7.35	87.73	2.89	0.59	95.67	10.83	000
35475		R	Repair arterial blockage	9.48	56.10	3.56	0.65	66.23	13.69	000
35476		A	Repair venous blockage	6.03	44.73	2.35	0.39	51.15	8.77	000
35480		A	Atherectomy, open	11.06	NA	4.04	1.28	NA	16.38	000
35481		A	Atherectomy, open	7.60	NA	2.87	1.10	NA	11.57	000
35482		A	Atherectomy, open	6.64	NA	2.56	0.89	NA	10.09	000
35483		A	Atherectomy, open	8.09	NA	3.02	1.11	NA	12.22	000
35484		A	Atherectomy, open	10.42	NA	3.77	1.28	NA	15.47	000
35485		A	Atherectomy, open	9.48	NA	3.53	1.31	NA	14.32	000
35490		A	Atherectomy, percutaneous	11.06	NA	4.70	0.76	NA	16.52	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
35491		A	Atherectomy, percutaneous	7.60	NA	3.29	0.74	NA	11.63	000
35492		A	Atherectomy, percutaneous	6.64	NA	3.19	0.48	NA	10.31	000
35493		A	Atherectomy, percutaneous	8.09	NA	3.80	0.58	NA	12.47	000
35494		A	Atherectomy, percutaneous	10.42	NA	4.46	0.72	NA	15.60	000
35495		A	Atherectomy, percutaneous	9.48	NA	4.39	0.71	NA	14.58	000
35500		A	Harvest vein for bypass	6.44	NA	2.02	0.90	NA	9.36	ZZZ
35501		A	Artery bypass graft	19.16	NA	8.46	2.71	NA	30.33	090
35506		A	Artery bypass graft	19.64	NA	9.46	2.78	NA	31.88	090
35507		A	Artery bypass graft	19.64	NA	9.42	2.83	NA	31.89	090
35508		A	Artery bypass graft	18.62	NA	9.44	2.83	NA	30.89	090
35509		A	Artery bypass graft	18.04	NA	8.76	2.61	NA	29.41	090
35510		A	Artery bypass graft	22.97	NA	10.17	2.10	NA	35.24	090
35511		A	Artery bypass graft	21.17	NA	9.35	2.80	NA	33.32	090
35512		A	Artery bypass graft	22.47	NA	10.00	2.10	NA	34.57	090
35515		A	Artery bypass graft	18.62	NA	9.28	2.74	NA	30.64	090
35516		A	Artery bypass graft	16.30	NA	6.80	2.32	NA	25.42	090
35518		A	Artery bypass graft	21.17	NA	8.97	2.95	NA	33.09	090
35521		A	Artery bypass graft	22.17	NA	9.83	3.03	NA	35.03	090
35522		A	Artery bypass graft	21.73	NA	9.75	2.10	NA	33.58	090
35525		A	Artery bypass graft	20.60	NA	9.37	2.10	NA	32.07	090
35526		A	Artery bypass graft	29.91	NA	12.50	3.59	NA	46.00	090
35531		A	Artery bypass graft	36.15	NA	14.47	5.02	NA	55.64	090
35533		A	Artery bypass graft	27.96	NA	11.72	3.70	NA	43.38	090
35536		A	Artery bypass graft	31.65	NA	12.94	4.45	NA	49.04	090
35541		A	Artery bypass graft	25.76	NA	11.20	3.61	NA	40.57	090
35546		A	Artery bypass graft	25.50	NA	10.86	3.61	NA	39.97	090
35548		A	Artery bypass graft	21.54	NA	9.42	2.94	NA	33.90	090
35549		A	Artery bypass graft	23.31	NA	10.37	3.26	NA	36.94	090
35551		A	Artery bypass graft	26.63	NA	11.49	3.54	NA	41.66	090
35556		A	Artery bypass graft	21.73	NA	9.72	3.04	NA	34.49	090
35558		A	Artery bypass graft	21.17	NA	9.54	2.92	NA	33.63	090
35560		A	Artery bypass graft	31.95	NA	13.31	4.66	NA	49.92	090
35563		A	Artery bypass graft	24.16	NA	10.52	3.40	NA	38.08	090
35565		A	Artery bypass graft	23.17	NA	10.13	3.24	NA	36.54	090
35566		A	Artery bypass graft	26.88	NA	11.38	3.78	NA	42.04	090
35571		A	Artery bypass graft	24.02	NA	10.84	3.39	NA	38.25	090
35572		A	Harvest femoropopliteal vein	6.81	NA	2.24	0.98	NA	10.03	ZZZ

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
35583		A	Vein bypass graft	22.34	NA	10.15	3.13	NA	35.62	090
35585		A	Vein bypass graft	28.35	NA	12.21	3.97	NA	44.53	090
35587		A	Vein bypass graft	24.71	NA	11.45	3.46	NA	39.62	090
35600		A	Harvest artery for cabg	4.94	NA	1.62	0.72	NA	7.28	ZZZ
35601		A	Artery bypass graft	17.47	NA	8.62	2.52	NA	28.61	090
35606		A	Artery bypass graft	18.68	NA	9.01	2.63	NA	30.32	090
35612		A	Artery bypass graft	15.74	NA	7.88	2.03	NA	25.65	090
35616		A	Artery bypass graft	15.68	NA	8.10	2.13	NA	25.91	090
35621		A	Artery bypass graft	19.97	NA	8.67	2.86	NA	31.50	090
35623		A	Bypass graft, not vein	23.96	NA	10.49	3.43	NA	37.88	090
35626		A	Artery bypass graft	27.71	NA	11.97	3.94	NA	43.62	090
35631		A	Artery bypass graft	33.95	NA	13.83	4.86	NA	52.64	090
35636		A	Artery bypass graft	29.46	NA	12.29	4.06	NA	45.81	090
35641		A	Artery bypass graft	24.53	NA	11.06	3.45	NA	39.04	090
35642		A	Artery bypass graft	17.95	NA	8.68	2.25	NA	28.88	090
35645		A	Artery bypass graft	17.44	NA	8.27	2.47	NA	28.18	090
35646		A	Artery bypass graft	30.95	NA	13.10	4.35	NA	48.40	090
35647		A	Artery bypass graft	27.96	NA	11.77	3.91	NA	43.64	090
35650		A	Artery bypass graft	18.97	NA	8.36	2.66	NA	29.99	090
35651		A	Artery bypass graft	25.00	NA	10.72	3.22	NA	38.94	090
35654		A	Artery bypass graft	24.96	NA	10.65	3.48	NA	39.09	090
35656		A	Artery bypass graft	19.50	NA	8.60	2.73	NA	30.83	090
35661		A	Artery bypass graft	18.97	NA	8.92	2.66	NA	30.55	090
35663		A	Artery bypass graft	21.97	NA	9.97	3.06	NA	35.00	090
35665		A	Artery bypass graft	20.97	NA	9.44	2.96	NA	33.37	090
35666		A	Artery bypass graft	22.16	NA	10.64	3.11	NA	35.91	090
35671		A	Artery bypass graft	19.30	NA	9.36	2.72	NA	31.38	090
35681		A	Composite bypass graft	1.60	NA	0.53	0.22	NA	2.35	ZZZ
35682		A	Composite bypass graft	7.19	NA	2.38	1.02	NA	10.59	ZZZ
35683		A	Composite bypass graft	8.49	NA	2.82	1.20	NA	12.51	ZZZ
35685		A	Bypass graft patency/patch	4.04	NA	1.35	0.58	NA	5.97	ZZZ
35686		A	Bypass graft/av fist patency	3.34	NA	1.13	0.47	NA	4.94	ZZZ
35691		A	Arterial transposition	18.02	NA	8.40	2.60	NA	29.02	090
35693		A	Arterial transposition	15.34	NA	7.72	2.20	NA	25.26	090
35694		A	Arterial transposition	19.13	NA	8.60	2.67	NA	30.40	090
35695		A	Arterial transposition	19.13	NA	8.55	2.71	NA	30.39	090
35697		A	Reimplant artery each	3.00	NA	1.02	0.41	NA	4.43	ZZZ

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
35700		A	Reoperation, bypass graft	3.08	NA	1.02	0.43	NA	4.53	ZZZ
35701		A	Exploration, carotid artery	8.49	NA	5.15	1.11	NA	14.75	090
35721		A	Exploration, femoral artery	7.17	NA	4.43	1.02	NA	12.62	090
35741		A	Exploration popliteal artery	7.99	NA	4.66	1.09	NA	13.74	090
35761		A	Exploration of artery/vein	5.36	NA	4.01	0.74	NA	10.11	090
35800		A	Explore neck vessels	7.01	NA	4.65	0.95	NA	12.61	090
35820		A	Explore chest vessels	12.86	NA	7.20	1.86	NA	21.92	090
35840		A	Explore abdominal vessels	9.76	NA	5.28	1.31	NA	16.35	090
35860		A	Explore limb vessels	5.54	NA	4.03	0.77	NA	10.34	090
35870		A	Repair vessel graft defect	22.14	NA	9.76	2.92	NA	34.82	090
35875		A	Removal of clot in graft	10.11	NA	5.18	1.38	NA	16.67	090
35876		A	Removal of clot in graft	16.97	NA	7.51	2.36	NA	26.84	090
35879		A	Revise graft w/vein	15.98	NA	7.69	2.26	NA	25.93	090
35881		A	Revise graft w/vein	17.97	NA	8.66	2.53	NA	29.16	090
35901		A	Excision, graft, neck	8.18	NA	5.30	1.14	NA	14.62	090
35903		A	Excision, graft, extremity	9.38	NA	6.15	1.29	NA	16.82	090
35905		A	Excision, graft, thorax	31.20	NA	13.18	4.37	NA	48.75	090
35907		A	Excision, graft, abdomen	34.95	NA	14.16	4.84	NA	53.95	090
36000		A	Place needle in vein	0.18	0.57	0.05	0.01	0.76	0.24	XXX
36002		A	Pseudoaneurysm injection trt	1.96	2.86	0.97	0.17	4.99	3.10	000
36005		A	Injection ext venography	0.95	7.65	0.31	0.06	8.66	1.32	000
36010		A	Place catheter in vein	2.43	19.30	0.79	0.19	21.92	3.41	XXX
36011		A	Place catheter in vein	3.14	27.82	1.06	0.28	31.24	4.48	XXX
36012		A	Place catheter in vein	3.51	18.95	1.19	0.24	22.70	4.94	XXX
36013		A	Place catheter in artery	2.52	21.36	0.69	0.23	24.11	3.44	XXX
36014		A	Place catheter in artery	3.02	20.12	1.03	0.19	23.33	4.24	XXX
36015		A	Place catheter in artery	3.51	23.66	1.19	0.22	27.39	4.92	XXX
36100		A	Establish access to artery	3.02	12.07	1.11	0.27	15.36	4.40	XXX
36120		A	Establish access to artery	2.01	10.70	0.65	0.15	12.86	2.81	XXX
36140		A	Establish access to artery	2.01	12.77	0.64	0.16	14.94	2.81	XXX
36145		A	Artery to vein shunt	2.01	12.55	0.66	0.13	14.69	2.80	XXX
36160		A	Establish access to aorta	2.52	13.48	0.84	0.25	16.25	3.61	XXX
36200		A	Place catheter in aorta	3.02	16.51	1.01	0.25	19.78	4.28	XXX
36215		A	Place catheter in artery	4.67	27.03	1.61	0.32	32.02	6.60	XXX
36216		A	Place catheter in artery	5.27	29.08	1.79	0.37	34.72	7.43	XXX
36217		A	Place catheter in artery	6.29	55.44	2.17	0.46	62.19	8.92	XXX
36218		A	Place catheter in artery	1.01	5.09	0.34	0.08	6.18	1.43	ZZZ

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
36245		A	Place catheter in artery	4.67	32.09	1.68	0.33	37.09	6.68	XXX
36246		A	Place catheter in artery	5.27	29.96	1.82	0.39	35.62	7.48	XXX
36247		A	Place catheter in artery	6.29	49.51	2.14	0.48	56.28	8.91	XXX
36248		A	Place catheter in artery	1.01	4.04	0.34	0.08	5.13	1.43	ZZZ
36260		A	Insertion of infusion pump	9.70	NA	4.88	1.28	NA	15.86	090
36261		A	Revision of infusion pump	5.44	NA	3.66	0.70	NA	9.80	090
36262		A	Removal of infusion pump	4.01	NA	2.75	0.52	NA	7.28	090
36299		C	Vessel injection procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
36400		A	Bl draw < 3 yrs fem/jugular	0.38	0.28	0.09	0.03	0.69	0.50	XXX
36405		A	Bl draw < 3 yrs scalp vein	0.31	0.26	0.08	0.03	0.60	0.42	XXX
36406		A	Bl draw < 3 yrs other vein	0.18	0.28	0.05	0.01	0.47	0.24	XXX
36410		A	Non-routine bl draw > 3 yrs	0.18	0.29	0.05	0.01	0.48	0.24	XXX
36415		I	Routine venipuncture	0.00	0.00	0.00	0.00	0.00	0.00	XXX
36416		B	Capillary blood draw	0.00	0.00	0.00	0.00	0.00	0.00	XXX
36420		A	Vein access cutdown < 1 yr	1.01	0.34	0.27	0.07	1.42	1.35	XXX
36425		A	Vein access cutdown > 1 yr	0.76	NA	0.22	0.06	NA	1.04	XXX
36430		A	Blood transfusion service	0.00	1.01	NA	0.06	1.07	NA	XXX
36440		A	Bl push transfuse, 2 yr or <	1.03	NA	0.29	0.10	NA	1.42	XXX
36450		A	Bl exchange/transfuse, nb	2.23	NA	0.71	0.21	NA	3.15	XXX
36455		A	Bl exchange/transfuse non-nb	2.43	NA	1.01	0.16	NA	3.60	XXX
36460		A	Transfusion service, fetal	6.58	NA	2.24	0.79	NA	9.61	XXX
36468		R	Injection(s), spider veins	0.00	0.00	0.00	0.00	0.00	0.00	000
36469		R	Injection(s), spider veins	0.00	0.00	0.00	0.00	0.00	0.00	000
36470		A	Injection therapy of vein	1.09	2.68	0.73	0.12	3.89	1.94	010
36471		A	Injection therapy of veins	1.57	3.07	0.96	0.19	4.83	2.72	010
36475		A	Endovenous rf, 1st vein	6.72	51.39	2.53	0.37	58.48	9.62	000
36476		A	Endovenous rf, vein add-on	3.38	7.88	1.14	0.18	11.44	4.70	ZZZ
36478		A	Endovenous laser, 1st vein	6.72	46.77	2.53	0.37	53.86	9.62	000
36479		A	Endovenous laser vein addon	3.38	7.99	1.14	0.18	11.55	4.70	ZZZ
36481		A	Insertion of catheter, vein	6.98	5.73	2.59	0.54	13.25	10.11	000
36500		A	Insertion of catheter, vein	3.51	NA	1.37	0.23	NA	5.11	000
36510		A	Insertion of catheter, vein	1.09	3.89	0.61	0.10	5.08	1.80	000
36511		A	Apheresis wbc	1.74	NA	0.73	0.08	NA	2.55	000
36512		A	Apheresis rbc	1.74	NA	0.74	0.08	NA	2.56	000
36513		A	Apheresis platelets	1.74	NA	0.73	0.17	NA	2.64	000
36514		A	Apheresis plasma	1.74	16.97	0.71	0.08	18.79	2.53	000
36515		A	Apheresis, adsorp/reinfuse	1.74	66.30	0.66	0.08	68.12	2.48	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
36516		A	Apheresis, selective	1.22	84.05	0.48	0.08	85.35	1.78	000
36522		A	Photopheresis	1.67	32.37	0.96	0.13	34.17	2.76	000
36540		B	Collect blood venous device	0.00	0.00	0.00	0.00	0.00	0.00	XXX
36550		A	Declot vascular device	0.00	0.39	NA	0.37	0.76	NA	XXX
36555		A	Insert non-tunnel cv cath	2.68	5.75	0.80	0.12	8.55	3.60	000
36556		A	Insert non-tunnel cv cath	2.50	5.62	0.74	0.19	8.31	3.43	000
36557		A	Insert tunneled cv cath	5.09	21.14	2.65	0.57	26.80	8.31	010
36558		A	Insert tunneled cv cath	4.79	21.04	2.55	0.57	26.40	7.91	010
36560		A	Insert tunneled cv cath	6.24	29.67	3.03	0.57	36.48	9.84	010
36561		A	Insert tunneled cv cath	5.99	29.58	2.95	0.57	36.14	9.51	010
36563		A	Insert tunneled cv cath	6.19	26.74	2.98	0.83	33.76	10.00	010
36565		A	Insert tunneled cv cath	5.99	24.70	2.95	0.57	31.26	9.51	010
36566		A	Insert tunneled cv cath	6.49	25.50	3.11	0.57	32.56	10.17	010
36568		A	Insert picc cath	1.92	7.53	0.58	0.12	9.57	2.62	000
36569		A	Insert picc cath	1.82	7.34	0.57	0.19	9.35	2.58	000
36570		A	Insert picvad cath	5.31	33.17	2.72	0.57	39.05	8.60	010
36571		A	Insert picvad cath	5.29	33.24	2.71	0.57	39.10	8.57	010
36575		A	Repair tunneled cv cath	0.67	4.05	0.26	0.21	4.93	1.14	000
36576		A	Repair tunneled cv cath	3.19	6.94	1.84	0.20	10.33	5.23	010
36578		A	Replace tunneled cv cath	3.49	11.13	2.30	0.20	14.82	5.99	010
36580		A	Replace cvad cath	1.31	6.94	0.41	0.19	8.44	1.91	000
36581		A	Replace tunneled cv cath	3.43	19.49	1.92	0.20	23.12	5.55	010
36582		A	Replace tunneled cv cath	5.19	26.01	2.86	0.20	31.40	8.25	010
36583		A	Replace tunneled cv cath	5.24	26.03	2.88	0.20	31.47	8.32	010
36584		A	Replace picc cath	1.20	6.97	0.55	0.19	8.36	1.94	000
36585		A	Replace picvad cath	4.79	27.82	2.73	0.20	32.81	7.72	010
36589		A	Removal tunneled cv cath	2.27	2.24	1.39	0.24	4.75	3.90	010
36590		A	Removal tunneled cv cath	3.30	3.37	1.72	0.43	7.10	5.45	010
36595		A	Mech remov tunneled cv cath	3.59	17.25	1.45	0.24	21.08	5.28	000
36596		A	Mech remov tunneled cv cath	0.75	3.69	0.50	0.05	4.49	1.30	000
36597		A	Reposition venous catheter	1.21	2.40	0.44	0.08	3.69	1.73	000
36600		A	Withdrawal of arterial blood	0.32	0.49	0.09	0.02	0.83	0.43	XXX
36620		A	Insertion catheter, artery	1.15	NA	0.23	0.08	NA	1.46	000
36625		A	Insertion catheter, artery	2.11	NA	0.53	0.25	NA	2.89	000
36640		A	Insertion catheter, artery	2.10	NA	1.04	0.21	NA	3.35	000
36660		A	Insertion catheter, artery	1.40	NA	0.44	0.14	NA	1.98	000
36680		A	Insert needle, bone cavity	1.20	NA	0.49	0.11	NA	1.80	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
36800		A	Insertion of cannula	2.43	NA	1.80	0.24	NA	4.47	000
36810		A	Insertion of cannula	3.96	NA	1.68	0.44	NA	6.08	000
36815		A	Insertion of cannula	2.62	NA	1.17	0.34	NA	4.13	000
36818		A	Av fuse, uppr arm, cephalic	11.52	NA	6.03	1.88	NA	19.43	090
36819		A	Av fuse, uppr arm, basilic	13.98	NA	6.37	1.92	NA	22.27	090
36820		A	Av fusion/forearm vein	13.98	NA	6.38	1.92	NA	22.28	090
36821		A	Av fusion direct any site	8.92	NA	4.65	1.21	NA	14.78	090
36822		A	Insertion of cannula(s)	5.41	NA	4.38	0.74	NA	10.53	090
36823		A	Insertion of cannula(s)	20.97	NA	9.37	2.82	NA	33.16	090
36825		A	Artery-vein autograft	9.83	NA	5.05	1.33	NA	16.21	090
36830		A	Artery-vein nonautograft	11.98	NA	5.23	1.64	NA	18.85	090
36831		A	Open thrombect av fistula	7.99	NA	3.94	1.08	NA	13.01	090
36832		A	Av fistula revision, open	10.48	NA	4.72	1.43	NA	16.63	090
36833		A	Av fistula revision	11.93	NA	5.20	1.64	NA	18.77	090
36834		A	Repair A-V aneurysm	9.92	NA	4.79	1.36	NA	16.07	090
36835		A	Artery to vein shunt	7.14	NA	4.32	0.98	NA	12.44	090
36838		A	Dist revas ligation, hemo	20.60	NA	9.38	2.99	NA	32.97	090
36860		A	External cannula declotting	2.01	1.77	0.68	0.14	3.92	2.83	000
36861		A	Cannula declotting	2.52	NA	1.49	0.26	NA	4.27	000
36870		A	Percut thrombect av fistula	5.15	53.03	3.15	0.33	58.51	8.63	090
37140		A	Revision of circulation	23.56	NA	10.48	1.99	NA	36.03	090
37145		A	Revision of circulation	24.57	NA	10.86	3.22	NA	38.65	090
37160		A	Revision of circulation	21.57	NA	9.25	2.78	NA	33.60	090
37180		A	Revision of circulation	24.57	NA	10.29	3.31	NA	38.17	090
37181		A	Splice spleen/kidney veins	26.64	NA	11.00	3.37	NA	41.01	090
37182		A	Insert hepatic shunt (tips)	16.97	NA	6.06	1.00	NA	24.03	000
37183		A	Remove hepatic shunt (tips)	7.99	NA	3.01	0.48	NA	11.48	000
37195		A	Thrombolytic therapy, stroke	+0.00	0.00	NA	0.00	0.00	NA	XXX
37200		A	Transcatheter biopsy	4.55	NA	1.50	0.27	NA	6.32	000
37201		A	Transcatheter therapy infuse	4.99	NA	2.54	0.36	NA	7.89	000
37202		A	Transcatheter therapy infuse	5.67	NA	3.03	0.46	NA	9.16	000
37203		A	Transcatheter retrieval	5.02	32.87	2.03	0.35	38.24	7.40	000
37204		A	Transcatheter occlusion	18.11	NA	5.90	1.51	NA	25.52	000
37205		A	Transcath iv stent, percut	8.27	NA	3.75	0.61	NA	12.63	000
37206		A	Transcath iv stent/perc addl	4.12	NA	1.43	0.32	NA	5.87	ZZZ
37207		A	Transcath iv stent, open	8.27	NA	3.16	1.13	NA	12.56	000
37208		A	Transcath iv stent/open addl	4.12	NA	1.38	0.57	NA	6.07	ZZZ

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
37209		A	Exchange arterial catheter	2.27	NA	0.74	0.16	NA	3.17	000
37215		R	Transcath stent, cca w/eps	18.71	NA	9.09	1.09	NA	28.89	090
37216		R	Transcath stent, cca w/o eps	17.98	NA	8.81	1.04	NA	27.83	090
37250		A	Iv us first vessel add-on	2.10	NA	0.75	0.21	NA	3.06	ZZZ
37251		A	Iv us each add vessel add-on	1.60	NA	0.55	0.19	NA	2.34	ZZZ
37500		A	Endoscopy ligate perf veins	10.98	NA	6.85	1.53	NA	19.36	090
37501		C	Vascular endoscopy procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
37565		A	Ligation of neck vein	10.86	NA	5.62	1.33	NA	17.81	090
37600		A	Ligation of neck artery	11.23	NA	6.63	1.41	NA	19.27	090
37605		A	Ligation of neck artery	13.09	NA	6.90	1.94	NA	21.93	090
37606		A	Ligation of neck artery	6.27	NA	4.56	1.23	NA	12.06	090
37607		A	Ligation of a-v fistula	6.15	NA	3.56	0.83	NA	10.54	090
37609		A	Temporal artery procedure	3.00	4.50	1.96	0.37	7.87	5.33	010
37615		A	Ligation of neck artery	5.72	NA	4.11	0.70	NA	10.53	090
37616		A	Ligation of chest artery	16.47	NA	8.08	2.29	NA	26.84	090
37617		A	Ligation of abdomen artery	22.03	NA	9.17	2.93	NA	34.13	090
37618		A	Ligation of extremity artery	4.83	NA	3.61	0.66	NA	9.10	090
37620		A	Revision of major vein	10.54	NA	5.71	0.93	NA	17.18	090
37650		A	Revision of major vein	7.79	NA	4.68	0.98	NA	13.45	090
37660		A	Revision of major vein	20.97	NA	9.05	2.46	NA	32.48	090
37700		A	Revise leg vein	3.72	NA	2.79	0.52	NA	7.03	090
37720		A	Removal of leg vein	5.65	NA	3.70	0.78	NA	10.13	090
37730		A	Removal of leg veins	7.32	NA	4.26	1.01	NA	12.59	090
37735		A	Removal of leg veins/lesion	10.51	NA	5.50	1.48	NA	17.49	090
37760		A	Ligation, leg veins, open	10.45	NA	5.34	1.39	NA	17.18	090
37765		A	Phleb veins - extrem - to 20	7.34	NA	4.62	0.48	NA	12.44	090
37766		A	Phleb veins - extrem 20+	9.29	NA	5.32	0.48	NA	15.09	090
37780		A	Revision of leg vein	3.83	NA	2.85	0.53	NA	7.21	090
37785		A	Ligate/divide/excise vein	3.83	5.19	2.72	0.51	9.53	7.06	090
37788		A	Revascularization, penis	21.98	NA	9.08	2.23	NA	33.29	090
37790		A	Penile venous occlusion	8.33	NA	4.37	0.59	NA	13.29	090
37799		C	Vascular surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
38100		A	Removal of spleen, total	14.48	NA	6.17	1.88	NA	22.53	090
38101		A	Removal of spleen, partial	15.29	NA	6.52	1.96	NA	23.77	090
38102		A	Removal of spleen, total	4.79	NA	1.64	0.62	NA	7.05	ZZZ
38115		A	Repair of ruptured spleen	15.80	NA	6.64	2.00	NA	24.44	090
38120		A	Laparoscopy, splenectomy	16.97	NA	7.38	2.21	NA	26.56	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
38129		C	Laparoscope proc, spleen	0.00	0.00	0.00	0.00	0.00	0.00	YYY
38200		A	Injection for spleen x-ray	2.64	NA	0.89	0.17	NA	3.70	000
38204		B	Bl donor search management	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38205		R	Harvest allogenic stem cells	1.50	NA	0.67	0.07	NA	2.24	000
38206		R	Harvest auto stem cells	1.50	NA	0.67	0.07	NA	2.24	000
38207		I	Cryopreserve stem cells	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38208		I	Thaw preserved stem cells	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38209		I	Wash harvest stem cells	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38210		I	T-cell depletion of harvest	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38211		I	Tumor cell deplete of harvst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38212		I	Rbc depletion of harvest	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38213		I	Platelet deplete of harvest	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38214		I	Volume deplete of harvest	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38215		I	Harvest stem cell concentrte	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38220		A	Bone marrow aspiration	1.08	3.72	0.52	0.06	4.86	1.66	XXX
38221		A	Bone marrow biopsy	1.37	3.93	0.65	0.07	5.37	2.09	XXX
38230		R	Bone marrow collection	4.53	NA	3.22	0.47	NA	8.22	010
38240		R	Bone marrow/stem transplant	2.24	NA	1.03	0.12	NA	3.39	XXX
38241		R	Bone marrow/stem transplant	2.24	NA	1.04	0.14	NA	3.42	XXX
38242		A	Lymphocyte infuse transplant	1.71	NA	0.78	0.10	NA	2.59	000
38300		A	Drainage, lymph node lesion	1.99	4.30	2.05	0.24	6.53	4.28	010
38305		A	Drainage, lymph node lesion	5.99	NA	4.44	0.85	NA	11.28	090
38308		A	Incision of lymph channels	6.44	NA	3.74	0.85	NA	11.03	090
38380		A	Thoracic duct procedure	7.45	NA	5.68	0.80	NA	13.93	090
38381		A	Thoracic duct procedure	12.86	NA	6.88	1.83	NA	21.57	090
38382		A	Thoracic duct procedure	10.06	NA	5.75	1.37	NA	17.18	090
38500		A	Biopsy/removal, lymph nodes	3.74	3.69	2.08	0.48	7.91	6.30	010
38505		A	Needle biopsy, lymph nodes	1.14	2.05	0.78	0.09	3.28	2.01	000
38510		A	Biopsy/removal, lymph nodes	6.42	5.54	3.48	0.74	12.70	10.64	010
38520		A	Biopsy/removal, lymph nodes	6.66	NA	4.05	0.84	NA	11.55	090
38525		A	Biopsy/removal, lymph nodes	6.06	NA	3.29	0.80	NA	10.15	090
38530		A	Biopsy/removal, lymph nodes	7.97	NA	4.39	1.10	NA	13.46	090
38542		A	Explore deep node(s), neck	5.90	NA	4.48	0.62	NA	11.00	090
38550		A	Removal, neck/armpit lesion	6.91	NA	3.91	0.87	NA	11.69	090
38555		A	Removal, neck/armpit lesion	14.12	NA	8.53	1.78	NA	24.43	090
38562		A	Removal, pelvic lymph nodes	10.47	NA	5.77	1.21	NA	17.45	090
38564		A	Removal, abdomen lymph nodes	10.81	NA	5.24	1.32	NA	17.37	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
38570		A	Laparoscopy, lymph node biop	9.24	NA	3.97	1.13	NA	14.34	010
38571		A	Laparoscopy, lymphadenectomy	14.66	NA	5.64	1.16	NA	21.46	010
38572		A	Laparoscopy, lymphadenectomy	16.57	NA	7.07	1.89	NA	25.53	010
38589		C	Laparoscope proc, lymphatic	0.00	0.00	0.00	0.00	0.00	0.00	YYY
38700		A	Removal of lymph nodes, neck	8.23	NA	6.23	0.76	NA	15.22	090
38720		A	Removal of lymph nodes, neck	13.59	NA	9.35	1.25	NA	24.19	090
38724		A	Removal of lymph nodes, neck	14.52	NA	9.83	1.31	NA	25.66	090
38740		A	Remove armpit lymph nodes	10.01	NA	4.94	1.31	NA	16.26	090
38745		A	Remove armpit lymph nodes	13.08	NA	6.07	1.71	NA	20.86	090
38746		A	Remove thoracic lymph nodes	4.88	NA	1.61	0.70	NA	7.19	ZZZ
38747		A	Remove abdominal lymph nodes	4.88	NA	1.67	0.63	NA	7.18	ZZZ
38760		A	Remove groin lymph nodes	12.93	NA	6.12	1.68	NA	20.73	090
38765		A	Remove groin lymph nodes	19.95	NA	8.80	2.46	NA	31.21	090
38770		A	Remove pelvis lymph nodes	13.21	NA	5.74	1.41	NA	20.36	090
38780		A	Remove abdomen lymph nodes	16.57	NA	8.20	1.87	NA	26.64	090
38790		A	Inject for lymphatic x-ray	1.29	7.35	0.76	0.13	8.77	2.18	000
38792		A	Identify sentinel node	0.52	NA	0.44	0.06	NA	1.02	000
38794		A	Access thoracic lymph duct	4.44	NA	3.45	0.31	NA	8.20	090
38999		C	Blood/lymph system procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
39000		A	Exploration of chest	6.09	NA	4.65	0.85	NA	11.59	090
39010		A	Exploration of chest	11.77	NA	7.54	1.67	NA	20.98	090
39200		A	Removal chest lesion	13.60	NA	7.53	1.91	NA	23.04	090
39220		A	Removal chest lesion	17.39	NA	9.36	2.38	NA	29.13	090
39400		A	Visualization of chest	5.60	NA	4.85	0.80	NA	11.25	010
39499		C	Chest procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
39501		A	Repair diaphragm laceration	13.17	NA	6.45	1.73	NA	21.35	090
39502		A	Repair paraesophageal hernia	16.31	NA	7.14	2.14	NA	25.59	090
39503		A	Repair of diaphragm hernia	94.86	NA	33.37	10.87	NA	139.10	090
39520		A	Repair of diaphragm hernia	16.08	NA	8.04	2.20	NA	26.32	090
39530		A	Repair of diaphragm hernia	15.39	NA	7.13	2.08	NA	24.60	090
39531		A	Repair of diaphragm hernia	16.40	NA	7.38	2.19	NA	25.97	090
39540		A	Repair of diaphragm hernia	13.30	NA	6.22	1.75	NA	21.27	090
39541		A	Repair of diaphragm hernia	14.39	NA	6.58	1.90	NA	22.87	090
39545		A	Revision of diaphragm	13.35	NA	7.54	1.81	NA	22.70	090
39560		A	Resect diaphragm, simple	11.98	NA	6.28	1.55	NA	19.81	090
39561		A	Resect diaphragm, complex	17.47	NA	9.33	2.36	NA	29.16	090
39599		C	Diaphragm surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY

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CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
4000F		I	Tobacco use txmnt counseling	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4001F		I	Tobacco use txmnt, pharmacol	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4002F		I	Statin therapy, rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4006F		I	Beta-blocker therapy, rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4009F		I	Ace inhibitor therapy, rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4011F		I	Oral antiplatelet tx, rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
40490		A	Biopsy of lip	1.22	1.63	0.61	0.06	2.91	1.89	000
40500		A	Partial excision of lip	4.27	6.89	4.33	0.39	11.55	8.99	090
40510		A	Partial excision of lip	4.69	6.61	4.01	0.48	11.78	9.18	090
40520		A	Partial excision of lip	4.66	7.54	4.11	0.52	12.72	9.29	090
40525		A	Reconstruct lip with flap	7.54	NA	6.30	0.85	NA	14.69	090
40527		A	Reconstruct lip with flap	9.12	NA	7.35	0.99	NA	17.46	090
40530		A	Partial removal of lip	5.39	7.81	4.58	0.55	13.75	10.52	090
40650		A	Repair lip	3.63	6.79	3.29	0.38	10.80	7.30	090
40652		A	Repair lip	4.25	7.74	4.26	0.50	12.49	9.01	090
40654		A	Repair lip	5.30	8.60	4.93	0.60	14.50	10.83	090
40700		A	Repair cleft lip/nasal	12.77	NA	9.07	0.95	NA	22.79	090
40701		A	Repair cleft lip/nasal	15.83	NA	11.33	1.64	NA	28.80	090
40702		A	Repair cleft lip/nasal	13.02	NA	8.25	1.24	NA	22.51	090
40720		A	Repair cleft lip/nasal	13.53	NA	9.89	1.78	NA	25.20	090
40761		A	Repair cleft lip/nasal	14.70	NA	10.27	1.91	NA	26.88	090
40799		C	Lip surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
40800		A	Drainage of mouth lesion	1.17	2.96	1.77	0.12	4.25	3.06	010
40801		A	Drainage of mouth lesion	2.53	4.02	2.74	0.31	6.86	5.58	010
40804		A	Removal, foreign body, mouth	1.24	3.39	1.85	0.11	4.74	3.20	010
40805		A	Removal, foreign body, mouth	2.69	4.48	2.81	0.31	7.48	5.81	010
40806		A	Incision of lip fold	0.31	1.83	0.50	0.04	2.18	0.85	000
40808		A	Biopsy of mouth lesion	0.96	2.65	1.48	0.10	3.71	2.54	010
40810		A	Excision of mouth lesion	1.31	2.88	1.66	0.13	4.32	3.10	010
40812		A	Excise/repair mouth lesion	2.31	3.72	2.40	0.28	6.31	4.99	010
40814		A	Excise/repair mouth lesion	3.41	4.94	3.89	0.41	8.76	7.71	090
40816		A	Excision of mouth lesion	3.66	5.17	4.00	0.41	9.24	8.07	090
40818		A	Excise oral mucosa for graft	2.41	5.17	3.97	0.21	7.79	6.59	090
40819		A	Excise lip or cheek fold	2.41	4.08	3.09	0.27	6.76	5.77	090
40820		A	Treatment of mouth lesion	1.28	3.93	2.44	0.11	5.32	3.83	010
40830		A	Repair mouth laceration	1.76	3.72	2.09	0.19	5.67	4.04	010
40831		A	Repair mouth laceration	2.46	4.66	3.05	0.29	7.41	5.80	010

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
40840		R	Reconstruction of mouth	8.72	9.78	6.97	1.05	19.55	16.74	090
40842		R	Reconstruction of mouth	8.72	10.06	6.78	1.08	19.86	16.58	090
40843		R	Reconstruction of mouth	12.08	11.95	7.81	1.38	25.41	21.27	090
40844		R	Reconstruction of mouth	15.99	15.76	11.56	1.97	33.72	29.52	090
40845		R	Reconstruction of mouth	18.55	17.06	13.21	1.99	37.60	33.75	090
40899		C	Mouth surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
41000		A	Drainage of mouth lesion	1.30	2.31	1.41	0.12	3.73	2.83	010
41005		A	Drainage of mouth lesion	1.26	3.33	1.72	0.12	4.71	3.10	010
41006		A	Drainage of mouth lesion	3.24	4.79	3.17	0.35	8.38	6.76	090
41007		A	Drainage of mouth lesion	3.10	5.14	3.02	0.31	8.55	6.43	090
41008		A	Drainage of mouth lesion	3.36	4.68	3.20	0.42	8.46	6.98	090
41009		A	Drainage of mouth lesion	3.58	4.97	3.57	0.46	9.01	7.61	090
41010		A	Incision of tongue fold	1.06	3.42	1.60	0.08	4.56	2.74	010
41015		A	Drainage of mouth lesion	3.95	5.40	4.14	0.46	9.81	8.55	090
41016		A	Drainage of mouth lesion	4.06	5.61	4.22	0.52	10.19	8.80	090
41017		A	Drainage of mouth lesion	4.06	5.63	4.30	0.53	10.22	8.89	090
41018		A	Drainage of mouth lesion	5.09	6.13	4.57	0.66	11.88	10.32	090
41100		A	Biopsy of tongue	1.63	2.42	1.42	0.15	4.20	3.20	010
41105		A	Biopsy of tongue	1.42	2.30	1.32	0.13	3.85	2.87	010
41108		A	Biopsy of floor of mouth	1.05	2.07	1.13	0.10	3.22	2.28	010
41110		A	Excision of tongue lesion	1.51	2.98	1.64	0.13	4.62	3.28	010
41112		A	Excision of tongue lesion	2.73	4.47	3.22	0.29	7.49	6.24	090
41113		A	Excision of tongue lesion	3.19	4.74	3.47	0.34	8.27	7.00	090
41114		A	Excision of tongue lesion	8.46	NA	7.19	0.83	NA	16.48	090
41115		A	Excision of tongue fold	1.74	3.29	1.85	0.18	5.21	3.77	010
41116		A	Excision of mouth lesion	2.44	4.35	2.80	0.23	7.02	5.47	090
41120		A	Partial removal of tongue	9.76	NA	15.31	0.83	NA	25.90	090
41130		A	Partial removal of tongue	11.13	NA	16.19	0.97	NA	28.29	090
41135		A	Tongue and neck surgery	23.06	NA	23.22	1.97	NA	48.25	090
41140		A	Removal of tongue	25.46	NA	26.67	2.24	NA	54.37	090
41145		A	Tongue removal, neck surgery	30.01	NA	30.54	2.58	NA	63.13	090
41150		A	Tongue, mouth, jaw surgery	23.01	NA	24.71	2.01	NA	49.73	090
41153		A	Tongue, mouth, neck surgery	23.73	NA	25.02	2.07	NA	50.82	090
41155		A	Tongue, jaw, & neck surgery	27.68	NA	26.80	2.42	NA	56.90	090
41250		A	Repair tongue laceration	1.91	2.74	1.18	0.19	4.84	3.28	010
41251		A	Repair tongue laceration	2.27	3.27	1.55	0.22	5.76	4.04	010
41252		A	Repair tongue laceration	2.97	3.89	2.25	0.29	7.15	5.51	010

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
41500		A	Fixation of tongue	3.70	NA	7.45	0.30	NA	11.45	090
41510		A	Tongue to lip surgery	3.41	NA	7.93	0.20	NA	11.54	090
41520		A	Reconstruction, tongue fold	2.73	4.62	3.62	0.27	7.62	6.62	090
41599		C	Tongue and mouth surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
41800		A	Drainage of gum lesion	1.17	2.59	1.28	0.12	3.88	2.57	010
41805		A	Removal foreign body, gum	1.24	2.67	2.21	0.13	4.04	3.58	010
41806		A	Removal foreign body,jawbone	2.69	3.58	3.03	0.36	6.63	6.08	010
41820		R	Excision, gum, each quadrant	0.00	0.00	0.00	0.00	0.00	0.00	000
41821		R	Excision of gum flap	0.00	0.00	0.00	0.00	0.00	0.00	000
41822		R	Excision of gum lesion	2.31	3.89	1.87	0.31	6.51	4.49	010
41823		R	Excision of gum lesion	3.30	5.56	4.01	0.46	9.32	7.77	090
41825		A	Excision of gum lesion	1.31	3.06	2.24	0.15	4.52	3.70	010
41826		A	Excision of gum lesion	2.31	2.43	2.10	0.30	5.04	4.71	010
41827		A	Excision of gum lesion	3.41	5.51	3.66	0.35	9.27	7.42	090
41828		R	Excision of gum lesion	3.09	3.80	2.96	0.44	7.33	6.49	010
41830		R	Removal of gum tissue	3.34	4.96	3.62	0.44	8.74	7.40	010
41850		R	Treatment of gum lesion	0.00	0.00	0.00	0.00	0.00	0.00	000
41870		R	Gum graft	0.00	0.00	0.00	0.00	0.00	0.00	000
41872		R	Repair gum	2.59	5.02	3.46	0.30	7.91	6.35	090
41874		R	Repair tooth socket	3.09	4.84	3.17	0.44	8.37	6.70	090
41899		C	Dental surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
42000		A	Drainage mouth roof lesion	1.23	2.56	1.25	0.12	3.91	2.60	010
42100		A	Biopsy roof of mouth	1.31	2.08	1.36	0.13	3.52	2.80	010
42104		A	Excision lesion, mouth roof	1.64	2.54	1.55	0.16	4.34	3.35	010
42106		A	Excision lesion, mouth roof	2.10	3.22	2.44	0.25	5.57	4.79	010
42107		A	Excision lesion, mouth roof	4.43	5.71	3.95	0.45	10.59	8.83	090
42120		A	Remove palate/lesion	6.16	NA	11.77	0.54	NA	18.47	090
42140		A	Excision of uvula	1.62	3.72	2.09	0.13	5.47	3.84	090
42145		A	Repair palate, pharynx/uvula	8.04	NA	7.49	0.65	NA	16.18	090
42160		A	Treatment mouth roof lesion	1.80	4.25	2.29	0.17	6.22	4.26	010
42180		A	Repair palate	2.50	3.07	2.10	0.21	5.78	4.81	010
42182		A	Repair palate	3.82	3.87	3.03	0.40	8.09	7.25	010
42200		A	Reconstruct cleft palate	11.98	NA	10.21	1.27	NA	23.46	090
42205		A	Reconstruct cleft palate	13.27	NA	10.07	1.56	NA	24.90	090
42210		A	Reconstruct cleft palate	14.48	NA	11.46	2.14	NA	28.08	090
42215		A	Reconstruct cleft palate	8.81	NA	9.07	1.30	NA	19.18	090
42220		A	Reconstruct cleft palate	7.01	NA	6.78	0.72	NA	14.51	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
42225		A	Reconstruct cleft palate	9.53	NA	17.06	0.89	NA	27.48	090
42226		A	Lengthening of palate	9.99	NA	14.70	1.01	NA	25.70	090
42227		A	Lengthening of palate	9.51	NA	15.54	0.98	NA	26.03	090
42235		A	Repair palate	7.86	NA	11.86	0.72	NA	20.44	090
42260		A	Repair nose to lip fistula	9.79	10.19	7.06	1.25	21.23	18.10	090
42280		A	Preparation, palate mold	1.54	1.96	1.14	0.19	3.69	2.87	010
42281		A	Insertion, palate prosthesis	1.93	2.63	1.87	0.17	4.73	3.97	010
42299		C	Palate/uvula surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
42300		A	Drainage of salivary gland	1.93	2.82	1.81	0.16	4.91	3.90	010
42305		A	Drainage of salivary gland	6.06	NA	4.72	0.53	NA	11.31	090
42310		A	Drainage of salivary gland	1.56	2.26	1.54	0.13	3.95	3.23	010
42320		A	Drainage of salivary gland	2.35	3.27	2.09	0.21	5.83	4.65	010
42325		A	Create salivary cyst drain	2.75	4.61	2.30	0.26	7.62	5.31	090
42326		A	Create salivary cyst drain	3.77	5.90	3.15	0.29	9.96	7.21	090
42330		A	Removal of salivary stone	2.21	3.14	1.84	0.19	5.54	4.24	010
42335		A	Removal of salivary stone	3.31	4.90	3.14	0.30	8.51	6.75	090
42340		A	Removal of salivary stone	4.59	6.04	3.93	0.43	11.06	8.95	090
42400		A	Biopsy of salivary gland	0.78	1.65	0.72	0.06	2.49	1.56	000
42405		A	Biopsy of salivary gland	3.29	4.00	2.45	0.28	7.57	6.02	010
42408		A	Excision of salivary cyst	4.53	5.91	3.61	0.45	10.89	8.59	090
42409		A	Drainage of salivary cyst	2.81	4.52	2.76	0.27	7.60	5.84	090
42410		A	Excise parotid gland/lesion	9.33	NA	6.22	0.91	NA	16.46	090
42415		A	Excise parotid gland/lesion	16.86	NA	10.86	1.46	NA	29.18	090
42420		A	Excise parotid gland/lesion	19.56	NA	12.37	1.67	NA	33.60	090
42425		A	Excise parotid gland/lesion	13.00	NA	8.61	1.13	NA	22.74	090
42426		A	Excise parotid gland/lesion	21.23	NA	13.01	1.85	NA	36.09	090
42440		A	Excise submaxillary gland	6.96	NA	4.79	0.60	NA	12.35	090
42450		A	Excise sublingual gland	4.61	5.90	4.25	0.42	10.93	9.28	090
42500		A	Repair salivary duct	4.29	5.68	4.18	0.41	10.38	8.88	090
42505		A	Repair salivary duct	6.17	7.12	5.36	0.56	13.85	12.09	090
42507		A	Parotid duct diversion	6.10	NA	6.53	0.49	NA	13.12	090
42508		A	Parotid duct diversion	9.09	NA	8.34	1.04	NA	18.47	090
42509		A	Parotid duct diversion	11.52	NA	10.19	0.93	NA	22.64	090
42510		A	Parotid duct diversion	8.14	NA	7.79	0.66	NA	16.59	090
42550		A	Injection for salivary x-ray	1.25	3.21	0.41	0.07	4.53	1.73	000
42600		A	Closure of salivary fistula	4.81	6.58	4.12	0.43	11.82	9.36	090
42650		A	Dilation of salivary duct	0.77	1.10	0.71	0.07	1.94	1.55	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
42660		A	Dilation of salivary duct	1.13	1.35	0.85	0.09	2.57	2.07	000
42665		A	Ligation of salivary duct	2.53	4.17	2.59	0.23	6.93	5.35	090
42699		C	Salivary surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
42700		A	Drainage of tonsil abscess	1.62	2.65	1.70	0.13	4.40	3.45	010
42720		A	Drainage of throat abscess	5.41	4.83	3.79	0.47	10.71	9.67	010
42725		A	Drainage of throat abscess	10.70	NA	8.22	0.96	NA	19.88	090
42800		A	Biopsy of throat	1.39	2.18	1.40	0.11	3.68	2.90	010
42802		A	Biopsy of throat	1.54	4.76	2.06	0.13	6.43	3.73	010
42804		A	Biopsy of upper nose/throat	1.24	3.74	1.73	0.10	5.08	3.07	010
42806		A	Biopsy of upper nose/throat	1.58	4.07	1.93	0.13	5.78	3.64	010
42808		A	Excise pharynx lesion	2.30	3.09	1.93	0.19	5.58	4.42	010
42809		A	Remove pharynx foreign body	1.81	2.33	1.33	0.16	4.30	3.30	010
42810		A	Excision of neck cyst	3.25	5.71	3.54	0.30	9.26	7.09	090
42815		A	Excision of neck cyst	7.06	NA	6.41	0.62	NA	14.09	090
42820		A	Remove tonsils and adenoids	3.90	NA	3.29	0.31	NA	7.50	090
42821		A	Remove tonsils and adenoids	4.28	NA	3.50	0.35	NA	8.13	090
42825		A	Removal of tonsils	3.41	NA	3.17	0.25	NA	6.83	090
42826		A	Removal of tonsils	3.37	NA	3.03	0.28	NA	6.68	090
42830		A	Removal of adenoids	2.57	NA	2.56	0.20	NA	5.33	090
42831		A	Removal of adenoids	2.71	NA	2.84	0.22	NA	5.77	090
42835		A	Removal of adenoids	2.30	NA	2.46	0.21	NA	4.97	090
42836		A	Removal of adenoids	3.18	NA	2.96	0.26	NA	6.40	090
42842		A	Extensive surgery of throat	8.75	NA	10.99	0.72	NA	20.46	090
42844		A	Extensive surgery of throat	14.29	NA	16.23	1.19	NA	31.71	090
42845		A	Extensive surgery of throat	24.25	NA	23.18	2.06	NA	49.49	090
42860		A	Excision of tonsil tags	2.22	NA	2.40	0.18	NA	4.80	090
42870		A	Excision of lingual tonsil	5.39	NA	8.57	0.44	NA	14.40	090
42890		A	Partial removal of pharynx	12.92	NA	14.15	1.09	NA	28.16	090
42892		A	Revision of pharyngeal walls	15.81	NA	17.17	1.35	NA	34.33	090
42894		A	Revision of pharyngeal walls	22.85	NA	22.02	1.91	NA	46.78	090
42900		A	Repair throat wound	5.24	NA	3.66	0.53	NA	9.43	010
42950		A	Reconstruction of throat	8.09	NA	11.87	0.72	NA	20.68	090
42953		A	Repair throat, esophagus	8.95	NA	17.33	0.90	NA	27.18	090
42955		A	Surgical opening of throat	7.38	NA	10.67	0.80	NA	18.85	090
42960		A	Control throat bleeding	2.33	NA	1.96	0.20	NA	4.49	010
42961		A	Control throat bleeding	5.58	NA	4.96	0.46	NA	11.00	090
42962		A	Control throat bleeding	7.13	NA	5.91	0.59	NA	13.63	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
42970		A	Control nose/throat bleeding	5.42	NA	4.18	0.39	NA	9.99	090
42971		A	Control nose/throat bleeding	6.20	NA	5.12	0.51	NA	11.83	090
42972		A	Control nose/throat bleeding	7.19	NA	5.70	0.62	NA	13.51	090
42999		C	Throat surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43020		A	Incision of esophagus	8.08	NA	5.41	0.88	NA	14.37	090
43030		A	Throat muscle surgery	7.68	NA	5.49	0.70	NA	13.87	090
43045		A	Incision of esophagus	20.09	NA	10.70	2.56	NA	33.35	090
43100		A	Excision of esophagus lesion	9.18	NA	6.22	0.92	NA	16.32	090
43101		A	Excision of esophagus lesion	16.22	NA	7.88	2.23	NA	26.33	090
43107		A	Removal of esophagus	39.94	NA	18.26	5.02	NA	63.22	090
43108		A	Removal of esophagus	34.14	NA	14.21	3.94	NA	52.29	090
43112		A	Removal of esophagus	43.43	NA	19.36	5.66	NA	68.45	090
43113		A	Removal of esophagus	35.22	NA	15.11	4.38	NA	54.71	090
43116		A	Partial removal of esophagus	31.17	NA	16.69	3.02	NA	50.88	090
43117		A	Partial removal of esophagus	39.94	NA	17.27	5.07	NA	62.28	090
43118		A	Partial removal of esophagus	33.15	NA	13.78	4.07	NA	51.00	090
43121		A	Partial removal of esophagus	29.15	NA	13.67	3.86	NA	46.68	090
43122		A	Partial removal of esophagus	39.94	NA	17.39	5.25	NA	62.58	090
43123		A	Partial removal of esophagus	33.15	NA	14.10	4.16	NA	51.41	090
43124		A	Removal of esophagus	27.28	NA	13.08	3.67	NA	44.03	090
43130		A	Removal of esophagus pouch	11.73	NA	7.56	1.18	NA	20.47	090
43135		A	Removal of esophagus pouch	16.08	NA	8.09	2.27	NA	26.44	090
43200		A	Esophagus endoscopy	1.59	4.13	1.07	0.13	5.85	2.79	000
43201		A	Esoph scope w/submucous inj	2.09	4.63	1.10	0.16	6.88	3.35	000
43202		A	Esophagus endoscopy, biopsy	1.89	5.54	0.94	0.16	7.59	2.99	000
43204		A	Esoph scope w/sclerosis inj	3.76	NA	1.52	0.30	NA	5.58	000
43205		A	Esophagus endoscopy/ligation	3.78	NA	1.52	0.28	NA	5.58	000
43215		A	Esophagus endoscopy	2.60	NA	1.20	0.23	NA	4.03	000
43216		A	Esophagus endoscopy/lesion	2.40	NA	1.06	0.20	NA	3.66	000
43217		A	Esophagus endoscopy	2.90	6.95	1.19	0.26	10.11	4.35	000
43219		A	Esophagus endoscopy	2.80	NA	1.35	0.24	NA	4.39	000
43220		A	Esoph endoscopy, dilation	2.10	NA	0.97	0.17	NA	3.24	000
43226		A	Esoph endoscopy, dilation	2.34	NA	1.03	0.19	NA	3.56	000
43227		A	Esoph endoscopy, repair	3.59	NA	1.45	0.28	NA	5.32	000
43228		A	Esoph endoscopy, ablation	3.76	NA	1.55	0.34	NA	5.65	000
43231		A	Esoph endoscopy w/us exam	3.19	NA	1.31	0.24	NA	4.74	000
43232		A	Esoph endoscopy w/us fn bx	4.47	NA	1.81	0.34	NA	6.62	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
43234		A	Upper GI endoscopy, exam	2.01	5.32	0.87	0.18	7.51	3.06	000
43235		A	Uppr gi endoscopy, diagnosis	2.39	5.17	1.02	0.19	7.75	3.60	000
43236		A	Uppr gi scope w/submuc inj	2.92	6.40	1.22	0.22	9.54	4.36	000
43237		A	Endoscopic us exam, esoph	3.98	NA	1.59	0.44	NA	6.01	000
43238		A	Uppr gi endoscopy w/us fn bx	5.02	NA	1.96	0.44	NA	7.42	000
43239		A	Upper GI endoscopy, biopsy	2.87	5.71	1.19	0.22	8.80	4.28	000
43240		A	Esoph endoscope w/drain cyst	6.85	NA	2.60	0.56	NA	10.01	000
43241		A	Upper GI endoscopy with tube	2.59	NA	1.10	0.21	NA	3.90	000
43242		A	Uppr gi endoscopy w/us fn bx	7.30	NA	2.73	0.53	NA	10.56	000
43243		A	Upper gi endoscopy & inject	4.56	NA	1.79	0.35	NA	6.70	000
43244		A	Upper GI endoscopy/ligation	5.04	NA	1.96	0.37	NA	7.37	000
43245		A	Uppr gi scope dilate strictr	3.18	NA	1.30	0.26	NA	4.74	000
43246		A	Place gastrostomy tube	4.32	NA	1.69	0.34	NA	6.35	000
43247		A	Operative upper GI endoscopy	3.38	NA	1.37	0.27	NA	5.02	000
43248		A	Uppr gi endoscopy/guide wire	3.15	NA	1.31	0.24	NA	4.70	000
43249		A	Esoph endoscopy, dilation	2.90	NA	1.21	0.22	NA	4.33	000
43250		A	Upper GI endoscopy/tumor	3.20	NA	1.31	0.26	NA	4.77	000
43251		A	Operative upper GI endoscopy	3.69	NA	1.48	0.29	NA	5.46	000
43255		A	Operative upper GI endoscopy	4.81	NA	1.88	0.36	NA	7.05	000
43256		A	Uppr gi endoscopy w/stent	4.34	NA	1.71	0.34	NA	6.39	000
43257		A	Uppr gi scope w/thrml txmnt	5.50	NA	2.20	0.36	NA	8.06	000
43258		A	Operative upper GI endoscopy	4.54	NA	1.78	0.34	NA	6.66	000
43259		A	Endoscopic ultrasound exam	5.19	NA	1.99	0.36	NA	7.54	000
43260		A	Endo cholangiopancreatograph	5.95	NA	2.28	0.44	NA	8.67	000
43261		A	Endo cholangiopancreatograph	6.26	NA	2.39	0.46	NA	9.11	000
43262		A	Endo cholangiopancreatograph	7.38	NA	2.78	0.54	NA	10.70	000
43263		A	Endo cholangiopancreatograph	7.28	NA	2.76	0.54	NA	10.58	000
43264		A	Endo cholangiopancreatograph	8.89	NA	3.31	0.65	NA	12.85	000
43265		A	Endo cholangiopancreatograph	10.00	NA	3.69	0.73	NA	14.42	000
43267		A	Endo cholangiopancreatograph	7.38	NA	2.78	0.55	NA	10.71	000
43268		A	Endo cholangiopancreatograph	7.38	NA	2.88	0.54	NA	10.80	000
43269		A	Endo cholangiopancreatograph	8.20	NA	3.07	0.61	NA	11.88	000
43271		A	Endo cholangiopancreatograph	7.38	NA	2.78	0.54	NA	10.70	000
43272		A	Endo cholangiopancreatograph	7.38	NA	2.78	0.55	NA	10.71	000
43280		A	Laparoscopy, fundoplasty	17.22	NA	7.27	2.25	NA	26.74	090
43289		C	Laparoscope proc, esoph	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43300		A	Repair of esophagus	9.13	NA	6.37	1.07	NA	16.57	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
43305		A	Repair esophagus and fistula	17.36	NA	10.69	1.58	NA	29.63	090
43310		A	Repair of esophagus	25.35	NA	11.06	3.39	NA	39.80	090
43312		A	Repair esophagus and fistula	28.38	NA	11.89	3.96	NA	44.23	090
43313		A	Esophagoplasty congenital	45.21	NA	18.81	5.40	NA	69.42	090
43314		A	Tracheo-esophagoplasty cong	50.19	NA	19.18	6.58	NA	75.95	090
43320		A	Fuse esophagus & stomach	19.90	NA	9.20	2.53	NA	31.63	090
43324		A	Revise esophagus & stomach	20.54	NA	8.76	2.72	NA	32.02	090
43325		A	Revise esophagus & stomach	20.03	NA	8.78	2.59	NA	31.40	090
43326		A	Revise esophagus & stomach	19.71	NA	9.29	2.78	NA	31.78	090
43330		A	Repair of esophagus	19.74	NA	8.53	2.58	NA	30.85	090
43331		A	Repair of esophagus	20.10	NA	9.78	2.83	NA	32.71	090
43340		A	Fuse esophagus & intestine	19.58	NA	8.96	2.45	NA	30.99	090
43341		A	Fuse esophagus & intestine	20.82	NA	10.01	2.88	NA	33.71	090
43350		A	Surgical opening, esophagus	15.76	NA	8.44	1.41	NA	25.61	090
43351		A	Surgical opening, esophagus	18.32	NA	9.79	2.44	NA	30.55	090
43352		A	Surgical opening, esophagus	15.24	NA	8.38	1.97	NA	25.59	090
43360		A	Gastrointestinal repair	35.65	NA	15.07	4.83	NA	55.55	090
43361		A	Gastrointestinal repair	40.44	NA	16.88	4.43	NA	61.75	090
43400		A	Ligate esophagus veins	21.17	NA	9.43	1.91	NA	32.51	090
43401		A	Esophagus surgery for veins	22.06	NA	9.48	3.01	NA	34.55	090
43405		A	Ligate/staple esophagus	19.98	NA	9.58	2.76	NA	32.32	090
43410		A	Repair esophagus wound	13.45	NA	7.63	1.75	NA	22.83	090
43415		A	Repair esophagus wound	24.96	NA	11.74	3.39	NA	40.09	090
43420		A	Repair esophagus opening	14.33	NA	7.40	1.44	NA	23.17	090
43425		A	Repair esophagus opening	21.00	NA	9.97	2.92	NA	33.89	090
43450		A	Dilate esophagus	1.38	2.63	0.69	0.11	4.12	2.18	000
43453		A	Dilate esophagus	1.51	6.06	0.73	0.11	7.68	2.35	000
43456		A	Dilate esophagus	2.57	13.74	1.10	0.20	16.51	3.87	000
43458		A	Dilate esophagus	3.06	6.65	1.28	0.24	9.95	4.58	000
43460		A	Pressure treatment esophagus	3.79	NA	1.49	0.32	NA	5.60	000
43496		C	Free jejunum flap, microvasc	0.00	0.00	0.00	0.00	0.00	0.00	090
43499		C	Esophagus surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43500		A	Surgical opening of stomach	11.03	NA	4.97	1.41	NA	17.41	090
43501		A	Surgical repair of stomach	20.01	NA	8.30	2.62	NA	30.93	090
43502		A	Surgical repair of stomach	23.10	NA	9.45	3.06	NA	35.61	090
43510		A	Surgical opening of stomach	13.06	NA	6.58	1.46	NA	21.10	090
43520		A	Incision of pyloric muscle	9.98	NA	5.25	1.32	NA	16.55	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
43600		A	Biopsy of stomach	1.91	NA	0.66	0.14	NA	2.71	000
43605		A	Biopsy of stomach	11.96	NA	5.28	1.57	NA	18.81	090
43610		A	Excision of stomach lesion	14.58	NA	6.14	1.90	NA	22.62	090
43611		A	Excision of stomach lesion	17.81	NA	7.56	2.32	NA	27.69	090
43620		A	Removal of stomach	29.99	NA	11.79	3.91	NA	45.69	090
43621		A	Removal of stomach	30.68	NA	11.97	4.00	NA	46.65	090
43622		A	Removal of stomach	32.48	NA	12.58	4.25	NA	49.31	090
43631		A	Removal of stomach, partial	22.56	NA	9.15	2.94	NA	34.65	090
43632		A	Removal of stomach, partial	22.56	NA	9.15	2.94	NA	34.65	090
43633		A	Removal of stomach, partial	23.07	NA	9.32	3.02	NA	35.41	090
43634		A	Removal of stomach, partial	25.08	NA	10.08	3.30	NA	38.46	090
43635		A	Removal of stomach, partial	2.06	NA	0.70	0.27	NA	3.03	ZZZ
43638		A	Removal of stomach, partial	28.96	NA	11.88	3.75	NA	44.59	090
43639		A	Removal of stomach, partial	29.61	NA	11.68	3.85	NA	45.14	090
43640		A	Vagotomy & pylorus repair	16.99	NA	7.25	2.22	NA	26.46	090
43641		A	Vagotomy & pylorus repair	17.24	NA	7.36	2.18	NA	26.78	090
43644		A	Lap gastric bypass/roux-en-y	27.83	NA	11.21	3.13	NA	42.17	090
43645		A	Lap gastr bypass incl smll i	29.96	NA	12.01	3.51	NA	45.48	090
43651		A	Laparoscopy, vagus nerve	10.13	NA	4.76	1.33	NA	16.22	090
43652		A	Laparoscopy, vagus nerve	12.13	NA	5.75	1.54	NA	19.42	090
43653		A	Laparoscopy, gastrostomy	7.72	NA	4.18	1.00	NA	12.90	090
43659		C	Laparoscope proc, stom	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43750		A	Place gastrostomy tube	4.48	NA	2.19	0.43	NA	7.10	010
43752		A	Nasal/orogastric w/stent	0.81	0.28	0.26	0.02	1.11	1.09	000
43760		A	Change gastrostomy tube	1.10	2.08	0.45	0.09	3.27	1.64	000
43761		A	Reposition gastrostomy tube	2.01	1.17	0.66	0.14	3.32	2.81	000
43800		A	Reconstruction of pylorus	13.67	NA	5.89	1.78	NA	21.34	090
43810		A	Fusion of stomach and bowel	14.63	NA	6.17	1.91	NA	22.71	090
43820		A	Fusion of stomach and bowel	15.35	NA	6.40	2.00	NA	23.75	090
43825		A	Fusion of stomach and bowel	19.19	NA	8.01	2.52	NA	29.72	090
43830		A	Place gastrostomy tube	9.52	NA	4.84	1.20	NA	15.56	090
43831		A	Place gastrostomy tube	7.83	NA	4.51	0.99	NA	13.33	090
43832		A	Place gastrostomy tube	15.58	NA	6.84	1.93	NA	24.35	090
43840		A	Repair of stomach lesion	15.54	NA	6.76	2.02	NA	24.32	090
43842		A	V-band gastroplasty	18.44	NA	7.79	2.42	NA	28.65	090
43843		A	Gastroplasty w/o v-band	18.62	NA	7.76	2.43	NA	28.81	090
43845		C	Gastroplasty duodenal switch	0.00	0.00	0.00	0.00	0.00	0.00	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
43846		A	Gastric bypass for obesity	24.01	NA	10.02	3.13	NA	37.16	090
43847		A	Gastric bypass incl small i	26.88	NA	10.89	3.51	NA	41.28	090
43848		A	Revision gastroplasty	29.35	NA	11.81	3.83	NA	44.99	090
43850		A	Revise stomach-bowel fusion	24.68	NA	9.81	3.18	NA	37.67	090
43855		A	Revise stomach-bowel fusion	26.12	NA	10.32	3.43	NA	39.87	090
43860		A	Revise stomach-bowel fusion	24.96	NA	9.96	3.25	NA	38.17	090
43865		A	Revise stomach-bowel fusion	26.48	NA	10.50	3.44	NA	40.42	090
43870		A	Repair stomach opening	9.68	NA	4.51	1.23	NA	15.42	090
43880		A	Repair stomach-bowel fistula	24.61	NA	9.89	3.18	NA	37.68	090
43999		C	Stomach surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44005		A	Freeing of bowel adhesion	16.21	NA	6.71	2.08	NA	25.00	090
44010		A	Incision of small bowel	12.50	NA	5.44	1.60	NA	19.54	090
44015		A	Insert needle cath bowel	2.62	NA	0.88	0.34	NA	3.84	ZZZ
44020		A	Explore small intestine	13.97	NA	5.93	1.79	NA	21.69	090
44021		A	Decompress small bowel	14.06	NA	5.96	1.79	NA	21.81	090
44025		A	Incision of large bowel	14.26	NA	6.02	1.79	NA	22.07	090
44050		A	Reduce bowel obstruction	14.01	NA	5.95	1.81	NA	21.77	090
44055		A	Correct malrotation of bowel	21.97	NA	8.72	2.81	NA	33.50	090
44100		A	Biopsy of bowel	2.01	NA	0.71	0.17	NA	2.89	000
44110		A	Excise intestine lesion(s)	11.79	NA	5.22	1.51	NA	18.52	090
44111		A	Excision of bowel lesion(s)	14.27	NA	6.10	1.83	NA	22.20	090
44120		A	Removal of small intestine	16.97	NA	7.07	2.19	NA	26.23	090
44121		A	Removal of small intestine	4.44	NA	1.52	0.57	NA	6.53	ZZZ
44125		A	Removal of small intestine	17.51	NA	7.25	2.23	NA	26.99	090
44126		A	Enterectomy w/o taper, cong	35.45	NA	14.11	4.66	NA	54.22	090
44127		A	Enterectomy w/taper, cong	40.94	NA	15.71	5.70	NA	62.35	090
44128		A	Enterectomy cong, add-on	4.44	NA	1.53	0.61	NA	6.58	ZZZ
44130		A	Bowel to bowel fusion	14.47	NA	6.21	1.84	NA	22.52	090
44132		R	Enterectomy, cadaver donor	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44133		R	Enterectomy, live donor	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44135		R	Intestine transplnt, cadaver	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44136		R	Intestine transplant, live	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44137		C	Remove intestinal allograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44139		A	Mobilization of colon	2.23	NA	0.76	0.28	NA	3.27	ZZZ
44140		A	Partial removal of colon	20.97	NA	8.64	2.67	NA	32.28	090
44141		A	Partial removal of colon	19.48	NA	10.04	2.49	NA	32.01	090
44143		A	Partial removal of colon	22.96	NA	10.68	2.95	NA	36.59	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
44144		A	Partial removal of colon	21.50	NA	9.61	2.77	NA	33.88	090
44145		A	Partial removal of colon	26.38	NA	10.80	3.24	NA	40.42	090
44146		A	Partial removal of colon	27.50	NA	12.85	3.37	NA	43.72	090
44147		A	Partial removal of colon	20.68	NA	8.68	2.51	NA	31.87	090
44150		A	Removal of colon	23.91	NA	12.02	3.00	NA	38.93	090
44151		A	Removal of colon/ileostomy	26.84	NA	13.39	3.44	NA	43.67	090
44152		A	Removal of colon/ileostomy	27.79	NA	11.59	3.47	NA	42.85	090
44153		A	Removal of colon/ileostomy	30.54	NA	14.37	3.52	NA	48.43	090
44155		A	Removal of colon/ileostomy	27.82	NA	13.30	3.24	NA	44.36	090
44156		A	Removal of colon/ileostomy	30.74	NA	15.03	3.94	NA	49.71	090
44160		A	Removal of colon	18.59	NA	7.74	2.33	NA	28.66	090
44200		A	Laparoscopy, enterolysis	14.42	NA	6.19	1.85	NA	22.46	090
44201		A	Laparoscopy, jejunostomy	9.77	NA	4.66	1.27	NA	15.70	090
44202		A	Lap resect s/intestine singl	22.01	NA	8.92	2.81	NA	33.74	090
44203		A	Lap resect s/intestine, addl	4.44	NA	1.50	0.57	NA	6.51	ZZZ
44204		A	Laparo partial colectomy	25.04	NA	9.95	3.07	NA	38.06	090
44205		A	Lap colectomy part w/ileum	22.20	NA	8.84	2.71	NA	33.75	090
44206		A	Lap part colectomy w/stoma	26.96	NA	11.25	3.41	NA	41.62	090
44207		A	L colectomy/coloproctostomy	29.96	NA	11.48	3.63	NA	45.07	090
44208		A	L colectomy/coloproctostomy	31.95	NA	13.13	3.84	NA	48.92	090
44210		A	Laparo total proctocolectomy	27.96	NA	11.87	3.39	NA	43.22	090
44211		A	Laparo total proctocolectomy	34.95	NA	14.67	4.14	NA	53.76	090
44212		A	Laparo total proctocolectomy	32.45	NA	13.68	3.66	NA	49.79	090
44238		C	Laparoscope proc, intestine	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44239		C	Laparoscope proc, rectum	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44300		A	Open bowel to skin	12.09	NA	5.48	1.56	NA	19.13	090
44310		A	Ileostomy/jejunostomy	15.93	NA	6.69	1.95	NA	24.57	090
44312		A	Revision of ileostomy	8.01	NA	3.99	0.93	NA	12.93	090
44314		A	Revision of ileostomy	15.03	NA	6.55	1.73	NA	23.31	090
44316		A	Devise bowel pouch	21.06	NA	8.54	2.36	NA	31.96	090
44320		A	Colostomy	17.61	NA	7.65	2.23	NA	27.49	090
44322		A	Colostomy with biopsies	11.96	NA	8.57	1.53	NA	22.06	090
44340		A	Revision of colostomy	7.71	NA	4.26	0.98	NA	12.95	090
44345		A	Revision of colostomy	15.41	NA	6.88	1.94	NA	24.23	090
44346		A	Revision of colostomy	16.96	NA	7.38	2.09	NA	26.43	090
44360		A	Small bowel endoscopy	2.59	NA	1.10	0.19	NA	3.88	000
44361		A	Small bowel endoscopy/biopsy	2.87	NA	1.20	0.21	NA	4.28	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
44363		A	Small bowel endoscopy	3.49	NA	1.38	0.27	NA	5.14	000
44364		A	Small bowel endoscopy	3.73	NA	1.49	0.27	NA	5.49	000
44365		A	Small bowel endoscopy	3.31	NA	1.36	0.24	NA	4.91	000
44366		A	Small bowel endoscopy	4.40	NA	1.73	0.32	NA	6.45	000
44369		A	Small bowel endoscopy	4.51	NA	1.73	0.33	NA	6.57	000
44370		A	Small bowel endoscopy/stent	4.79	NA	1.97	0.37	NA	7.13	000
44372		A	Small bowel endoscopy	4.40	NA	1.73	0.35	NA	6.48	000
44373		A	Small bowel endoscopy	3.49	NA	1.42	0.27	NA	5.18	000
44376		A	Small bowel endoscopy	5.25	NA	2.02	0.43	NA	7.70	000
44377		A	Small bowel endoscopy/biopsy	5.52	NA	2.13	0.40	NA	8.05	000
44378		A	Small bowel endoscopy	7.12	NA	2.69	0.53	NA	10.34	000
44379		A	S bowel endoscope w/stent	7.46	NA	2.91	0.62	NA	10.99	000
44380		A	Small bowel endoscopy	1.05	NA	0.55	0.08	NA	1.68	000
44382		A	Small bowel endoscopy	1.27	NA	0.63	0.12	NA	2.02	000
44383		A	Ileoscopy w/stent	2.94	NA	1.27	0.22	NA	4.43	000
44385		A	Endoscopy of bowel pouch	1.82	3.35	0.75	0.15	5.32	2.72	000
44386		A	Endoscopy, bowel pouch/biop	2.12	6.64	0.88	0.19	8.95	3.19	000
44388		A	Colonoscopy	2.82	5.08	1.15	0.26	8.16	4.23	000
44389		A	Colonoscopy with biopsy	3.13	6.62	1.27	0.27	10.02	4.67	000
44390		A	Colonoscopy for foreign body	3.82	7.11	1.49	0.32	11.25	5.63	000
44391		A	Colonoscopy for bleeding	4.31	8.72	1.69	0.34	13.37	6.34	000
44392		A	Colonoscopy & polypectomy	3.81	6.58	1.49	0.34	10.73	5.64	000
44393		A	Colonoscopy, lesion removal	4.83	6.90	1.86	0.42	12.15	7.11	000
44394		A	Colonoscopy w/snare	4.42	7.81	1.72	0.38	12.61	6.52	000
44397		A	Colonoscopy w/stent	4.70	NA	1.79	0.39	NA	6.88	000
44500		A	Intro, gastrointestinal tube	0.49	NA	0.16	0.03	NA	0.68	000
44602		A	Suture, small intestine	16.01	NA	6.39	2.05	NA	24.45	090
44603		A	Suture, small intestine	18.63	NA	7.27	2.38	NA	28.28	090
44604		A	Suture, large intestine	16.01	NA	6.45	2.04	NA	24.50	090
44605		A	Repair of bowel lesion	19.50	NA	8.39	2.48	NA	30.37	090
44615		A	Intestinal stricturoplasty	15.91	NA	6.67	2.01	NA	24.59	090
44620		A	Repair bowel opening	12.18	NA	5.32	1.51	NA	19.01	090
44625		A	Repair bowel opening	15.03	NA	6.30	1.83	NA	23.16	090
44626		A	Repair bowel opening	25.32	NA	9.81	3.22	NA	38.35	090
44640		A	Repair bowel-skin fistula	21.62	NA	8.57	2.72	NA	32.91	090
44650		A	Repair bowel fistula	22.54	NA	8.88	2.84	NA	34.26	090
44660		A	Repair bowel-bladder fistula	21.33	NA	8.34	2.12	NA	31.79	090

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CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
44661		A	Repair bowel-bladder fistula	24.77	NA	9.55	2.79	NA	37.11	090
44680		A	Surgical revision, intestine	15.38	NA	6.44	1.89	NA	23.71	090
44700		A	Suspend bowel w/prosthesis	16.09	NA	6.66	1.80	NA	24.55	090
44701		A	Intraop colon lavage add-on	3.10	NA	1.06	0.37	NA	4.53	ZZZ
44715		C	Prepare donor intestine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44720		A	Prep donor intestine/venous	5.00	NA	1.71	0.37	NA	7.08	XXX
44721		A	Prep donor intestine/artery	7.00	NA	2.39	0.97	NA	10.36	XXX
44799		C	Unlisted procedure intestine	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44800		A	Excision of bowel pouch	11.21	NA	5.38	1.42	NA	18.01	090
44820		A	Excision of mesentery lesion	12.07	NA	5.48	1.53	NA	19.08	090
44850		A	Repair of mesentery	10.72	NA	5.00	1.37	NA	17.09	090
44899		C	Bowel surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44900		A	Drain app abscess, open	10.12	NA	4.69	1.29	NA	16.10	090
44901		A	Drain app abscess, percut	3.37	27.89	1.11	0.23	31.49	4.71	000
44950		A	Appendectomy	9.99	NA	4.31	1.30	NA	15.60	090
44955		A	Appendectomy add-on	1.53	NA	0.54	0.19	NA	2.26	ZZZ
44960		A	Appendectomy	12.32	NA	5.33	1.61	NA	19.26	090
44970		A	Laparoscopy, appendectomy	8.69	NA	4.08	1.13	NA	13.90	090
44979		C	Laparoscope proc, app	0.00	0.00	0.00	0.00	0.00	0.00	YYY
45000		A	Drainage of pelvic abscess	4.51	NA	2.96	0.51	NA	7.98	090
45005		A	Drainage of rectal abscess	1.99	4.05	1.58	0.24	6.28	3.81	010
45020		A	Drainage of rectal abscess	4.71	NA	3.27	0.54	NA	8.52	090
45100		A	Biopsy of rectum	3.67	NA	2.36	0.42	NA	6.45	090
45108		A	Removal of anorectal lesion	4.75	NA	2.77	0.58	NA	8.10	090
45110		A	Removal of rectum	27.96	NA	12.39	3.32	NA	43.67	090
45111		A	Partial removal of rectum	16.46	NA	7.16	2.04	NA	25.66	090
45112		A	Removal of rectum	30.49	NA	11.76	3.38	NA	45.63	090
45113		A	Partial proctectomy	30.53	NA	12.59	3.37	NA	46.49	090
45114		A	Partial removal of rectum	27.28	NA	10.87	3.31	NA	41.46	090
45116		A	Partial removal of rectum	24.54	NA	10.02	2.91	NA	37.47	090
45119		A	Remove rectum w/reservoir	30.79	NA	12.45	3.31	NA	46.55	090
45120		A	Removal of rectum	24.56	NA	10.12	2.86	NA	37.54	090
45121		A	Removal of rectum and colon	27.00	NA	11.10	3.21	NA	41.31	090
45123		A	Partial proctectomy	16.68	NA	6.85	1.83	NA	25.36	090
45126		A	Pelvic exenteration	45.09	NA	19.20	4.27	NA	68.56	090
45130		A	Excision of rectal prolapse	16.42	NA	6.76	1.76	NA	24.94	090
45135		A	Excision of rectal prolapse	19.25	NA	8.41	2.34	NA	30.00	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
45136		A	Excise ileoanal reservior	27.26	NA	12.51	2.71	NA	42.48	090
45150		A	Excision of rectal stricture	5.66	NA	2.96	0.59	NA	9.21	090
45160		A	Excision of rectal lesion	15.30	NA	6.64	1.66	NA	23.60	090
45170		A	Excision of rectal lesion	11.47	NA	5.23	1.34	NA	18.04	090
45190		A	Destruction, rectal tumor	9.73	NA	4.62	1.09	NA	15.44	090
45300		A	Proctosigmoidoscopy dx	0.38	1.53	0.28	0.04	1.95	0.70	000
45303		A	Proctosigmoidoscopy dilate	0.44	18.68	0.33	0.05	19.17	0.82	000
45305		A	Proctosigmoidoscopy w/bx	1.01	2.63	0.50	0.11	3.75	1.62	000
45307		A	Proctosigmoidoscopy fb	0.94	3.03	0.48	0.11	4.08	1.53	000
45308		A	Proctosigmoidoscopy removal	0.83	1.99	0.44	0.09	2.91	1.36	000
45309		A	Proctosigmoidoscopy removal	2.01	2.81	0.84	0.22	5.04	3.07	000
45315		A	Proctosigmoidoscopy removal	1.40	2.86	0.63	0.15	4.41	2.18	000
45317		A	Proctosigmoidoscopy bleed	1.50	2.43	0.66	0.15	4.08	2.31	000
45320		A	Proctosigmoidoscopy ablate	1.58	2.91	0.71	0.16	4.65	2.45	000
45321		A	Proctosigmoidoscopy volvul	1.17	NA	0.56	0.13	NA	1.86	000
45327		A	Proctosigmoidoscopy w/stent	1.65	NA	0.69	0.16	NA	2.50	000
45330		A	Diagnostic sigmoidoscopy	0.96	2.27	0.50	0.08	3.31	1.54	000
45331		A	Sigmoidoscopy and biopsy	1.15	3.07	0.59	0.09	4.31	1.83	000
45332		A	Sigmoidoscopy w/fb removal	1.79	5.00	0.80	0.16	6.95	2.75	000
45333		A	Sigmoidoscopy & polypectomy	1.79	4.87	0.80	0.15	6.81	2.74	000
45334		A	Sigmoidoscopy for bleeding	2.73	NA	1.14	0.21	NA	4.08	000
45335		A	Sigmoidoscopy w/submuc inj	1.46	3.21	0.69	0.11	4.78	2.26	000
45337		A	Sigmoidoscopy & decompress	2.36	NA	1.00	0.21	NA	3.57	000
45338		A	Sigmoidoscopy w/tumr remove	2.34	5.21	1.00	0.19	7.74	3.53	000
45339		A	Sigmoidoscopy w/ablate tumr	3.14	3.46	1.28	0.26	6.86	4.68	000
45340		A	Sig w/balloon dilation	1.89	6.17	0.83	0.15	8.21	2.87	000
45341		A	Sigmoidoscopy w/ultrasound	2.60	NA	1.07	0.20	NA	3.87	000
45342		A	Sigmoidoscopy w/us guide bx	4.05	NA	1.54	0.30	NA	5.89	000
45345		A	Sigmoidoscopy w/stent	2.92	NA	1.16	0.23	NA	4.31	000
45355		A	Surgical colonoscopy	3.51	NA	1.38	0.35	NA	5.24	000
45378		A	Diagnostic colonoscopy	3.69	6.14	1.47	0.30	10.13	5.46	000
45378	53	A	Diagnostic colonoscopy	0.96	2.27	0.50	0.08	3.31	1.54	000
45379		A	Colonoscopy w/fb removal	4.68	7.66	1.81	0.39	12.73	6.88	000
45380		A	Colonoscopy and biopsy	4.43	7.19	1.73	0.35	11.97	6.51	000
45381		A	Colonoscopy, submucous inj	4.19	7.11	1.65	0.32	11.62	6.16	000
45382		A	Colonoscopy/control bleeding	5.68	9.94	2.18	0.43	16.05	8.29	000
45383		A	Lesion removal colonoscopy	5.86	7.92	2.22	0.48	14.26	8.56	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
45384		A	Lesion remove colonoscopy	4.69	6.80	1.82	0.38	11.87	6.89	000
45385		A	Lesion removal colonoscopy	5.30	7.80	2.03	0.42	13.52	7.75	000
45386		A	Colonoscopy dilate stricture	4.57	12.40	1.78	0.39	17.36	6.74	000
45387		A	Colonoscopy w/stent	5.90	NA	2.33	0.48	NA	8.71	000
45391		A	Colonoscopy w/endoscope us	5.09	NA	1.97	0.42	NA	7.48	000
45392		A	Colonoscopy w/endoscopic fnb	6.54	NA	2.48	0.42	NA	9.44	000
45500		A	Repair of rectum	7.28	NA	3.53	0.73	NA	11.54	090
45505		A	Repair of rectum	7.57	NA	3.85	0.85	NA	12.27	090
45520		A	Treatment of rectal prolapse	0.55	1.64	0.37	0.05	2.24	0.97	000
45540		A	Correct rectal prolapse	16.25	NA	6.79	1.82	NA	24.86	090
45541		A	Correct rectal prolapse	13.38	NA	5.94	1.55	NA	20.87	090
45550		A	Repair rectum/remove sigmoid	22.97	NA	9.21	2.58	NA	34.76	090
45560		A	Repair of rectocele	10.56	NA	5.05	1.13	NA	16.74	090
45562		A	Exploration/repair of rectum	15.36	NA	6.98	1.81	NA	24.15	090
45563		A	Exploration/repair of rectum	23.43	NA	10.51	3.04	NA	36.98	090
45800		A	Repair rect/bladder fistula	17.74	NA	7.42	1.83	NA	26.99	090
45805		A	Repair fistula w/colostomy	20.75	NA	9.50	2.06	NA	32.31	090
45820		A	Repair rectourethral fistula	18.45	NA	7.62	1.59	NA	27.66	090
45825		A	Repair fistula w/colostomy	21.22	NA	9.81	2.29	NA	33.32	090
45900		A	Reduction of rectal prolapse	2.61	NA	1.50	0.30	NA	4.41	010
45905		A	Dilation of anal sphincter	2.30	NA	1.43	0.27	NA	4.00	010
45910		A	Dilation of rectal narrowing	2.80	NA	1.66	0.29	NA	4.75	010
45915		A	Remove rectal obstruction	3.14	4.32	2.09	0.30	7.76	5.53	010
45999		C	Rectum surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
46020		A	Placement of seton	2.90	2.33	1.85	0.31	5.54	5.06	010
46030		A	Removal of rectal marker	1.23	1.35	0.71	0.13	2.71	2.07	010
46040		A	Incision of rectal abscess	4.95	5.49	3.58	0.60	11.04	9.13	090
46045		A	Incision of rectal abscess	4.31	NA	2.89	0.53	NA	7.73	090
46050		A	Incision of anal abscess	1.19	2.54	0.84	0.13	3.86	2.16	010
46060		A	Incision of rectal abscess	5.68	NA	3.24	0.66	NA	9.58	090
46070		A	Incision of anal septum	2.71	NA	1.83	0.35	NA	4.89	090
46080		A	Incision of anal sphincter	2.49	2.36	1.13	0.30	5.15	3.92	010
46083		A	Incise external hemorrhoid	1.40	2.52	0.92	0.15	4.07	2.47	010
46200		A	Removal of anal fissure	3.41	3.85	2.86	0.38	7.64	6.65	090
46210		A	Removal of anal crypt	2.67	5.11	2.62	0.31	8.09	5.60	090
46211		A	Removal of anal crypts	4.24	5.40	3.50	0.47	10.11	8.21	090
46220		A	Removal of anal tag	1.56	2.29	0.95	0.17	4.02	2.68	010

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
46221		A	Ligation of hemorrhoid(s)	2.04	2.64	1.74	0.22	4.90	4.00	010
46230		A	Removal of anal tags	2.57	3.07	1.29	0.29	5.93	4.15	010
46250		A	Hemorrhoidectomy	3.88	5.30	2.61	0.47	9.65	6.96	090
46255		A	Hemorrhoidectomy	4.59	5.83	2.83	0.56	10.98	7.98	090
46257		A	Remove hemorrhoids & fissure	5.39	NA	2.87	0.63	NA	8.89	090
46258		A	Remove hemorrhoids & fistula	5.72	NA	3.27	0.68	NA	9.67	090
46260		A	Hemorrhoidectomy	6.36	NA	3.18	0.75	NA	10.29	090
46261		A	Remove hemorrhoids & fissure	7.07	NA	3.60	0.79	NA	11.46	090
46262		A	Remove hemorrhoids & fistula	7.49	NA	3.73	0.82	NA	12.04	090
46270		A	Removal of anal fistula	3.71	4.99	2.83	0.46	9.16	7.00	090
46275		A	Removal of anal fistula	4.55	4.63	2.97	0.52	9.70	8.04	090
46280		A	Removal of anal fistula	5.97	NA	3.25	0.66	NA	9.88	090
46285		A	Removal of anal fistula	4.08	3.76	2.74	0.43	8.27	7.25	090
46288		A	Repair anal fistula	7.12	NA	3.67	0.79	NA	11.58	090
46320		A	Removal of hemorrhoid clot	1.61	2.12	0.85	0.18	3.91	2.64	010
46500		A	Injection into hemorrhoid(s)	1.61	2.11	1.15	0.16	3.88	2.92	010
46600		A	Diagnostic anoscopy	0.50	1.56	0.34	0.05	2.11	0.89	000
46604		A	Anoscopy and dilation	1.31	9.12	0.62	0.12	10.55	2.05	000
46606		A	Anoscopy and biopsy	0.81	3.78	0.43	0.09	4.68	1.33	000
46608		A	Anoscopy, remove for body	1.51	4.40	0.65	0.16	6.07	2.32	000
46610		A	Anoscopy, remove lesion	1.32	4.03	0.61	0.15	5.50	2.08	000
46611		A	Anoscopy	1.81	3.33	0.78	0.19	5.33	2.78	000
46612		A	Anoscopy, remove lesions	2.34	5.18	0.98	0.27	7.79	3.59	000
46614		A	Anoscopy, control bleeding	2.01	2.32	0.84	0.20	4.53	3.05	000
46615		A	Anoscopy	2.68	2.48	1.07	0.32	5.48	4.07	000
46700		A	Repair of anal stricture	9.12	NA	4.20	0.93	NA	14.25	090
46705		A	Repair of anal stricture	6.89	NA	3.68	0.90	NA	11.47	090
46706		A	Repr of anal fistula w/glue	2.39	NA	1.25	0.27	NA	3.91	010
46715		A	Rep perf anoper fistu	7.19	NA	3.57	0.92	NA	11.68	090
46716		A	Rep perf anoper/vestib fistu	15.05	NA	7.97	1.57	NA	24.59	090
46730		A	Construction of absent anus	26.71	NA	12.02	2.45	NA	41.18	090
46735		A	Construction of absent anus	32.12	NA	13.54	3.18	NA	48.84	090
46740		A	Construction of absent anus	29.96	NA	13.22	2.40	NA	45.58	090
46742		A	Repair of imperforated anus	35.75	NA	17.38	3.17	NA	56.30	090
46744		A	Repair of cloacal anomaly	52.55	NA	21.11	6.33	NA	79.99	090
46746		A	Repair of cloacal anomaly	58.13	NA	25.14	7.62	NA	90.89	090
46748		A	Repair of cloacal anomaly	64.11	NA	23.63	3.34	NA	91.08	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
46750		A	Repair of anal sphincter	10.23	NA	5.05	1.09	NA	16.37	090
46751		A	Repair of anal sphincter	8.76	NA	5.41	0.94	NA	15.11	090
46753		A	Reconstruction of anus	8.28	NA	3.84	0.94	NA	13.06	090
46754		A	Removal of suture from anus	2.20	3.59	1.67	0.19	5.98	4.06	010
46760		A	Repair of anal sphincter	14.41	NA	7.08	1.56	NA	23.05	090
46761		A	Repair of anal sphincter	13.82	NA	6.00	1.41	NA	21.23	090
46762		A	Implant artificial sphincter	12.69	NA	5.51	1.23	NA	19.43	090
46900		A	Destruction, anal lesion(s)	1.91	2.58	1.27	0.17	4.66	3.35	010
46910		A	Destruction, anal lesion(s)	1.86	2.90	1.06	0.18	4.94	3.10	010
46916		A	Cryosurgery, anal lesion(s)	1.86	3.15	1.39	0.11	5.12	3.36	010
46917		A	Laser surgery, anal lesions	1.86	9.12	1.12	0.21	11.19	3.19	010
46922		A	Excision of anal lesion(s)	1.86	3.27	1.07	0.21	5.34	3.14	010
46924		A	Destruction, anal lesion(s)	2.76	8.68	1.35	0.26	11.70	4.37	010
46934		A	Destruction of hemorrhoids	3.50	5.07	2.95	0.31	8.88	6.76	090
46935		A	Destruction of hemorrhoids	2.43	3.46	1.21	0.23	6.12	3.87	010
46936		A	Destruction of hemorrhoids	3.68	4.87	2.49	0.34	8.89	6.51	090
46937		A	Cryotherapy of rectal lesion	2.69	2.77	1.22	0.14	5.60	4.05	010
46938		A	Cryotherapy of rectal lesion	4.65	3.99	3.05	0.58	9.22	8.28	090
46940		A	Treatment of anal fissure	2.32	1.99	1.09	0.22	4.53	3.63	010
46942		A	Treatment of anal fissure	2.04	1.83	1.02	0.19	4.06	3.25	010
46945		A	Ligation of hemorrhoids	1.84	3.26	2.47	0.19	5.29	4.50	090
46946		A	Ligation of hemorrhoids	2.58	3.72	2.39	0.26	6.56	5.23	090
46947		A	Hemorrhoidopexy by stapling	5.20	NA	2.71	0.75	NA	8.66	090
46999		C	Anus surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
47000		A	Needle biopsy of liver	1.90	3.07	0.63	0.12	5.09	2.65	000
47001		A	Needle biopsy, liver add-on	1.90	NA	0.65	0.24	NA	2.79	ZZZ
47010		A	Open drainage, liver lesion	15.99	NA	8.39	1.77	NA	26.15	090
47011		A	Percut drain, liver lesion	3.69	NA	1.21	0.22	NA	5.12	000
47015		A	Inject/aspirate liver cyst	15.09	NA	7.48	1.79	NA	24.36	090
47100		A	Wedge biopsy of liver	11.65	NA	6.03	1.50	NA	19.18	090
47120		A	Partial removal of liver	35.45	NA	15.14	4.54	NA	55.13	090
47122		A	Extensive removal of liver	55.05	NA	21.44	7.10	NA	83.59	090
47125		A	Partial removal of liver	49.12	NA	19.50	6.17	NA	74.79	090
47130		A	Partial removal of liver	53.27	NA	20.96	6.76	NA	80.99	090
47133		X	Removal of donor liver	0.00	0.00	0.00	0.00	0.00	0.00	XXX
47135		R	Transplantation of liver	81.40	NA	31.50	9.65	NA	122.55	090
47136		R	Transplantation of liver	68.50	NA	27.01	8.36	NA	103.87	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
47140		A	Partial removal, donor liver	54.92	NA	22.27	5.13	NA	82.32	090
47141		A	Partial removal, donor liver	67.40	NA	26.90	5.13	NA	99.43	090
47142		A	Partial removal, donor liver	74.89	NA	29.46	5.13	NA	109.48	090
47143		C	Prep donor liver, whole	0.00	0.00	0.00	0.00	0.00	0.00	XXX
47144		C	Prep donor liver, 3-segment	0.00	0.00	0.00	0.00	0.00	0.00	090
47145		C	Prep donor liver, lobe split	0.00	0.00	0.00	0.00	0.00	0.00	090
47146		A	Prep donor liver/venous	6.00	NA	2.05	0.83	NA	8.88	XXX
47147		A	Prep donor liver/arterial	7.00	NA	2.39	0.97	NA	10.36	XXX
47300		A	Surgery for liver lesion	15.06	NA	7.22	1.92	NA	24.20	090
47350		A	Repair liver wound	19.53	NA	8.86	2.51	NA	30.90	090
47360		A	Repair liver wound	26.88	NA	11.57	3.31	NA	41.76	090
47361		A	Repair liver wound	47.05	NA	18.51	5.79	NA	71.35	090
47362		A	Repair liver wound	18.48	NA	8.71	2.39	NA	29.58	090
47370		A	Laparo ablate liver tumor rf	19.66	NA	8.13	2.46	NA	30.25	090
47371		A	Laparo ablate liver cryosurg	19.66	NA	8.14	2.58	NA	30.38	090
47379		C	Laparoscope procedure, liver	0.00	0.00	0.00	0.00	0.00	0.00	YYY
47380		A	Open ablate liver tumor rf	22.97	NA	9.35	2.78	NA	35.10	090
47381		A	Open ablate liver tumor cryo	23.24	NA	9.58	2.81	NA	35.63	090
47382		A	Percut ablate liver rf	15.17	NA	6.07	0.97	NA	22.21	010
47399		C	Liver surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
47400		A	Incision of liver duct	32.44	NA	13.43	3.11	NA	48.98	090
47420		A	Incision of bile duct	19.85	NA	8.75	2.59	NA	31.19	090
47425		A	Incision of bile duct	19.80	NA	8.80	2.57	NA	31.17	090
47460		A	Incise bile duct sphincter	18.01	NA	8.36	2.10	NA	28.47	090
47480		A	Incision of gallbladder	10.80	NA	5.90	1.39	NA	18.09	090
47490		A	Incision of gallbladder	7.22	NA	5.56	0.44	NA	13.22	090
47500		A	Injection for liver x-rays	1.96	NA	0.64	0.12	NA	2.72	000
47505		A	Injection for liver x-rays	0.76	NA	0.25	0.05	NA	1.06	000
47510		A	Insert catheter, bile duct	7.82	NA	5.01	0.48	NA	13.31	090
47511		A	Insert bile duct drain	10.48	NA	5.08	0.63	NA	16.19	090
47525		A	Change bile duct catheter	5.54	15.09	2.80	0.33	20.96	8.67	010
47530		A	Revise/reinsert bile tube	5.84	33.78	3.71	0.37	39.99	9.92	090
47550		A	Bile duct endoscopy add-on	3.02	NA	1.02	0.39	NA	4.43	ZZZ
47552		A	Biliary endoscopy thru skin	6.03	NA	2.37	0.43	NA	8.83	000
47553		A	Biliary endoscopy thru skin	6.34	NA	2.06	0.40	NA	8.80	000
47554		A	Biliary endoscopy thru skin	9.05	NA	3.35	0.95	NA	13.35	000
47555		A	Biliary endoscopy thru skin	7.55	NA	2.46	0.45	NA	10.46	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
47556		A	Biliary endoscopy thru skin	8.55	NA	2.78	0.51	NA	11.84	000
47560		A	Laparoscopy w/cholangio	4.88	NA	1.67	0.64	NA	7.19	000
47561		A	Laparo w/cholangio/biopsy	5.17	NA	1.91	0.64	NA	7.72	000
47562		A	Laparoscopic cholecystectomy	11.07	NA	4.98	1.44	NA	17.49	090
47563		A	Laparo cholecystectomy/graph	11.92	NA	5.29	1.56	NA	18.77	090
47564		A	Laparo cholecystectomy/explr	14.21	NA	5.94	1.86	NA	22.01	090
47570		A	Laparo cholecystoenterostomy	12.56	NA	5.36	1.63	NA	19.55	090
47579		C	Laparoscope proc, biliary	0.00	0.00	0.00	0.00	0.00	0.00	YYY
47600		A	Removal of gallbladder	13.56	NA	6.12	1.77	NA	21.45	090
47605		A	Removal of gallbladder	14.67	NA	6.49	1.92	NA	23.08	090
47610		A	Removal of gallbladder	18.79	NA	7.92	2.45	NA	29.16	090
47612		A	Removal of gallbladder	18.75	NA	7.87	2.46	NA	29.08	090
47620		A	Removal of gallbladder	20.61	NA	8.51	2.70	NA	31.82	090
47630		A	Remove bile duct stone	9.10	NA	4.88	0.65	NA	14.63	090
47700		A	Exploration of bile ducts	15.60	NA	7.40	2.02	NA	25.02	090
47701		A	Bile duct revision	27.77	NA	11.47	3.64	NA	42.88	090
47711		A	Excision of bile duct tumor	23.00	NA	9.91	3.01	NA	35.92	090
47712		A	Excision of bile duct tumor	30.19	NA	12.40	3.87	NA	46.46	090
47715		A	Excision of bile duct cyst	18.77	NA	8.42	2.45	NA	29.64	090
47716		A	Fusion of bile duct cyst	16.42	NA	7.81	2.12	NA	26.35	090
47720		A	Fuse gallbladder & bowel	15.89	NA	7.46	2.08	NA	25.43	090
47721		A	Fuse upper gi structures	19.09	NA	8.55	2.48	NA	30.12	090
47740		A	Fuse gallbladder & bowel	18.45	NA	8.36	2.35	NA	29.16	090
47741		A	Fuse gallbladder & bowel	21.31	NA	9.27	2.81	NA	33.39	090
47760		A	Fuse bile ducts and bowel	25.81	NA	10.83	3.37	NA	40.01	090
47765		A	Fuse liver ducts & bowel	24.84	NA	10.78	3.24	NA	38.86	090
47780		A	Fuse bile ducts and bowel	26.46	NA	11.19	3.43	NA	41.08	090
47785		A	Fuse bile ducts and bowel	31.13	NA	12.89	3.99	NA	48.01	090
47800		A	Reconstruction of bile ducts	23.27	NA	10.04	2.98	NA	36.29	090
47801		A	Placement, bile duct support	15.15	NA	8.14	1.16	NA	24.45	090
47802		A	Fuse liver duct & intestine	21.52	NA	9.65	2.82	NA	33.99	090
47900		A	Suture bile duct injury	19.87	NA	8.85	2.63	NA	31.35	090
47999		C	Bile tract surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
48000		A	Drainage of abdomen	28.03	NA	11.49	3.37	NA	42.89	090
48001		A	Placement of drain, pancreas	35.40	NA	13.86	4.60	NA	53.86	090
48005		A	Resect/debride pancreas	42.11	NA	16.54	5.45	NA	64.10	090
48020		A	Removal of pancreatic stone	15.68	NA	7.29	2.10	NA	25.07	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
48100		A	Biopsy of pancreas, open	12.21	NA	5.58	1.56	NA	19.35	090
48102		A	Needle biopsy, pancreas	4.67	7.95	1.94	0.29	12.91	6.90	010
48120		A	Removal of pancreas lesion	15.83	NA	6.84	2.06	NA	24.73	090
48140		A	Partial removal of pancreas	22.91	NA	9.52	2.97	NA	35.40	090
48145		A	Partial removal of pancreas	23.98	NA	9.81	3.15	NA	36.94	090
48146		A	Pancreatectomy	26.36	NA	11.97	3.45	NA	41.78	090
48148		A	Removal of pancreatic duct	17.31	NA	7.59	2.22	NA	27.12	090
48150		A	Partial removal of pancreas	47.93	NA	19.48	6.23	NA	73.64	090
48152		A	Pancreatectomy	43.68	NA	18.18	5.77	NA	67.63	090
48153		A	Pancreatectomy	47.82	NA	19.52	6.26	NA	73.60	090
48154		A	Pancreatectomy	44.03	NA	18.21	5.77	NA	68.01	090
48155		A	Removal of pancreas	24.60	NA	11.65	3.20	NA	39.45	090
48160		N	Pancreas removal/transplant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
48180		A	Fuse pancreas and bowel	24.68	NA	10.14	3.22	NA	38.04	090
48400		A	Injection, intraop add-on	1.95	NA	0.64	0.15	NA	2.74	ZZZ
48500		A	Surgery of pancreatic cyst	15.26	NA	7.32	2.00	NA	24.58	090
48510		A	Drain pancreatic pseudocyst	14.29	NA	7.43	1.78	NA	23.50	090
48511		A	Drain pancreatic pseudocyst	3.99	20.89	1.31	0.24	25.12	5.54	000
48520		A	Fuse pancreas cyst and bowel	15.57	NA	6.69	2.02	NA	24.28	090
48540		A	Fuse pancreas cyst and bowel	19.69	NA	8.10	2.53	NA	30.32	090
48545		A	Pancreatorrhaphy	18.15	NA	7.97	2.32	NA	28.44	090
48547		A	Duodenal exclusion	25.79	NA	10.47	3.33	NA	39.59	090
48550		X	Donor pancreatectomy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
48551		C	Prep donor pancreas	0.00	0.00	0.00	0.00	0.00	0.00	XXX
48552		A	Prep donor pancreas/venous	4.30	NA	1.46	0.31	NA	6.07	XXX
48554		R	Transpl allograft pancreas	34.12	NA	18.25	4.13	NA	56.50	090
48556		A	Removal, allograft pancreas	15.69	NA	8.06	2.00	NA	25.75	090
48999		C	Pancreas surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
49000		A	Exploration of abdomen	11.66	NA	5.37	1.48	NA	18.51	090
49002		A	Reopening of abdomen	10.47	NA	5.01	1.34	NA	16.82	090
49010		A	Exploration behind abdomen	12.26	NA	5.89	1.51	NA	19.66	090
49020		A	Drain abdominal abscess	22.81	NA	10.18	2.75	NA	35.74	090
49021		A	Drain abdominal abscess	3.37	21.05	1.11	0.20	24.62	4.68	000
49040		A	Drain, open, abdom abscess	13.50	NA	6.41	1.65	NA	21.56	090
49041		A	Drain, percut, abdom abscess	3.99	19.51	1.31	0.24	23.74	5.54	000
49060		A	Drain, open, retrop abscess	15.84	NA	7.42	1.75	NA	25.01	090
49061		A	Drain, percut, retroper absc	3.69	19.62	1.21	0.22	23.53	5.12	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
49062		A	Drain to peritoneal cavity	11.34	NA	5.42	1.40	NA	18.16	090
49080		A	Puncture, peritoneal cavity	1.35	3.98	0.46	0.09	5.42	1.90	000
49081		A	Removal of abdominal fluid	1.26	2.58	0.43	0.09	3.93	1.78	000
49085		A	Remove abdomen foreign body	12.12	NA	5.49	1.55	NA	19.16	090
49180		A	Biopsy, abdominal mass	1.73	3.10	0.57	0.11	4.94	2.41	000
49200		A	Removal of abdominal lesion	10.23	NA	5.02	1.20	NA	16.45	090
49201		A	Remove abdom lesion, complex	14.82	NA	7.02	1.77	NA	23.61	090
49215		A	Excise sacral spine tumor	33.45	NA	14.04	4.24	NA	51.73	090
49220		A	Multiple surgery, abdomen	14.86	NA	6.62	1.88	NA	23.36	090
49250		A	Excision of umbilicus	8.34	NA	4.26	1.07	NA	13.67	090
49255		A	Removal of omentum	11.12	NA	5.60	1.40	NA	18.12	090
49320		A	Diag laparo separate proc	5.09	NA	2.63	0.63	NA	8.35	010
49321		A	Laparoscopy, biopsy	5.39	NA	2.64	0.69	NA	8.72	010
49322		A	Laparoscopy, aspiration	5.69	NA	2.99	0.71	NA	9.39	010
49323		A	Laparo drain lymphocele	9.47	NA	4.49	1.18	NA	15.14	090
49329		C	Laparo proc, abdm/per/oment	0.00	0.00	0.00	0.00	0.00	0.00	YYY
49400		A	Air injection into abdomen	1.88	3.07	0.62	0.15	5.10	2.65	000
49419		A	Insrt abdom cath for chemotx	6.64	NA	3.56	0.80	NA	11.00	090
49420		A	Insert abdom drain, temp	2.22	NA	1.09	0.21	NA	3.52	000
49421		A	Insert abdom drain, perm	5.53	NA	3.15	0.70	NA	9.38	090
49422		A	Remove perm cannula/catheter	6.24	NA	2.89	0.79	NA	9.92	010
49423		A	Exchange drainage catheter	1.46	14.07	0.52	0.09	15.62	2.07	000
49424		A	Assess cyst, contrast inject	0.76	3.71	0.29	0.05	4.52	1.10	000
49425		A	Insert abdomen-venous drain	11.35	NA	5.59	1.50	NA	18.44	090
49426		A	Revise abdomen-venous shunt	9.62	NA	4.76	1.25	NA	15.63	090
49427		A	Injection, abdominal shunt	0.89	NA	0.30	0.07	NA	1.26	000
49428		A	Ligation of shunt	6.05	NA	3.92	0.80	NA	10.77	010
49429		A	Removal of shunt	7.39	NA	3.42	1.00	NA	11.81	010
49491		A	Rpr hern preemie reduc	11.11	NA	5.05	1.40	NA	17.56	090
49492		A	Rpr ing hern premie, blocked	14.01	NA	6.10	1.78	NA	21.89	090
49495		A	Rpr ing hernia baby, reduc	5.88	NA	2.95	0.73	NA	9.56	090
49496		A	Rpr ing hernia baby, blocked	8.78	NA	4.27	1.07	NA	14.12	090
49500		A	Rpr ing hernia, init, reduce	5.47	NA	3.11	0.71	NA	9.29	090
49501		A	Rpr ing hernia, init blocked	8.87	NA	4.20	1.08	NA	14.15	090
49505		A	Prp i/hern init reduc >5 yr	7.59	NA	3.74	1.01	NA	12.34	090
49507		A	Prp i/hern init block >5 yr	9.56	NA	4.45	1.25	NA	15.26	090
49520		A	Rerepair ing hernia, reduce	9.62	NA	4.43	1.27	NA	15.32	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
49521		A	Rerepair ing hernia, blocked	11.95	NA	5.23	1.56	NA	18.74	090
49525		A	Repair ing hernia, sliding	8.56	NA	4.07	1.11	NA	13.74	090
49540		A	Repair lumbar hernia	10.37	NA	4.74	1.36	NA	16.47	090
49550		A	Rpr rem hernia, init, reduce	8.62	NA	4.12	1.13	NA	13.87	090
49553		A	Rpr fem hernia, init blocked	9.43	NA	4.41	1.23	NA	15.07	090
49555		A	Rerepair fem hernia, reduce	9.02	NA	4.26	1.18	NA	14.46	090
49557		A	Rerepair fem hernia, blocked	11.13	NA	4.98	1.46	NA	17.57	090
49560		A	Rpr ventral hern init, reduc	11.55	NA	5.14	1.50	NA	18.19	090
49561		A	Rpr ventral hern init, block	14.23	NA	6.05	1.85	NA	22.13	090
49565		A	Rerepair ventrl hern, reduce	11.55	NA	5.21	1.51	NA	18.27	090
49566		A	Rerepair ventrl hern, block	14.38	NA	6.12	1.87	NA	22.37	090
49568		A	Hernia repair w/mesh	4.88	NA	1.67	0.64	NA	7.19	ZZZ
49570		A	Rpr epigastric hern, reduce	5.68	NA	3.16	0.74	NA	9.58	090
49572		A	Rpr epigastric hern, blocked	6.72	NA	3.46	0.88	NA	11.06	090
49580		A	Rpr umbil hern, reduc < 5 yr	4.10	NA	2.59	0.50	NA	7.19	090
49582		A	Rpr umbil hern, block < 5 yr	6.64	NA	3.46	0.88	NA	10.98	090
49585		A	Rpr umbil hern, reduc > 5 yr	6.22	NA	3.29	0.81	NA	10.32	090
49587		A	Rpr umbil hern, block > 5 yr	7.55	NA	3.73	0.98	NA	12.26	090
49590		A	Repair spigelian hernia	8.53	NA	4.08	1.11	NA	13.72	090
49600		A	Repair umbilical lesion	10.94	NA	5.32	1.32	NA	17.58	090
49605		A	Repair umbilical lesion	75.89	NA	28.50	9.29	NA	113.68	090
49606		A	Repair umbilical lesion	18.57	NA	7.68	2.42	NA	28.67	090
49610		A	Repair umbilical lesion	10.48	NA	5.19	1.07	NA	16.74	090
49611		A	Repair umbilical lesion	8.91	NA	6.97	0.78	NA	16.66	090
49650		A	Laparo hernia repair initial	6.26	NA	3.19	0.92	NA	10.37	090
49651		A	Laparo hernia repair recur	8.23	NA	4.04	1.13	NA	13.40	090
49659		C	Laparo proc, hernia repair	0.00	0.00	0.00	0.00	0.00	0.00	YYY
49900		A	Repair of abdominal wall	12.26	NA	6.22	1.55	NA	20.03	090
49904		A	Omental flap, extra-abdom	19.97	NA	15.21	2.63	NA	37.81	090
49905		A	Omental flap, intra-abdom	6.54	NA	2.29	0.77	NA	9.60	ZZZ
49906		C	Free omental flap, microvasc	0.00	0.00	0.00	0.00	0.00	0.00	090
49999		C	Abdomen surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
50010		A	Exploration of kidney	10.96	NA	5.21	0.94	NA	17.11	090
50020		A	Renal abscess, open drain	14.64	NA	7.74	1.28	NA	23.66	090
50021		A	Renal abscess, percut drain	3.37	21.65	1.10	0.20	25.22	4.67	000
50040		A	Drainage of kidney	14.92	NA	6.80	1.07	NA	22.79	090
50045		A	Exploration of kidney	15.44	NA	6.59	1.26	NA	23.29	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
50060		A	Removal of kidney stone	19.27	NA	7.82	1.36	NA	28.45	090
50065		A	Incision of kidney	20.76	NA	6.07	1.58	NA	28.41	090
50070		A	Incision of kidney	20.29	NA	8.21	1.43	NA	29.93	090
50075		A	Removal of kidney stone	25.30	NA	9.89	1.80	NA	36.99	090
50080		A	Removal of kidney stone	14.69	NA	6.27	1.04	NA	22.00	090
50081		A	Removal of kidney stone	21.77	NA	8.75	1.54	NA	32.06	090
50100		A	Revise kidney blood vessels	16.07	NA	7.78	2.02	NA	25.87	090
50120		A	Exploration of kidney	15.89	NA	6.76	1.22	NA	23.87	090
50125		A	Explore and drain kidney	16.50	NA	6.96	1.43	NA	24.89	090
50130		A	Removal of kidney stone	17.26	NA	7.16	1.22	NA	25.64	090
50135		A	Exploration of kidney	19.15	NA	7.77	1.37	NA	28.29	090
50200		A	Biopsy of kidney	2.63	NA	1.29	0.16	NA	4.08	000
50205		A	Biopsy of kidney	11.29	NA	5.01	1.30	NA	17.60	090
50220		A	Remove kidney, open	17.12	NA	7.23	1.38	NA	25.73	090
50225		A	Removal kidney open, complex	20.20	NA	8.14	1.50	NA	29.84	090
50230		A	Removal kidney open, radical	22.04	NA	8.57	1.59	NA	32.20	090
50234		A	Removal of kidney & ureter	22.37	NA	8.82	1.61	NA	32.80	090
50236		A	Removal of kidney & ureter	24.82	NA	10.24	1.75	NA	36.81	090
50240		A	Partial removal of kidney	21.97	NA	9.00	1.59	NA	32.56	090
50280		A	Removal of kidney lesion	15.65	NA	6.68	1.19	NA	23.52	090
50290		A	Removal of kidney lesion	14.71	NA	6.45	1.39	NA	22.55	090
50300		X	Remove cadaver donor kidney	0.00	0.00	0.00	0.00	0.00	0.00	XXX
50320		A	Remove kidney, living donor	22.18	NA	10.65	2.36	NA	35.19	090
50323		C	Prep cadaver renal allograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
50325		C	Prep donor renal graft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
50327		A	Prep renal graft/venous	4.00	NA	1.35	0.29	NA	5.64	XXX
50328		A	Prep renal graft/arterial	3.50	NA	1.18	0.26	NA	4.94	XXX
50329		A	Prep renal graft/ureteral	3.34	NA	1.13	0.25	NA	4.72	XXX
50340		A	Removal of kidney	12.13	NA	6.49	1.64	NA	20.26	090
50360		A	Transplantation of kidney	31.48	NA	15.47	3.78	NA	50.73	090
50365		A	Transplantation of kidney	36.75	NA	18.19	4.39	NA	59.33	090
50370		A	Remove transplanted kidney	13.70	NA	7.14	1.65	NA	22.49	090
50380		A	Reimplantation of kidney	20.73	NA	12.02	2.41	NA	35.16	090
50390		A	Drainage of kidney lesion	1.96	NA	0.64	0.12	NA	2.72	000
50391		A	Instll rx agnt into rnal tub	1.96	1.58	0.63	0.14	3.68	2.73	000
50392		A	Insert kidney drain	3.37	NA	1.52	0.21	NA	5.10	000
50393		A	Insert ureteral tube	4.15	NA	1.78	0.25	NA	6.18	000

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CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
50394		A	Injection for kidney x-ray	0.76	2.68	0.66	0.05	3.49	1.47	000
50395		A	Create passage to kidney	3.37	NA	1.50	0.21	NA	5.08	000
50396		A	Measure kidney pressure	2.09	NA	1.08	0.13	NA	3.30	000
50398		A	Change kidney tube	1.46	16.31	0.52	0.09	17.86	2.07	000
50400		A	Revision of kidney/ureter	19.47	NA	7.87	1.40	NA	28.74	090
50405		A	Revision of kidney/ureter	23.89	NA	9.02	1.76	NA	34.67	090
50500		A	Repair of kidney wound	19.54	NA	8.38	2.00	NA	29.92	090
50520		A	Close kidney-skin fistula	17.20	NA	7.42	1.49	NA	26.11	090
50525		A	Repair renal-abdomen fistula	22.24	NA	8.99	1.82	NA	33.05	090
50526		A	Repair renal-abdomen fistula	23.98	NA	9.85	1.95	NA	35.78	090
50540		A	Revision of horseshoe kidney	19.90	NA	8.32	1.35	NA	29.57	090
50541		A	Laparo ablate renal cyst	15.98	NA	6.48	1.15	NA	23.61	090
50542		A	Laparo ablate renal mass	19.97	NA	8.13	1.39	NA	29.49	090
50543		A	Laparo partial nephrectomy	25.46	NA	10.19	1.84	NA	37.49	090
50544		A	Laparoscopy, pyeloplasty	22.37	NA	8.52	1.57	NA	32.46	090
50545		A	Laparo radical nephrectomy	23.96	NA	9.18	1.74	NA	34.88	090
50546		A	Laparoscopic nephrectomy	20.45	NA	8.36	1.56	NA	30.37	090
50547		A	Laparo removal donor kidney	25.46	NA	11.10	2.74	NA	39.30	090
50548		A	Laparo remove w/ureter	24.36	NA	9.17	1.74	NA	35.27	090
50549		C	Laparoscope proc, renal	0.00	0.00	0.00	0.00	0.00	0.00	YYY
50551		A	Kidney endoscopy	5.59	4.14	1.97	0.41	10.14	7.97	000
50553		A	Kidney endoscopy	5.98	4.36	2.17	0.39	10.73	8.54	000
50555		A	Kidney endoscopy & biopsy	6.52	4.81	2.33	0.46	11.79	9.31	000
50557		A	Kidney endoscopy & treatment	6.61	4.58	2.29	0.47	11.66	9.37	000
50561		A	Kidney endoscopy & treatment	7.58	5.08	2.64	0.54	13.20	10.76	000
50562		A	Renal scope w/tumor resect	10.90	NA	4.31	0.76	NA	15.97	090
50570		A	Kidney endoscopy	9.53	NA	3.21	0.68	NA	13.42	000
50572		A	Kidney endoscopy	10.33	NA	3.50	0.84	NA	14.67	000
50574		A	Kidney endoscopy & biopsy	11.00	NA	3.74	0.79	NA	15.53	000
50575		A	Kidney endoscopy	13.96	NA	4.63	1.00	NA	19.59	000
50576		A	Kidney endoscopy & treatment	10.97	NA	3.66	0.78	NA	15.41	000
50580		A	Kidney endoscopy & treatment	11.84	NA	3.96	0.88	NA	16.68	000
50590		A	Fragmenting of kidney stone	9.08	12.39	4.11	0.65	22.12	13.84	090
50600		A	Exploration of ureter	15.82	NA	6.66	1.21	NA	23.69	090
50605		A	Insert ureteral support	15.44	NA	6.73	1.46	NA	23.63	090
50610		A	Removal of ureter stone	15.90	NA	6.96	1.38	NA	24.24	090
50620		A	Removal of ureter stone	15.14	NA	6.33	1.09	NA	22.56	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
50630		A	Removal of ureter stone	14.92	NA	6.27	1.11	NA	22.30	090
50650		A	Removal of ureter	17.38	NA	7.22	1.26	NA	25.86	090
50660		A	Removal of ureter	19.52	NA	7.95	1.43	NA	28.90	090
50684		A	Injection for ureter x-ray	0.76	4.97	0.47	0.05	5.78	1.28	000
50686		A	Measure ureter pressure	1.51	3.44	0.82	0.11	5.06	2.44	000
50688		A	Change of ureter tube	1.17	NA	1.06	0.07	NA	2.30	010
50690		A	Injection for ureter x-ray	1.16	1.82	0.72	0.07	3.05	1.95	000
50700		A	Revision of ureter	15.19	NA	7.11	1.28	NA	23.58	090
50715		A	Release of ureter	18.87	NA	8.73	2.11	NA	29.71	090
50722		A	Release of ureter	16.33	NA	7.80	1.88	NA	26.01	090
50725		A	Release/revise ureter	18.46	NA	8.04	1.51	NA	28.01	090
50727		A	Revise ureter	8.17	NA	4.27	0.62	NA	13.06	090
50728		A	Revise ureter	12.00	NA	5.55	1.01	NA	18.56	090
50740		A	Fusion of ureter & kidney	18.39	NA	7.73	1.96	NA	28.08	090
50750		A	Fusion of ureter & kidney	19.48	NA	7.98	1.38	NA	28.84	090
50760		A	Fusion of ureters	18.39	NA	7.67	1.58	NA	27.64	090
50770		A	Splicing of ureters	19.48	NA	7.97	1.48	NA	28.93	090
50780		A	Reimplant ureter in bladder	18.33	NA	7.58	1.53	NA	27.44	090
50782		A	Reimplant ureter in bladder	19.51	NA	8.76	1.58	NA	29.85	090
50783		A	Reimplant ureter in bladder	20.52	NA	8.21	1.97	NA	30.70	090
50785		A	Reimplant ureter in bladder	20.49	NA	8.29	1.56	NA	30.34	090
50800		A	Implant ureter in bowel	14.50	NA	6.46	1.20	NA	22.16	090
50810		A	Fusion of ureter & bowel	20.02	NA	9.08	2.30	NA	31.40	090
50815		A	Urine shunt to intestine	19.90	NA	8.44	1.60	NA	29.94	090
50820		A	Construct bowel bladder	21.86	NA	8.63	1.88	NA	32.37	090
50825		A	Construct bowel bladder	28.14	NA	11.12	2.08	NA	41.34	090
50830		A	Revise urine flow	31.23	NA	12.16	2.34	NA	45.73	090
50840		A	Replace ureter by bowel	19.97	NA	8.42	1.51	NA	29.90	090
50845		A	Appendico-vesicostomy	20.86	NA	8.89	1.53	NA	31.28	090
50860		A	Transplant ureter to skin	15.34	NA	6.61	1.30	NA	23.25	090
50900		A	Repair of ureter	13.60	NA	6.13	1.17	NA	20.90	090
50920		A	Closure ureter/skin fistula	14.31	NA	6.56	1.01	NA	21.88	090
50930		A	Closure ureter/bowel fistula	18.69	NA	7.96	1.28	NA	27.93	090
50940		A	Release of ureter	14.49	NA	6.39	1.26	NA	22.14	090
50945		A	Laparoscopy ureterolithotomy	16.97	NA	7.03	1.36	NA	25.36	090
50947		A	Laparo new ureter/bladder	24.46	NA	9.68	2.14	NA	36.28	090
50948		A	Laparo new ureter/bladder	22.47	NA	8.68	1.69	NA	32.84	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
50949		C	Laparoscope proc, ureter	0.00	0.00	0.00	0.00	0.00	0.00	YYY
50951		A	Endoscopy of ureter	5.83	4.29	2.05	0.42	10.54	8.30	000
50953		A	Endoscopy of ureter	6.23	4.40	2.36	0.44	11.07	9.03	000
50955		A	Ureter endoscopy & biopsy	6.74	6.41	2.68	0.48	13.63	9.90	000
50957		A	Ureter endoscopy & treatment	6.78	4.56	2.37	0.49	11.83	9.64	000
50961		A	Ureter endoscopy & treatment	6.04	4.36	2.18	0.41	10.81	8.63	000
50970		A	Ureter endoscopy	7.13	NA	2.46	0.52	NA	10.11	000
50972		A	Ureter endoscopy & catheter	6.88	NA	2.46	0.50	NA	9.84	000
50974		A	Ureter endoscopy & biopsy	9.16	NA	3.10	0.64	NA	12.90	000
50976		A	Ureter endoscopy & treatment	9.03	NA	3.06	0.65	NA	12.74	000
50980		A	Ureter endoscopy & treatment	6.84	NA	2.37	0.50	NA	9.71	000
51000		A	Drainage of bladder	0.78	1.94	0.24	0.06	2.78	1.08	000
51005		A	Drainage of bladder	1.02	4.70	0.34	0.10	5.82	1.46	000
51010		A	Drainage of bladder	3.52	5.60	1.87	0.28	9.40	5.67	010
51020		A	Incise & treat bladder	6.70	NA	3.85	0.49	NA	11.04	090
51030		A	Incise & treat bladder	6.76	NA	3.97	0.58	NA	11.31	090
51040		A	Incise & drain bladder	4.39	NA	2.76	0.32	NA	7.47	090
51045		A	Incise bladder/drain ureter	6.76	NA	3.92	0.55	NA	11.23	090
51050		A	Removal of bladder stone	6.91	NA	3.64	0.49	NA	11.04	090
51060		A	Removal of ureter stone	8.84	NA	4.50	0.61	NA	13.95	090
51065		A	Remove ureter calculus	8.84	NA	4.35	0.64	NA	13.83	090
51080		A	Drainage of bladder abscess	5.95	NA	3.54	0.44	NA	9.93	090
51500		A	Removal of bladder cyst	10.12	NA	5.00	1.03	NA	16.15	090
51520		A	Removal of bladder lesion	9.28	NA	4.67	0.69	NA	14.64	090
51525		A	Removal of bladder lesion	13.95	NA	6.12	1.01	NA	21.08	090
51530		A	Removal of bladder lesion	12.36	NA	5.74	1.06	NA	19.16	090
51535		A	Repair of ureter lesion	12.55	NA	6.10	1.21	NA	19.86	090
51550		A	Partial removal of bladder	15.64	NA	6.72	1.34	NA	23.70	090
51555		A	Partial removal of bladder	21.20	NA	8.65	1.72	NA	31.57	090
51565		A	Revise bladder & ureter(s)	21.59	NA	8.95	1.66	NA	32.20	090
51570		A	Removal of bladder	24.20	NA	9.73	1.84	NA	35.77	090
51575		A	Removal of bladder & nodes	30.40	NA	12.02	2.16	NA	44.58	090
51580		A	Remove bladder/revise tract	31.03	NA	12.48	2.22	NA	45.73	090
51585		A	Removal of bladder & nodes	35.18	NA	13.69	2.48	NA	51.35	090
51590		A	Remove bladder/revise tract	32.61	NA	12.60	2.32	NA	47.53	090
51595		A	Remove bladder/revise tract	37.08	NA	14.12	2.62	NA	53.82	090
51596		A	Remove bladder/create pouch	39.46	NA	15.22	2.78	NA	57.46	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
51597		A	Removal of pelvic structures	38.29	NA	14.82	2.83	NA	55.94	090
51600		A	Injection for bladder x-ray	0.88	5.05	0.29	0.06	5.99	1.23	000
51605		A	Preparation for bladder xray	0.64	6.05	0.35	0.04	6.73	1.03	000
51610		A	Injection for bladder x-ray	1.05	2.28	0.60	0.07	3.40	1.72	000
51700		A	Irrigation of bladder	0.88	1.60	0.28	0.07	2.55	1.23	000
51701		A	Insert bladder catheter	0.50	1.58	0.19	0.04	2.12	0.73	000
51702		A	Insert temp bladder cath	0.50	2.08	0.24	0.04	2.62	0.78	000
51703		A	Insert bladder cath, complex	1.47	2.73	0.56	0.11	4.31	2.14	000
51705		A	Change of bladder tube	1.02	2.27	0.61	0.07	3.36	1.70	010
51710		A	Change of bladder tube	1.49	3.33	0.77	0.11	4.93	2.37	010
51715		A	Endoscopic injection/implant	3.73	3.90	1.35	0.29	7.92	5.37	000
51720		A	Treatment of bladder lesion	1.96	1.74	0.69	0.14	3.84	2.79	000
51725		A	Simple cystometrogram	1.51	5.59	NA	0.16	7.26	NA	000
51725	26	A	Simple cystometrogram	1.51	0.49	0.49	0.12	2.12	2.12	000
51725	TC	A	Simple cystometrogram	0.00	5.10	NA	0.04	5.14	NA	000
51726		A	Complex cystometrogram	1.71	7.50	NA	0.18	9.39	NA	000
51726	26	A	Complex cystometrogram	1.71	0.56	0.56	0.13	2.40	2.40	000
51726	TC	A	Complex cystometrogram	0.00	6.94	NA	0.05	6.99	NA	000
51736		A	Urine flow measurement	0.61	0.58	NA	0.06	1.25	NA	000
51736	26	A	Urine flow measurement	0.61	0.20	0.20	0.05	0.86	0.86	000
51736	TC	A	Urine flow measurement	0.00	0.38	NA	0.01	0.39	NA	000
51741		A	Electro-uroflowmetry, first	1.14	0.79	NA	0.11	2.04	NA	000
51741	26	A	Electro-uroflowmetry, first	1.14	0.37	0.37	0.09	1.60	1.60	000
51741	TC	A	Electro-uroflowmetry, first	0.00	0.42	NA	0.02	0.44	NA	000
51772		A	Urethra pressure profile	1.61	5.58	NA	0.19	7.38	NA	000
51772	26	A	Urethra pressure profile	1.61	0.55	0.55	0.14	2.30	2.30	000
51772	TC	A	Urethra pressure profile	0.00	5.03	NA	0.05	5.08	NA	000
51784		A	Anal/urinary muscle study	1.53	3.98	NA	0.16	5.67	NA	000
51784	26	A	Anal/urinary muscle study	1.53	0.50	0.50	0.12	2.15	2.15	000
51784	TC	A	Anal/urinary muscle study	0.00	3.48	NA	0.04	3.52	NA	000
51785		A	Anal/urinary muscle study	1.53	4.44	NA	0.15	6.12	NA	000
51785	26	A	Anal/urinary muscle study	1.53	0.50	0.50	0.11	2.14	2.14	000
51785	TC	A	Anal/urinary muscle study	0.00	3.94	NA	0.04	3.98	NA	000
51792		A	Urinary reflex study	1.10	5.99	NA	0.20	7.29	NA	000
51792	26	A	Urinary reflex study	1.10	0.41	0.41	0.07	1.58	1.58	000
51792	TC	A	Urinary reflex study	0.00	5.58	NA	0.13	5.71	NA	000
51795		A	Urine voiding pressure study	1.53	7.29	NA	0.22	9.04	NA	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
51795	26	A	Urine voiding pressure study	1.53	0.50	0.50	0.12	2.15	2.15	000
51795	TC	A	Urine voiding pressure study	0.00	6.79	NA	0.10	6.89	NA	000
51797		A	Intraabdominal pressure test	1.60	5.78	NA	0.17	7.55	NA	000
51797	26	A	Intraabdominal pressure test	1.60	0.53	0.53	0.12	2.25	2.25	000
51797	TC	A	Intraabdominal pressure test	0.00	5.25	NA	0.05	5.30	NA	000
51798		A	Us urine capacity measure	0.00	0.34	NA	0.08	0.42	NA	XXX
51800		A	Revision of bladder/urethra	17.39	NA	7.56	1.35	NA	26.30	090
51820		A	Revision of urinary tract	17.86	NA	8.28	1.73	NA	27.87	090
51840		A	Attach bladder/urethra	10.69	NA	5.56	1.07	NA	17.32	090
51841		A	Attach bladder/urethra	13.01	NA	6.37	1.26	NA	20.64	090
51845		A	Repair bladder neck	9.72	NA	4.74	0.80	NA	15.26	090
51860		A	Repair of bladder wound	12.00	NA	5.75	1.16	NA	18.91	090
51865		A	Repair of bladder wound	15.02	NA	6.67	1.26	NA	22.95	090
51880		A	Repair of bladder opening	7.65	NA	3.95	0.72	NA	12.32	090
51900		A	Repair bladder/vagina lesion	12.95	NA	6.06	1.21	NA	20.22	090
51920		A	Close bladder-uterus fistula	11.79	NA	5.63	1.18	NA	18.60	090
51925		A	Hysterectomy/bladder repair	15.56	NA	8.61	2.02	NA	26.19	090
51940		A	Correction of bladder defect	28.39	NA	12.07	2.12	NA	42.58	090
51960		A	Revision of bladder & bowel	22.98	NA	9.63	1.65	NA	34.26	090
51980		A	Construct bladder opening	11.34	NA	5.37	0.86	NA	17.57	090
51990		A	Laparo urethral suspension	12.48	NA	6.14	1.40	NA	20.02	090
51992		A	Laparo sling operation	13.99	NA	6.20	1.40	NA	21.59	090
52000		A	Cystoscopy	2.01	3.30	0.76	0.14	5.45	2.91	000
52001		A	Cystoscopy, removal of clots	5.44	5.07	1.86	0.39	10.90	7.69	000
52005		A	Cystoscopy & ureter catheter	2.37	5.56	0.89	0.17	8.10	3.43	000
52007		A	Cystoscopy and biopsy	3.02	16.44	1.15	0.22	19.68	4.39	000
52010		A	Cystoscopy & duct catheter	3.02	10.75	1.15	0.22	13.99	4.39	000
52204		A	Cystoscopy	2.37	14.51	0.90	0.17	17.05	3.44	000
52214		A	Cystoscopy and treatment	3.70	38.10	1.33	0.26	42.06	5.29	000
52224		A	Cystoscopy and treatment	3.14	36.45	1.15	0.22	39.81	4.51	000
52234		A	Cystoscopy and treatment	4.62	NA	1.66	0.33	NA	6.61	000
52235		A	Cystoscopy and treatment	5.44	NA	1.93	0.39	NA	7.76	000
52240		A	Cystoscopy and treatment	9.71	NA	3.30	0.69	NA	13.70	000
52250		A	Cystoscopy and radiotracer	4.49	NA	1.65	0.32	NA	6.46	000
52260		A	Cystoscopy and treatment	3.91	NA	1.42	0.28	NA	5.61	000
52265		A	Cystoscopy and treatment	2.94	13.34	1.11	0.22	16.50	4.27	000
52270		A	Cystoscopy & revise urethra	3.36	11.03	1.24	0.24	14.63	4.84	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
52275		A	Cystoscopy & revise urethra	4.69	15.55	1.66	0.33	20.57	6.68	000
52276		A	Cystoscopy and treatment	4.99	NA	1.78	0.35	NA	7.12	000
52277		A	Cystoscopy and treatment	6.16	NA	2.22	0.44	NA	8.82	000
52281		A	Cystoscopy and treatment	2.80	7.09	1.08	0.20	10.09	4.08	000
52282		A	Cystoscopy, implant stent	6.39	NA	2.23	0.47	NA	9.09	000
52283		A	Cystoscopy and treatment	3.73	3.94	1.36	0.26	7.93	5.37	000
52285		A	Cystoscopy and treatment	3.60	4.01	1.33	0.26	7.87	5.19	000
52290		A	Cystoscopy and treatment	4.58	NA	1.65	0.32	NA	6.55	000
52300		A	Cystoscopy and treatment	5.30	NA	1.90	0.38	NA	7.58	000
52301		A	Cystoscopy and treatment	5.50	NA	1.98	0.46	NA	7.94	000
52305		A	Cystoscopy and treatment	5.30	NA	1.85	0.38	NA	7.53	000
52310		A	Cystoscopy and treatment	2.81	4.69	1.03	0.20	7.70	4.04	000
52315		A	Cystoscopy and treatment	5.20	8.66	1.83	0.37	14.23	7.40	000
52317		A	Remove bladder stone	6.71	28.94	2.28	0.48	36.13	9.47	000
52318		A	Remove bladder stone	9.18	NA	3.09	0.65	NA	12.92	000
52320		A	Cystoscopy and treatment	4.69	NA	1.63	0.34	NA	6.66	000
52325		A	Cystoscopy, stone removal	6.15	NA	2.11	0.44	NA	8.70	000
52327		A	Cystoscopy, inject material	5.18	31.81	1.81	0.38	37.37	7.37	000
52330		A	Cystoscopy and treatment	5.03	38.82	1.75	0.36	44.21	7.14	000
52332		A	Cystoscopy and treatment	2.83	5.74	1.05	0.21	8.78	4.09	000
52334		A	Create passage to kidney	4.82	NA	1.73	0.34	NA	6.89	000
52341		A	Cysto w/ureter stricture tx	5.99	NA	2.21	0.43	NA	8.63	000
52342		A	Cysto w/up stricture tx	6.49	NA	2.34	0.46	NA	9.29	000
52343		A	Cysto w/renal stricture tx	7.19	NA	2.58	0.52	NA	10.29	000
52344		A	Cysto/uretero, stricture tx	7.69	NA	2.79	0.55	NA	11.03	000
52345		A	Cysto/uretero w/up stricture	8.19	NA	2.95	0.58	NA	11.72	000
52346		A	Cystouretero w/renal strict	9.22	NA	3.28	0.67	NA	13.17	000
52351		A	Cystouretero & or pyeloscope	5.85	NA	2.14	0.42	NA	8.41	000
52352		A	Cystouretero w/stone remove	6.87	NA	2.50	0.49	NA	9.86	000
52353		A	Cystouretero w/lithotripsy	7.96	NA	2.85	0.57	NA	11.38	000
52354		A	Cystouretero w/biopsy	7.33	NA	2.67	0.52	NA	10.52	000
52355		A	Cystouretero w/excise tumor	8.81	NA	3.14	0.63	NA	12.58	000
52400		A	Cystouretero w/congen repr	9.67	NA	3.73	0.69	NA	14.09	090
52402		A	Cystourethro cut ejacul duct	5.27	NA	1.70	0.40	NA	7.37	000
52450		A	Incision of prostate	7.63	NA	3.67	0.54	NA	11.84	090
52500		A	Revision of bladder neck	8.46	NA	3.92	0.60	NA	12.98	090
52510		A	Dilation prostatic urethra	6.71	NA	3.11	0.48	NA	10.30	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
52601		A	Prostatectomy (TURP)	12.35	NA	5.10	0.87	NA	18.32	090
52606		A	Control postop bleeding	8.12	NA	3.55	0.58	NA	12.25	090
52612		A	Prostatectomy, first stage	7.97	NA	3.73	0.57	NA	12.27	090
52614		A	Prostatectomy, second stage	6.83	NA	3.34	0.48	NA	10.65	090
52620		A	Remove residual prostate	6.60	NA	2.98	0.47	NA	10.05	090
52630		A	Remove prostate regrowth	7.25	NA	3.19	0.51	NA	10.95	090
52640		A	Relieve bladder contracture	6.61	NA	2.96	0.47	NA	10.04	090
52647		A	Laser surgery of prostate	10.34	73.94	4.53	0.73	85.01	15.60	090
52648		A	Laser surgery of prostate	11.19	NA	4.79	0.79	NA	16.77	090
52700		A	Drainage of prostate abscess	6.79	NA	3.18	0.48	NA	10.45	090
53000		A	Incision of urethra	2.28	NA	1.54	0.16	NA	3.98	010
53010		A	Incision of urethra	3.63	NA	2.91	0.25	NA	6.79	090
53020		A	Incision of urethra	1.77	3.00	0.67	0.13	4.90	2.57	000
53025		A	Incision of urethra	1.13	3.73	0.51	0.08	4.94	1.72	000
53040		A	Drainage of urethra abscess	6.39	NA	3.43	0.47	NA	10.29	090
53060		A	Drainage of urethra abscess	2.63	2.08	1.37	0.27	4.98	4.27	010
53080		A	Drainage of urinary leakage	6.28	NA	5.95	0.52	NA	12.75	090
53085		A	Drainage of urinary leakage	10.25	NA	7.40	0.91	NA	18.56	090
53200		A	Biopsy of urethra	2.59	1.32	0.98	0.21	4.12	3.78	000
53210		A	Removal of urethra	12.55	NA	5.83	0.93	NA	19.31	090
53215		A	Removal of urethra	15.56	NA	6.62	1.11	NA	23.29	090
53220		A	Treatment of urethra lesion	6.99	NA	3.71	0.53	NA	11.23	090
53230		A	Removal of urethra lesion	9.57	NA	4.71	0.73	NA	15.01	090
53235		A	Removal of urethra lesion	10.12	NA	4.90	0.73	NA	15.75	090
53240		A	Surgery for urethra pouch	6.44	NA	3.52	0.53	NA	10.49	090
53250		A	Removal of urethra gland	5.88	NA	3.29	0.49	NA	9.66	090
53260		A	Treatment of urethra lesion	2.98	2.24	1.42	0.26	5.48	4.66	010
53265		A	Treatment of urethra lesion	3.12	2.71	1.42	0.24	6.07	4.78	010
53270		A	Removal of urethra gland	3.09	2.20	1.54	0.30	5.59	4.93	010
53275		A	Repair of urethra defect	4.52	NA	2.25	0.33	NA	7.10	010
53400		A	Revise urethra, stage 1	12.75	NA	6.02	1.00	NA	19.77	090
53405		A	Revise urethra, stage 2	14.46	NA	6.31	1.09	NA	21.86	090
53410		A	Reconstruction of urethra	16.42	NA	7.05	1.19	NA	24.66	090
53415		A	Reconstruction of urethra	19.38	NA	7.33	1.38	NA	28.09	090
53420		A	Reconstruct urethra, stage 1	14.06	NA	6.28	1.01	NA	21.35	090
53425		A	Reconstruct urethra, stage 2	15.96	NA	6.88	1.13	NA	23.97	090
53430		A	Reconstruction of urethra	16.32	NA	6.99	1.20	NA	24.51	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
53431		A	Reconstruct urethra/bladder	19.86	NA	8.05	1.45	NA	29.36	090
53440		A	Male sling procedure	13.60	NA	5.97	0.97	NA	20.54	090
53442		A	Remove/revise male sling	11.55	NA	5.43	0.83	NA	17.81	090
53444		A	Insert tandem cuff	13.38	NA	5.87	0.94	NA	20.19	090
53445		A	Insert uro/ves nck sphincter	14.04	NA	7.08	1.00	NA	22.12	090
53446		A	Remove uro sphincter	10.21	NA	5.21	0.73	NA	16.15	090
53447		A	Remove/replace ur sphincter	13.47	NA	6.42	0.95	NA	20.84	090
53448		A	Remov/replc ur sphinctr comp	21.12	NA	9.04	1.52	NA	31.68	090
53449		A	Repair uro sphincter	9.69	NA	4.72	0.69	NA	15.10	090
53450		A	Revision of urethra	6.13	NA	3.29	0.43	NA	9.85	090
53460		A	Revision of urethra	7.11	NA	3.69	0.52	NA	11.32	090
53500		A	Urethrlys, transvag w/ scope	12.19	NA	6.20	0.91	NA	19.30	090
53502		A	Repair of urethra injury	7.62	NA	3.98	0.63	NA	12.23	090
53505		A	Repair of urethra injury	7.62	NA	3.86	0.54	NA	12.02	090
53510		A	Repair of urethra injury	10.09	NA	5.16	0.77	NA	16.02	090
53515		A	Repair of urethra injury	13.29	NA	5.92	1.05	NA	20.26	090
53520		A	Repair of urethra defect	8.67	NA	4.47	0.63	NA	13.77	090
53600		A	Dilate urethra stricture	1.21	1.14	0.43	0.09	2.44	1.73	000
53601		A	Dilate urethra stricture	0.98	1.27	0.37	0.07	2.32	1.42	000
53605		A	Dilate urethra stricture	1.28	NA	0.41	0.09	NA	1.78	000
53620		A	Dilate urethra stricture	1.62	1.99	0.59	0.12	3.73	2.33	000
53621		A	Dilate urethra stricture	1.35	2.07	0.49	0.10	3.52	1.94	000
53660		A	Dilation of urethra	0.71	1.31	0.31	0.05	2.07	1.07	000
53661		A	Dilation of urethra	0.72	1.30	0.29	0.05	2.07	1.06	000
53665		A	Dilation of urethra	0.76	NA	0.25	0.06	NA	1.07	000
53850		A	Prostatic microwave thermotx	9.44	94.06	3.94	0.67	104.17	14.05	090
53852		A	Prostatic rf thermotx	9.87	86.77	4.37	0.70	99.34	14.94	090
53853		A	Prostatic water thermother	5.23	55.34	2.85	0.37	60.94	8.45	090
53899		C	Urology surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
54000		A	Slitting of prepuce	1.54	2.91	0.93	0.11	4.56	2.58	010
54001		A	Slitting of prepuce	2.19	3.18	1.11	0.16	5.53	3.46	010
54015		A	Drain penis lesion	5.31	NA	2.55	0.38	NA	8.24	010
54050		A	Destruction, penis lesion(s)	1.24	1.66	1.03	0.08	2.98	2.35	010
54055		A	Destruction, penis lesion(s)	1.22	1.57	0.80	0.08	2.87	2.10	010
54056		A	Cryosurgery, penis lesion(s)	1.24	1.69	1.13	0.06	2.99	2.43	010
54057		A	Laser surg, penis lesion(s)	1.24	2.21	0.83	0.09	3.54	2.16	010
54060		A	Excision of penis lesion(s)	1.93	3.10	1.06	0.14	5.17	3.13	010

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
54065		A	Destruction, penis lesion(s)	2.42	2.63	1.23	0.14	5.19	3.79	010
54100		A	Biopsy of penis	1.90	2.80	0.82	0.11	4.81	2.83	000
54105		A	Biopsy of penis	3.49	4.28	1.93	0.25	8.02	5.67	010
54110		A	Treatment of penis lesion	10.11	NA	4.75	0.74	NA	15.60	090
54111		A	Treat penis lesion, graft	13.55	NA	5.76	0.97	NA	20.28	090
54112		A	Treat penis lesion, graft	15.84	NA	6.79	1.12	NA	23.75	090
54115		A	Treatment of penis lesion	6.14	4.37	3.45	0.45	10.96	10.04	090
54120		A	Partial removal of penis	9.96	NA	4.67	0.68	NA	15.31	090
54125		A	Removal of penis	13.51	NA	5.82	0.98	NA	20.31	090
54130		A	Remove penis & nodes	20.11	NA	8.17	1.51	NA	29.79	090
54135		A	Remove penis & nodes	26.32	NA	10.16	1.86	NA	38.34	090
54150		A	Circumcision	1.81	4.35	0.70	0.16	6.32	2.67	XXX
54152		A	Circumcision	2.31	NA	1.20	0.19	NA	3.70	010
54160		A	Circumcision	2.48	4.14	1.09	0.19	6.81	3.76	010
54161		A	Circumcision	3.27	NA	1.56	0.24	NA	5.07	010
54162		A	Lysis penil circumic lesion	3.00	4.65	1.44	0.22	7.87	4.66	010
54163		A	Repair of circumcision	3.00	NA	2.00	0.22	NA	5.22	010
54164		A	Frenulotomy of penis	2.50	NA	1.83	0.19	NA	4.52	010
54200		A	Treatment of penis lesion	1.06	1.79	0.97	0.08	2.93	2.11	010
54205		A	Treatment of penis lesion	7.92	NA	4.68	0.56	NA	13.16	090
54220		A	Treatment of penis lesion	2.42	3.84	0.95	0.18	6.44	3.55	000
54230		A	Prepare penis study	1.34	1.08	0.63	0.09	2.51	2.06	000
54231		A	Dynamic cavernosometry	2.04	1.37	0.87	0.16	3.57	3.07	000
54235		A	Penile injection	1.19	0.96	0.58	0.09	2.24	1.86	000
54240		A	Penis study	1.31	1.03	NA	0.16	2.50	NA	000
54240	26	A	Penis study	1.31	0.43	0.43	0.10	1.84	1.84	000
54240	TC	A	Penis study	0.00	0.60	NA	0.06	0.66	NA	000
54250		A	Penis study	2.22	0.91	NA	0.18	3.31	NA	000
54250	26	A	Penis study	2.22	0.71	0.71	0.16	3.09	3.09	000
54250	TC	A	Penis study	0.00	0.20	NA	0.02	0.22	NA	000
54300		A	Revision of penis	10.39	NA	5.56	0.76	NA	16.71	090
54304		A	Revision of penis	12.47	NA	6.32	0.87	NA	19.66	090
54308		A	Reconstruction of urethra	11.81	NA	5.95	0.84	NA	18.60	090
54312		A	Reconstruction of urethra	13.55	NA	6.98	1.23	NA	21.76	090
54316		A	Reconstruction of urethra	16.79	NA	7.94	1.21	NA	25.94	090
54318		A	Reconstruction of urethra	11.23	NA	5.78	1.39	NA	18.40	090
54322		A	Reconstruction of urethra	12.99	NA	6.45	0.92	NA	20.36	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
54324		A	Reconstruction of urethra	16.29	NA	7.95	1.13	NA	25.37	090
54326		A	Reconstruction of urethra	15.70	NA	7.77	1.11	NA	24.58	090
54328		A	Revise penis/urethra	15.63	NA	7.24	0.97	NA	23.84	090
54332		A	Revise penis/urethra	17.05	NA	7.72	1.20	NA	25.97	090
54336		A	Revise penis/urethra	20.01	NA	10.28	2.19	NA	32.48	090
54340		A	Secondary urethral surgery	8.90	NA	5.03	0.63	NA	14.56	090
54344		A	Secondary urethral surgery	15.92	NA	7.74	1.53	NA	25.19	090
54348		A	Secondary urethral surgery	17.12	NA	8.34	1.23	NA	26.69	090
54352		A	Reconstruct urethra/penis	24.70	NA	11.17	2.22	NA	38.09	090
54360		A	Penis plastic surgery	11.91	NA	6.02	0.85	NA	18.78	090
54380		A	Repair penis	13.16	NA	6.60	0.93	NA	20.69	090
54385		A	Repair penis	15.37	NA	8.25	0.86	NA	24.48	090
54390		A	Repair penis and bladder	21.58	NA	9.40	1.54	NA	32.52	090
54400		A	Insert semi-rigid prosthesis	8.98	NA	4.34	0.64	NA	13.96	090
54401		A	Insert self-contd prosthesis	10.26	NA	5.72	0.73	NA	16.71	090
54405		A	Insert multi-comp penis pros	13.41	NA	5.91	0.95	NA	20.27	090
54406		A	Remove muti-comp penis pros	12.08	NA	5.41	0.86	NA	18.35	090
54408		A	Repair multi-comp penis pros	12.73	NA	5.72	0.91	NA	19.36	090
54410		A	Remove/replace penis prosth	15.48	NA	6.61	1.10	NA	23.19	090
54411		A	Remov/replc penis pros, comp	15.98	NA	7.03	1.12	NA	24.13	090
54415		A	Remove self-contd penis pros	8.19	NA	4.19	0.58	NA	12.96	090
54416		A	Remv/repl penis contain pros	10.85	NA	5.36	0.77	NA	16.98	090
54417		A	Remv/replc penis pros, compl	14.17	NA	6.16	1.00	NA	21.33	090
54420		A	Revision of penis	11.40	NA	5.56	0.80	NA	17.76	090
54430		A	Revision of penis	10.13	NA	5.10	0.72	NA	15.95	090
54435		A	Revision of penis	6.11	NA	3.61	0.44	NA	10.16	090
54440		C	Repair of penis	0.00	0.00	0.00	0.00	0.00	0.00	090
54450		A	Preputial stretching	1.12	0.95	0.44	0.08	2.15	1.64	000
54500		A	Biopsy of testis	1.31	0.61	0.56	0.09	2.01	1.96	000
54505		A	Biopsy of testis	3.45	NA	1.91	0.27	NA	5.63	010
54512		A	Excise lesion testis	8.57	NA	4.12	0.68	NA	13.37	090
54520		A	Removal of testis	5.22	NA	2.78	0.50	NA	8.50	090
54522		A	Orchiectomy, partial	9.49	NA	4.86	0.89	NA	15.24	090
54530		A	Removal of testis	8.57	NA	4.23	0.66	NA	13.46	090
54535		A	Extensive testis surgery	12.14	NA	5.53	0.98	NA	18.65	090
54550		A	Exploration for testis	7.77	NA	3.80	0.59	NA	12.16	090
54560		A	Exploration for testis	11.11	NA	5.15	0.90	NA	17.16	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
54600		A	Reduce testis torsion	7.00	NA	3.54	0.52	NA	11.06	090
54620		A	Suspension of testis	4.89	NA	2.43	0.37	NA	7.69	010
54640		A	Suspension of testis	6.89	NA	3.73	0.63	NA	11.25	090
54650		A	Orchiopexy (Fowler-Stephens)	11.43	NA	5.39	1.15	NA	17.97	090
54660		A	Revision of testis	5.10	NA	2.99	0.44	NA	8.53	090
54670		A	Repair testis injury	6.40	NA	3.53	0.46	NA	10.39	090
54680		A	Relocation of testis(es)	12.63	NA	6.14	1.16	NA	19.93	090
54690		A	Laparoscopy, orchiectomy	10.94	NA	4.93	1.01	NA	16.88	090
54692		A	Laparoscopy, orchiopexy	12.86	NA	5.42	1.30	NA	19.58	090
54699		C	Laparoscope proc, testis	0.00	0.00	0.00	0.00	0.00	0.00	YYY
54700		A	Drainage of scrotum	3.42	NA	1.93	0.28	NA	5.63	010
54800		A	Biopsy of epididymis	2.33	0.94	0.90	0.23	3.50	3.46	000
54820		A	Exploration of epididymis	5.13	NA	2.93	0.40	NA	8.46	090
54830		A	Remove epididymis lesion	5.37	NA	3.01	0.41	NA	8.79	090
54840		A	Remove epididymis lesion	5.19	NA	2.77	0.38	NA	8.34	090
54860		A	Removal of epididymis	6.31	NA	3.30	0.45	NA	10.06	090
54861		A	Removal of epididymis	8.89	NA	4.30	0.63	NA	13.82	090
54900		A	Fusion of spermatic ducts	13.18	NA	5.78	0.93	NA	19.89	090
54901		A	Fusion of spermatic ducts	17.91	NA	7.51	1.81	NA	27.23	090
55000		A	Drainage of hydrocele	1.43	2.06	0.65	0.11	3.60	2.19	000
55040		A	Removal of hydrocele	5.35	NA	2.89	0.43	NA	8.67	090
55041		A	Removal of hydroceles	7.73	NA	3.96	0.60	NA	12.29	090
55060		A	Repair of hydrocele	5.51	NA	3.07	0.46	NA	9.04	090
55100		A	Drainage of scrotum abscess	2.13	3.67	1.56	0.17	5.97	3.86	010
55110		A	Explore scrotum	5.69	NA	3.12	0.43	NA	9.24	090
55120		A	Removal of scrotum lesion	5.08	NA	2.94	0.39	NA	8.41	090
55150		A	Removal of scrotum	7.21	NA	3.83	0.57	NA	11.61	090
55175		A	Revision of scrotum	5.23	NA	3.00	0.39	NA	8.62	090
55180		A	Revision of scrotum	10.70	NA	5.35	0.90	NA	16.95	090
55200		A	Incision of sperm duct	4.23	12.31	2.37	0.32	16.86	6.92	090
55250		A	Removal of sperm duct(s)	3.29	11.47	2.21	0.26	15.02	5.76	090
55300		A	Prepare, sperm duct x-ray	3.50	NA	1.31	0.25	NA	5.06	000
55400		A	Repair of sperm duct	8.48	NA	4.05	0.64	NA	13.17	090
55450		A	Ligation of sperm duct	4.11	6.99	1.86	0.29	11.39	6.26	010
55500		A	Removal of hydrocele	5.58	NA	3.08	0.56	NA	9.22	090
55520		A	Removal of sperm cord lesion	6.02	NA	3.24	0.74	NA	10.00	090
55530		A	Revise spermatic cord veins	5.65	NA	3.00	0.45	NA	9.10	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
55535		A	Revise spermatic cord veins	6.55	NA	3.39	0.49	NA	10.43	090
55540		A	Revise hernia & sperm veins	7.66	NA	3.79	0.94	NA	12.39	090
55550		A	Laparo ligate spermatic vein	6.56	NA	3.29	0.57	NA	10.42	090
55559		C	Laparo proc, spermatic cord	0.00	0.00	0.00	0.00	0.00	0.00	YYY
55600		A	Incise sperm duct pouch	6.37	NA	3.32	0.63	NA	10.32	090
55605		A	Incise sperm duct pouch	7.95	NA	4.28	0.64	NA	12.87	090
55650		A	Remove sperm duct pouch	11.78	NA	5.26	0.96	NA	18.00	090
55680		A	Remove sperm pouch lesion	5.18	NA	2.96	0.47	NA	8.61	090
55700		A	Biopsy of prostate	1.57	4.19	0.64	0.11	5.87	2.32	000
55705		A	Biopsy of prostate	4.56	NA	2.29	0.33	NA	7.18	010
55720		A	Drainage of prostate abscess	7.63	NA	3.81	0.94	NA	12.38	090
55725		A	Drainage of prostate abscess	8.67	NA	4.48	0.70	NA	13.85	090
55801		A	Removal of prostate	17.77	NA	7.60	1.34	NA	26.71	090
55810		A	Extensive prostate surgery	22.55	NA	8.92	1.59	NA	33.06	090
55812		A	Extensive prostate surgery	27.47	NA	10.96	2.03	NA	40.46	090
55815		A	Extensive prostate surgery	30.41	NA	11.87	2.16	NA	44.44	090
55821		A	Removal of prostate	14.23	NA	6.19	1.01	NA	21.43	090
55831		A	Removal of prostate	15.60	NA	6.64	1.11	NA	23.35	090
55840		A	Extensive prostate surgery	22.66	NA	9.26	1.61	NA	33.53	090
55842		A	Extensive prostate surgery	24.34	NA	9.82	1.70	NA	35.86	090
55845		A	Extensive prostate surgery	28.51	NA	10.91	2.02	NA	41.44	090
55859		A	Percut/needle insert, pros	12.50	NA	5.83	0.87	NA	19.20	090
55860		A	Surgical exposure, prostate	14.43	NA	6.39	1.02	NA	21.84	090
55862		A	Extensive prostate surgery	18.36	NA	7.83	1.48	NA	27.67	090
55865		A	Extensive prostate surgery	22.84	NA	9.24	1.61	NA	33.69	090
55866		A	Laparo radical prostatectomy	30.69	NA	11.70	2.15	NA	44.54	090
55870		A	Electroejaculation	2.58	1.53	1.08	0.16	4.27	3.82	000
55873		A	Cryoablate prostate	19.44	NA	8.93	1.37	NA	29.74	090
55899		C	Genital surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
55970		N	Sex transformation, M to F	0.00	0.00	0.00	0.00	0.00	0.00	XXX
55980		N	Sex transformation, F to M	0.00	0.00	0.00	0.00	0.00	0.00	XXX
56405		A	I & D of vulva/perineum	1.44	1.33	1.14	0.17	2.94	2.75	010
56420		A	Drainage of gland abscess	1.39	2.27	1.04	0.16	3.82	2.59	010
56440		A	Surgery for vulva lesion	2.84	NA	1.71	0.34	NA	4.89	010
56441		A	Lysis of labial lesion(s)	1.97	1.81	1.41	0.20	3.98	3.58	010
56501		A	Destroy, vulva lesions, sim	1.53	1.78	1.24	0.17	3.48	2.94	010
56515		A	Destroy vulva lesion/s compl	2.76	2.54	1.81	0.32	5.62	4.89	010

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
56605		A	Biopsy of vulva/perineum	1.10	1.07	0.46	0.13	2.30	1.69	000
56606		A	Biopsy of vulva/perineum	0.55	0.49	0.22	0.07	1.11	0.84	ZZZ
56620		A	Partial removal of vulva	7.46	NA	4.79	0.89	NA	13.14	090
56625		A	Complete removal of vulva	8.39	NA	5.31	1.00	NA	14.70	090
56630		A	Extensive vulva surgery	12.34	NA	6.83	1.47	NA	20.64	090
56631		A	Extensive vulva surgery	16.18	NA	8.80	1.92	NA	26.90	090
56632		A	Extensive vulva surgery	20.26	NA	9.51	2.33	NA	32.10	090
56633		A	Extensive vulva surgery	16.45	NA	8.59	1.93	NA	26.97	090
56634		A	Extensive vulva surgery	17.85	NA	9.42	2.14	NA	29.41	090
56637		A	Extensive vulva surgery	21.94	NA	11.06	2.54	NA	35.54	090
56640		A	Extensive vulva surgery	22.14	NA	10.61	2.80	NA	35.55	090
56700		A	Partial removal of hymen	2.52	NA	1.83	0.30	NA	4.65	010
56720		A	Incision of hymen	0.68	NA	0.51	0.08	NA	1.27	000
56740		A	Remove vagina gland lesion	4.56	NA	2.56	0.54	NA	7.66	010
56800		A	Repair of vagina	3.88	NA	2.19	0.44	NA	6.51	010
56805		A	Repair clitoris	18.83	NA	9.41	2.13	NA	30.37	090
56810		A	Repair of perineum	4.12	NA	2.29	0.48	NA	6.89	010
56820		A	Exam of vulva w/scope	1.50	1.31	0.65	0.18	2.99	2.33	000
56821		A	Exam/biopsy of vulva w/scope	2.05	1.75	0.91	0.24	4.04	3.20	000
57000		A	Exploration of vagina	2.97	NA	1.72	0.31	NA	5.00	010
57010		A	Drainage of pelvic abscess	6.02	NA	3.80	0.68	NA	10.50	090
57020		A	Drainage of pelvic fluid	1.50	0.94	0.59	0.17	2.61	2.26	000
57022		A	I & d vaginal hematoma, pp	2.56	NA	1.49	0.26	NA	4.31	010
57023		A	I & d vag hematoma, non-ob	4.74	NA	2.57	0.55	NA	7.86	010
57061		A	Destroy vag lesions, simple	1.25	1.65	1.12	0.15	3.05	2.52	010
57065		A	Destroy vag lesions, complex	2.61	2.29	1.67	0.31	5.21	4.59	010
57100		A	Biopsy of vagina	1.20	1.08	0.48	0.14	2.42	1.82	000
57105		A	Biopsy of vagina	1.69	1.79	1.42	0.20	3.68	3.31	010
57106		A	Remove vagina wall, partial	6.35	NA	4.18	0.73	NA	11.26	090
57107		A	Remove vagina tissue, part	22.97	NA	10.46	2.65	NA	36.08	090
57109		A	Vaginectomy partial w/nodes	26.96	NA	11.24	3.14	NA	41.34	090
57110		A	Remove vagina wall, complete	14.27	NA	7.27	1.69	NA	23.23	090
57111		A	Remove vagina tissue, compl	26.96	NA	12.61	3.16	NA	42.73	090
57112		A	Vaginectomy w/nodes, compl	28.96	NA	12.09	3.04	NA	44.09	090
57120		A	Closure of vagina	7.40	NA	4.60	0.87	NA	12.87	090
57130		A	Remove vagina lesion	2.43	2.15	1.54	0.29	4.87	4.26	010
57135		A	Remove vagina lesion	2.67	2.26	1.65	0.31	5.24	4.63	010

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
57150		A	Treat vagina infection	0.55	1.10	0.21	0.06	1.71	0.82	000
57155		A	Insert uteri tandems/ovoids	6.26	NA	4.56	0.43	NA	11.25	090
57160		A	Insert pessary/other device	0.89	1.01	0.34	0.10	2.00	1.33	000
57170		A	Fitting of diaphragm/cap	0.91	1.48	0.33	0.11	2.50	1.35	000
57180		A	Treat vaginal bleeding	1.58	2.16	1.26	0.18	3.92	3.02	010
57200		A	Repair of vagina	3.93	NA	2.89	0.45	NA	7.27	090
57210		A	Repair vagina/perineum	5.16	NA	3.43	0.61	NA	9.20	090
57220		A	Revision of urethra	4.30	NA	3.10	0.50	NA	7.90	090
57230		A	Repair of urethral lesion	5.63	NA	3.40	0.55	NA	9.58	090
57240		A	Repair bladder & vagina	6.06	NA	3.81	0.62	NA	10.49	090
57250		A	Repair rectum & vagina	5.52	NA	3.57	0.65	NA	9.74	090
57260		A	Repair of vagina	8.26	NA	4.83	0.97	NA	14.06	090
57265		A	Extensive repair of vagina	11.32	NA	6.03	1.32	NA	18.67	090
57267		A	Insert mesh/pelvic flr addon	4.88	NA	1.97	0.64	NA	7.49	ZZZ
57268		A	Repair of bowel bulge	6.75	NA	4.19	0.78	NA	11.72	090
57270		A	Repair of bowel pouch	12.09	NA	6.24	1.41	NA	19.74	090
57280		A	Suspension of vagina	15.02	NA	7.36	1.66	NA	24.04	090
57282		A	Colpopexy, extraperitoneal	6.86	NA	4.50	1.02	NA	12.38	090
57283		A	Colpopexy, intraperitoneal	10.84	NA	5.91	1.02	NA	17.77	090
57284		A	Repair paravaginal defect	12.68	NA	7.14	1.41	NA	21.23	090
57287		A	Revise/remove sling repair	10.69	NA	5.47	0.91	NA	17.07	090
57288		A	Repair bladder defect	13.00	NA	5.90	1.12	NA	20.02	090
57289		A	Repair bladder & vagina	11.56	NA	6.03	1.21	NA	18.80	090
57291		A	Construction of vagina	7.94	NA	4.92	0.93	NA	13.79	090
57292		A	Construct vagina with graft	13.07	NA	6.93	1.56	NA	21.56	090
57300		A	Repair rectum-vagina fistula	7.60	NA	4.28	0.86	NA	12.74	090
57305		A	Repair rectum-vagina fistula	13.75	NA	6.26	1.69	NA	21.70	090
57307		A	Fistula repair & colostomy	15.91	NA	6.99	1.92	NA	24.82	090
57308		A	Fistula repair, transperine	9.93	NA	5.09	1.13	NA	16.15	090
57310		A	Repair urethrovaginal lesion	6.77	NA	3.83	0.54	NA	11.14	090
57311		A	Repair urethrovaginal lesion	7.97	NA	4.11	0.65	NA	12.73	090
57320		A	Repair bladder-vagina lesion	8.00	NA	4.36	0.68	NA	13.04	090
57330		A	Repair bladder-vagina lesion	12.33	NA	5.70	1.06	NA	19.09	090
57335		A	Repair vagina	18.70	NA	9.02	1.89	NA	29.61	090
57400		A	Dilation of vagina	2.27	NA	1.11	0.25	NA	3.63	000
57410		A	Pelvic examination	1.75	2.01	0.89	0.17	3.93	2.81	000
57415		A	Remove vaginal foreign body	2.17	NA	1.42	0.24	NA	3.83	010

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
57420		A	Exam of vagina w/scope	1.60	1.35	0.67	0.18	3.13	2.45	000
57421		A	Exam/biopsy of vag w/scope	2.20	1.84	0.96	0.26	4.30	3.42	000
57425		A	Laparoscopy, surg, colpopexy	15.73	NA	6.63	1.74	NA	24.10	090
57452		A	Exam of cervix w/scope	1.50	1.28	0.76	0.17	2.95	2.43	000
57454		A	Bx/curett of cervix w/scope	2.33	1.64	1.15	0.28	4.25	3.76	000
57455		A	Biopsy of cervix w/scope	1.99	1.72	0.87	0.24	3.95	3.10	000
57456		A	Endocerv curettage w/scope	1.85	1.65	0.82	0.22	3.72	2.89	000
57460		A	Bx of cervix w/scope, leep	2.83	5.84	1.38	0.34	9.01	4.55	000
57461		A	Conz of cervix w/scope, leep	3.43	6.10	1.47	0.41	9.94	5.31	000
57500		A	Biopsy of cervix	0.97	2.54	0.63	0.11	3.62	1.71	000
57505		A	Endocervical curettage	1.14	1.46	1.10	0.13	2.73	2.37	010
57510		A	Cauterization of cervix	1.90	1.56	1.04	0.22	3.68	3.16	010
57511		A	Cryocautery of cervix	1.90	1.82	1.37	0.22	3.94	3.49	010
57513		A	Laser surgery of cervix	1.90	1.72	1.40	0.23	3.85	3.53	010
57520		A	Conization of cervix	4.03	3.93	2.87	0.48	8.44	7.38	090
57522		A	Conization of cervix	3.35	3.15	2.45	0.40	6.90	6.20	090
57530		A	Removal of cervix	4.78	NA	3.38	0.58	NA	8.74	090
57531		A	Removal of cervix, radical	27.96	NA	13.16	3.31	NA	44.43	090
57540		A	Removal of residual cervix	12.20	NA	6.23	1.48	NA	19.91	090
57545		A	Remove cervix/repair pelvis	13.01	NA	6.67	1.51	NA	21.19	090
57550		A	Removal of residual cervix	5.52	NA	3.82	0.66	NA	10.00	090
57555		A	Remove cervix/repair vagina	8.94	NA	5.08	1.07	NA	15.09	090
57556		A	Remove cervix, repair bowel	8.36	NA	4.85	0.93	NA	14.14	090
57700		A	Revision of cervix	3.54	NA	3.10	0.41	NA	7.05	090
57720		A	Revision of cervix	4.12	NA	3.10	0.48	NA	7.70	090
57800		A	Dilation of cervical canal	0.77	0.76	0.47	0.09	1.62	1.33	000
57820		A	D & c of residual cervix	1.67	1.47	1.14	0.20	3.34	3.01	010
58100		A	Biopsy of uterus lining	1.53	1.32	0.72	0.18	3.03	2.43	000
58120		A	Dilation and curettage	3.27	2.30	1.87	0.39	5.96	5.53	010
58140		A	Myomectomy abdom method	14.58	NA	7.10	1.78	NA	23.46	090
58145		A	Myomectomy vag method	8.03	NA	4.79	0.96	NA	13.78	090
58146		A	Myomectomy abdom complex	18.97	NA	9.00	2.27	NA	30.24	090
58150		A	Total hysterectomy	15.22	NA	7.48	1.81	NA	24.51	090
58152		A	Total hysterectomy	20.57	NA	9.85	2.41	NA	32.83	090
58180		A	Partial hysterectomy	15.27	NA	7.45	1.64	NA	24.36	090
58200		A	Extensive hysterectomy	21.56	NA	9.99	2.49	NA	34.04	090
58210		A	Extensive hysterectomy	28.81	NA	13.19	3.30	NA	45.30	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
58240		A	Removal of pelvis contents	38.33	NA	17.61	4.15	NA	60.09	090
58260		A	Vaginal hysterectomy	12.96	NA	6.69	1.55	NA	21.20	090
58262		A	Vag hyst including t/o	14.75	NA	7.38	1.77	NA	23.90	090
58263		A	Vag hyst w/t/o & vag repair	16.04	NA	7.88	1.92	NA	25.84	090
58267		A	Vag hyst w/urinary repair	17.01	NA	8.37	2.04	NA	27.42	090
58270		A	Vag hyst w/enterocele repair	14.24	NA	7.06	1.70	NA	23.00	090
58275		A	Hysterectomy/revise vagina	15.74	NA	7.77	1.86	NA	25.37	090
58280		A	Hysterectomy/revise vagina	16.98	NA	8.25	1.99	NA	27.22	090
58285		A	Extensive hysterectomy	22.23	NA	9.94	2.68	NA	34.85	090
58290		A	Vag hyst complex	18.97	NA	9.12	2.28	NA	30.37	090
58291		A	Vag hyst incl t/o, complex	20.76	NA	9.87	2.48	NA	33.11	090
58292		A	Vag hyst t/o & repair, compl	22.05	NA	10.36	2.67	NA	35.08	090
58293		A	Vag hyst w/uro repair, compl	23.03	NA	10.65	2.75	NA	36.43	090
58294		A	Vag hyst w/enterocele, compl	20.25	NA	9.55	2.32	NA	32.12	090
58300		N	Insert intrauterine device	+1.01	1.42	0.38	0.12	2.55	1.51	XXX
58301		A	Remove intrauterine device	1.27	1.32	0.48	0.15	2.74	1.90	000
58321		A	Artificial insemination	0.92	1.15	0.37	0.10	2.17	1.39	000
58322		A	Artificial insemination	1.10	1.20	0.42	0.13	2.43	1.65	000
58323		A	Sperm washing	0.23	0.53	0.09	0.03	0.79	0.35	000
58340		A	Catheter for hysterography	0.88	3.16	0.65	0.09	4.13	1.62	000
58345		A	Reopen fallopian tube	4.65	NA	2.43	0.41	NA	7.49	010
58346		A	Insert heyman uteri capsule	6.74	NA	3.92	0.58	NA	11.24	090
58350		A	Reopen fallopian tube	1.01	1.49	0.92	0.12	2.62	2.05	010
58353		A	Endometr ablate, thermal	3.55	35.66	2.05	0.42	39.63	6.02	010
58356		A	Endometrial cryoablation	6.36	6.84	2.65	0.82	14.02	9.83	010
58400		A	Suspension of uterus	6.35	NA	3.93	0.74	NA	11.02	090
58410		A	Suspension of uterus	12.71	NA	6.43	1.45	NA	20.59	090
58520		A	Repair of ruptured uterus	11.90	NA	6.03	1.47	NA	19.40	090
58540		A	Revision of uterus	14.62	NA	6.95	1.76	NA	23.33	090
58545		A	Laparoscopic myomectomy	14.58	NA	7.18	1.76	NA	23.52	090
58546		A	Laparo-myomectomy, complex	18.97	NA	8.91	2.28	NA	30.16	090
58550		A	Laparo-asst vag hysterectomy	14.17	NA	7.29	1.70	NA	23.16	090
58552		A	Laparo-vag hyst incl t/o	15.98	NA	8.01	1.70	NA	25.69	090
58553		A	Laparo-vag hyst, complex	18.97	NA	8.91	2.29	NA	30.17	090
58554		A	Laparo-vag hyst w/t/o, compl	21.97	NA	10.39	2.24	NA	34.60	090
58555		A	Hysteroscopy, dx, sep proc	3.33	2.19	1.55	0.40	5.92	5.28	000
58558		A	Hysteroscopy, biopsy	4.74	NA	2.17	0.57	NA	7.48	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
58559		A	Hysteroscopy, lysis	6.16	NA	2.73	0.73	NA	9.62	000
58560		A	Hysteroscopy, resect septum	6.99	NA	3.08	0.83	NA	10.90	000
58561		A	Hysteroscopy, remove myoma	9.99	NA	4.28	1.19	NA	15.46	000
58562		A	Hysteroscopy, remove fb	5.20	NA	2.35	0.62	NA	8.17	000
58563		A	Hysteroscopy, ablation	6.16	56.19	2.75	0.74	63.09	9.65	000
58565		A	Hysteroscopy, sterilization	7.02	49.56	3.90	1.19	57.77	12.11	090
58578		C	Laparo proc, uterus	0.00	0.00	0.00	0.00	0.00	0.00	YYY
58579		C	Hysteroscope procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
58600		A	Division of fallopian tube	5.59	NA	3.33	0.65	NA	9.57	090
58605		A	Division of fallopian tube	4.99	NA	3.11	0.59	NA	8.69	090
58611		A	Ligate oviduct(s) add-on	1.45	NA	0.57	0.17	NA	2.19	ZZZ
58615		A	Occlude fallopian tube(s)	3.89	NA	2.70	0.47	NA	7.06	010
58660		A	Laparoscopy, lysis	11.27	NA	5.25	1.38	NA	17.90	090
58661		A	Laparoscopy, remove adnexa	11.03	NA	5.12	1.33	NA	17.48	010
58662		A	Laparoscopy, excise lesions	11.77	NA	5.78	1.42	NA	18.97	090
58670		A	Laparoscopy, tubal cautery	5.59	NA	3.27	0.67	NA	9.53	090
58671		A	Laparoscopy, tubal block	5.59	NA	3.27	0.67	NA	9.53	090
58672		A	Laparoscopy, fimbrioplasty	12.86	NA	6.18	1.58	NA	20.62	090
58673		A	Laparoscopy, salpingostomy	13.72	NA	6.57	1.66	NA	21.95	090
58679		C	Laparo proc, oviduct-ovary	0.00	0.00	0.00	0.00	0.00	0.00	YYY
58700		A	Removal of fallopian tube	12.03	NA	5.98	1.50	NA	19.51	090
58720		A	Removal of ovary/tube(s)	11.34	NA	5.77	1.37	NA	18.48	090
58740		A	Revise fallopian tube(s)	13.98	NA	7.13	1.67	NA	22.78	090
58750		A	Repair oviduct	14.82	NA	7.36	1.83	NA	24.01	090
58752		A	Revise ovarian tube(s)	14.82	NA	6.94	1.78	NA	23.54	090
58760		A	Remove tubal obstruction	13.11	NA	6.71	1.78	NA	21.60	090
58770		A	Create new tubal opening	13.95	NA	6.90	1.72	NA	22.57	090
58800		A	Drainage of ovarian cyst(s)	4.13	3.64	2.90	0.42	8.19	7.45	090
58805		A	Drainage of ovarian cyst(s)	5.87	NA	3.50	0.66	NA	10.03	090
58820		A	Drain ovary abscess, open	4.21	NA	3.29	0.52	NA	8.02	090
58822		A	Drain ovary abscess, percut	10.11	NA	5.21	1.15	NA	16.47	090
58823		A	Drain pelvic abscess, percut	3.37	21.32	1.12	0.25	24.94	4.74	000
58825		A	Transposition, ovary(s)	10.96	NA	5.79	1.32	NA	18.07	090
58900		A	Biopsy of ovary(s)	5.98	NA	3.57	0.68	NA	10.23	090
58920		A	Partial removal of ovary(s)	11.34	NA	5.57	1.41	NA	18.32	090
58925		A	Removal of ovarian cyst(s)	11.34	NA	5.68	1.39	NA	18.41	090
58940		A	Removal of ovary(s)	7.28	NA	4.10	0.89	NA	12.27	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
58943		A	Removal of ovary(s)	18.40	NA	8.64	2.20	NA	29.24	090
58950		A	Resect ovarian malignancy	16.90	NA	8.40	2.01	NA	27.31	090
58951		A	Resect ovarian malignancy	22.35	NA	10.44	2.59	NA	35.38	090
58952		A	Resect ovarian malignancy	24.97	NA	11.75	2.96	NA	39.68	090
58953		A	Tah, rad dissect for debulk	31.95	NA	14.54	3.75	NA	50.24	090
58954		A	Tah rad debulk/lymph remove	34.95	NA	15.70	4.11	NA	54.76	090
58956		A	Bso, omentectomy w/tah	20.78	NA	10.31	3.98	NA	35.07	090
58960		A	Exploration of abdomen	14.63	NA	7.35	1.76	NA	23.74	090
58970		A	Retrieval of oocyte	3.52	2.31	1.49	0.42	6.25	5.43	000
58974		C	Transfer of embryo	0.00	0.00	0.00	0.00	0.00	0.00	000
58976		A	Transfer of embryo	3.82	2.68	1.82	0.47	6.97	6.11	000
58999		C	Genital surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
59000		A	Amniocentesis, diagnostic	1.30	2.07	0.67	0.31	3.68	2.28	000
59001		A	Amniocentesis, therapeutic	3.00	NA	1.41	0.71	NA	5.12	000
59012		A	Fetal cord puncture,prenatal	3.44	NA	1.54	0.81	NA	5.79	000
59015		A	Chorion biopsy	2.20	1.55	1.04	0.52	4.27	3.76	000
59020		A	Fetal contract stress test	0.66	0.78	NA	0.26	1.70	NA	000
59020	26	A	Fetal contract stress test	0.66	0.26	0.26	0.16	1.08	1.08	000
59020	TC	A	Fetal contract stress test	0.00	0.52	NA	0.10	0.62	NA	000
59025		A	Fetal non-stress test	0.53	0.44	NA	0.14	1.11	NA	000
59025	26	A	Fetal non-stress test	0.53	0.21	0.21	0.12	0.86	0.86	000
59025	TC	A	Fetal non-stress test	0.00	0.23	NA	0.02	0.25	NA	000
59030		A	Fetal scalp blood sample	1.99	NA	0.77	0.47	NA	3.23	000
59050		A	Fetal monitor w/report	0.89	NA	0.35	0.21	NA	1.45	XXX
59051		A	Fetal monitor/interpret only	0.74	NA	0.29	0.17	NA	1.20	XXX
59070		A	Transabdom amnioinfus w/us	5.24	5.15	2.31	0.28	10.67	7.83	000
59072		A	Umbilical cord occlud w/us	8.99	NA	3.12	0.16	NA	12.27	000
59074		A	Fetal fluid drainage w/us	5.24	4.57	2.31	0.28	10.09	7.83	000
59076		A	Fetal shunt placement, w/us	8.99	NA	3.12	0.16	NA	12.27	000
59100		A	Remove uterus lesion	12.33	NA	6.45	2.91	NA	21.69	090
59120		A	Treat ectopic pregnancy	11.47	NA	6.24	2.66	NA	20.37	090
59121		A	Treat ectopic pregnancy	11.65	NA	6.32	2.75	NA	20.72	090
59130		A	Treat ectopic pregnancy	14.20	NA	4.79	3.35	NA	22.34	090
59135		A	Treat ectopic pregnancy	13.86	NA	7.22	3.27	NA	24.35	090
59136		A	Treat ectopic pregnancy	13.16	NA	6.60	3.11	NA	22.87	090
59140		A	Treat ectopic pregnancy	5.45	2.21	2.21	1.29	8.95	8.95	090
59150		A	Treat ectopic pregnancy	11.65	NA	5.99	2.75	NA	20.39	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
59151		A	Treat ectopic pregnancy	11.47	NA	6.05	2.71	NA	20.23	090
59160		A	D & c after delivery	2.71	3.29	2.13	0.64	6.64	5.48	010
59200		A	Insert cervical dilator	0.79	1.19	0.30	0.19	2.17	1.28	000
59300		A	Episiotomy or vaginal repair	2.41	2.17	0.96	0.57	5.15	3.94	000
59320		A	Revision of cervix	2.48	NA	1.24	0.58	NA	4.30	000
59325		A	Revision of cervix	4.06	NA	1.89	0.88	NA	6.83	000
59350		A	Repair of uterus	4.94	NA	1.87	1.17	NA	7.98	000
59400		A	Obstetrical care	23.03	NA	15.32	5.43	NA	43.78	MMM
59409		A	Obstetrical care	13.48	NA	5.30	3.18	NA	21.96	MMM
59410		A	Obstetrical care	14.76	NA	6.30	3.48	NA	24.54	MMM
59412		A	Antepartum manipulation	1.71	NA	0.81	0.40	NA	2.92	MMM
59414		A	Deliver placenta	1.61	NA	0.64	0.38	NA	2.63	MMM
59425		A	Antepartum care only	4.80	4.20	1.85	1.13	10.13	7.78	MMM
59426		A	Antepartum care only	8.27	7.54	3.22	1.95	17.76	13.44	MMM
59430		A	Care after delivery	2.13	1.23	0.94	0.50	3.86	3.57	MMM
59510		A	Cesarean delivery	26.18	NA	17.26	6.18	NA	49.62	MMM
59514		A	Cesarean delivery only	15.95	NA	6.21	3.76	NA	25.92	MMM
59515		A	Cesarean delivery	17.34	NA	7.83	4.09	NA	29.26	MMM
59525		A	Remove uterus after cesarean	8.53	NA	3.30	1.93	NA	13.76	ZZZ
59610		A	Vbac delivery	24.58	NA	15.86	5.80	NA	46.24	MMM
59612		A	Vbac delivery only	15.04	NA	6.05	3.55	NA	24.64	MMM
59614		A	Vbac care after delivery	16.32	NA	6.93	3.85	NA	27.10	MMM
59618		A	Attempted vbac delivery	27.74	NA	18.23	6.54	NA	52.51	MMM
59620		A	Attempted vbac delivery only	17.50	NA	6.76	4.13	NA	28.39	MMM
59622		A	Attempted vbac after care	18.90	NA	8.63	4.46	NA	31.99	MMM
59812		A	Treatment of miscarriage	4.00	NA	2.54	0.94	NA	7.48	090
59820		A	Care of miscarriage	4.00	4.42	3.56	0.94	9.36	8.50	090
59821		A	Treatment of miscarriage	4.46	4.27	3.40	1.05	9.78	8.91	090
59830		A	Treat uterus infection	6.10	NA	3.98	1.44	NA	11.52	090
59840		R	Abortion	3.01	NA	2.12	0.71	NA	5.84	010
59841		R	Abortion	5.23	3.49	2.97	1.23	9.95	9.43	010
59850		R	Abortion	5.90	NA	3.25	1.28	NA	10.43	090
59851		R	Abortion	5.92	NA	3.74	1.28	NA	10.94	090
59852		R	Abortion	8.23	NA	5.04	1.79	NA	15.06	090
59855		R	Abortion	6.11	NA	3.54	1.44	NA	11.09	090
59856		R	Abortion	7.47	NA	4.06	1.76	NA	13.29	090
59857		R	Abortion	9.28	NA	4.71	2.00	NA	15.99	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
59866		R	Abortion (mpr)	3.99	NA	1.89	0.87	NA	6.75	000
59870		A	Evacuate mole of uterus	6.00	NA	4.48	1.42	NA	11.90	090
59871		A	Remove cerclage suture	2.13	1.74	1.13	0.50	4.37	3.76	000
59897		C	Fetal invas px w/us	0.00	0.00	0.00	0.00	0.00	0.00	YYY
59898		C	Laparo proc, ob care/deliver	0.00	0.00	0.00	0.00	0.00	0.00	YYY
59899		C	Maternity care procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
60000		A	Drain thyroid/tongue cyst	1.76	1.92	1.71	0.14	3.82	3.61	010
60001		A	Aspirate/inject thyriod cyst	0.97	1.41	0.33	0.07	2.45	1.37	000
60100		A	Biopsy of thyroid	1.56	1.40	0.53	0.10	3.06	2.19	000
60200		A	Remove thyroid lesion	9.54	NA	5.98	1.01	NA	16.53	090
60210		A	Partial thyroid excision	10.86	NA	5.63	1.23	NA	17.72	090
60212		A	Partial thyroid excision	16.01	NA	7.67	1.92	NA	25.60	090
60220		A	Partial removal of thyroid	11.88	NA	6.14	1.33	NA	19.35	090
60225		A	Partial removal of thyroid	14.17	NA	7.40	1.63	NA	23.20	090
60240		A	Removal of thyroid	16.04	NA	7.58	1.85	NA	25.47	090
60252		A	Removal of thyroid	20.54	NA	10.09	2.31	NA	32.94	090
60254		A	Extensive thyroid surgery	26.95	NA	14.14	2.63	NA	43.72	090
60260		A	Repeat thyroid surgery	17.44	NA	8.64	1.94	NA	28.02	090
60270		A	Removal of thyroid	20.24	NA	10.45	2.28	NA	32.97	090
60271		A	Removal of thyroid	16.80	NA	8.58	1.79	NA	27.17	090
60280		A	Remove thyroid duct lesion	5.86	NA	4.66	0.54	NA	11.06	090
60281		A	Remove thyroid duct lesion	8.52	NA	5.83	0.73	NA	15.08	090
60500		A	Explore parathyroid glands	16.21	NA	7.40	2.00	NA	25.61	090
60502		A	Re-explore parathyroids	20.32	NA	9.35	2.51	NA	32.18	090
60505		A	Explore parathyroid glands	21.46	NA	10.92	2.62	NA	35.00	090
60512		A	Autotransplant parathyroid	4.44	NA	1.62	0.54	NA	6.60	ZZZ
60520		A	Removal of thymus gland	16.78	NA	8.29	2.15	NA	27.22	090
60521		A	Removal of thymus gland	18.84	NA	9.54	2.75	NA	31.13	090
60522		A	Removal of thymus gland	23.06	NA	11.26	3.22	NA	37.54	090
60540		A	Explore adrenal gland	17.00	NA	7.58	1.76	NA	26.34	090
60545		A	Explore adrenal gland	19.85	NA	8.53	2.09	NA	30.47	090
60600		A	Remove carotid body lesion	17.90	NA	10.96	2.19	NA	31.05	090
60605		A	Remove carotid body lesion	20.21	NA	12.25	2.46	NA	34.92	090
60650		A	Laparoscopy adrenalectomy	19.97	NA	7.98	2.27	NA	30.22	090
60659		C	Laparo proc, endocrine	0.00	0.00	0.00	0.00	0.00	0.00	YYY
60699		C	Endocrine surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
61000		A	Remove cranial cavity fluid	1.58	NA	0.95	0.13	NA	2.66	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
61001		A	Remove cranial cavity fluid	1.49	NA	1.06	0.16	NA	2.71	000
61020		A	Remove brain cavity fluid	1.51	NA	1.34	0.29	NA	3.14	000
61026		A	Injection into brain canal	1.69	NA	1.39	0.28	NA	3.36	000
61050		A	Remove brain canal fluid	1.51	NA	1.27	0.11	NA	2.89	000
61055		A	Injection into brain canal	2.10	NA	1.42	0.16	NA	3.68	000
61070		A	Brain canal shunt procedure	0.89	NA	1.01	0.15	NA	2.05	000
61105		A	Twist drill hole	5.13	NA	3.93	1.28	NA	10.34	090
61107		A	Drill skull for implantation	4.99	NA	2.53	1.23	NA	8.75	000
61108		A	Drill skull for drainage	10.17	NA	7.14	2.53	NA	19.84	090
61120		A	Burr hole for puncture	8.75	NA	5.99	1.91	NA	16.65	090
61140		A	Pierce skull for biopsy	15.88	NA	9.88	4.03	NA	29.79	090
61150		A	Pierce skull for drainage	17.54	NA	10.37	4.28	NA	32.19	090
61151		A	Pierce skull for drainage	12.40	NA	7.81	2.97	NA	23.18	090
61154		A	Pierce skull & remove clot	14.97	NA	9.48	4.07	NA	28.52	090
61156		A	Pierce skull for drainage	16.30	NA	9.83	4.05	NA	30.18	090
61210		A	Pierce skull, implant device	5.83	NA	2.91	1.45	NA	10.19	000
61215		A	Insert brain-fluid device	4.88	NA	4.00	1.20	NA	10.08	090
61250		A	Pierce skull & explore	10.40	NA	6.85	2.73	NA	19.98	090
61253		A	Pierce skull & explore	12.34	NA	7.72	2.59	NA	22.65	090
61304		A	Open skull for exploration	21.93	NA	12.83	5.19	NA	39.95	090
61305		A	Open skull for exploration	26.57	NA	15.31	5.78	NA	47.66	090
61312		A	Open skull for drainage	24.53	NA	15.04	6.14	NA	45.71	090
61313		A	Open skull for drainage	24.89	NA	14.80	6.26	NA	45.95	090
61314		A	Open skull for drainage	24.19	NA	13.03	6.12	NA	43.34	090
61315		A	Open skull for drainage	27.64	NA	16.01	6.91	NA	50.56	090
61316		A	Implt cran bone flap to abdo	1.39	NA	0.60	0.34	NA	2.33	ZZZ
61320		A	Open skull for drainage	25.58	NA	14.75	6.24	NA	46.57	090
61321		A	Open skull for drainage	28.46	NA	16.12	6.92	NA	51.50	090
61322		A	Decompressive craniotomy	29.46	NA	15.66	7.26	NA	52.38	090
61323		A	Decompressive lobectomy	30.95	NA	16.08	7.81	NA	54.84	090
61330		A	Decompress eye socket	23.29	NA	13.72	2.34	NA	39.35	090
61332		A	Explore/biopsy eye socket	27.24	NA	15.59	4.61	NA	47.44	090
61333		A	Explore orbit/remove lesion	27.91	NA	15.57	3.81	NA	47.29	090
61334		A	Explore orbit/remove object	18.24	NA	10.63	1.73	NA	30.60	090
61340		A	Subtemporal decompression	18.63	NA	11.12	4.59	NA	34.34	090
61343		A	Incise skull (press relief)	29.73	NA	16.80	7.40	NA	53.93	090
61345		A	Relieve cranial pressure	27.16	NA	15.39	6.68	NA	49.23	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
61440		A	Incise skull for surgery	26.59	NA	14.20	6.83	NA	47.62	090
61450		A	Incise skull for surgery	25.91	NA	14.28	5.73	NA	45.92	090
61458		A	Incise skull for brain wound	27.25	NA	15.51	6.72	NA	49.48	090
61460		A	Incise skull for surgery	28.35	NA	16.41	5.88	NA	50.64	090
61470		A	Incise skull for surgery	26.02	NA	13.85	5.83	NA	45.70	090
61480		A	Incise skull for surgery	26.45	NA	15.27	6.68	NA	48.40	090
61490		A	Incise skull for surgery	25.62	NA	14.32	6.85	NA	46.79	090
61500		A	Removal of skull lesion	17.89	NA	10.80	3.93	NA	32.62	090
61501		A	Remove infected skull bone	14.82	NA	9.20	3.01	NA	27.03	090
61510		A	Removal of brain lesion	28.41	NA	16.69	7.09	NA	52.19	090
61512		A	Remove brain lining lesion	35.04	NA	19.67	8.76	NA	63.47	090
61514		A	Removal of brain abscess	25.22	NA	14.43	6.26	NA	45.91	090
61516		A	Removal of brain lesion	24.57	NA	14.26	6.19	NA	45.02	090
61517		A	Implt brain chemotx add-on	1.38	NA	0.64	0.34	NA	2.36	ZZZ
61518		A	Removal of brain lesion	37.26	NA	21.09	9.30	NA	67.65	090
61519		A	Remove brain lining lesion	41.33	NA	22.64	10.10	NA	74.07	090
61520		A	Removal of brain lesion	54.76	NA	30.32	10.72	NA	95.80	090
61521		A	Removal of brain lesion	44.41	NA	24.21	10.52	NA	79.14	090
61522		A	Removal of brain abscess	29.41	NA	16.41	7.43	NA	53.25	090
61524		A	Removal of brain lesion	27.82	NA	15.66	6.66	NA	50.14	090
61526		A	Removal of brain lesion	52.09	NA	29.48	6.82	NA	88.39	090
61530		A	Removal of brain lesion	43.79	NA	25.05	6.00	NA	74.84	090
61531		A	Implant brain electrodes	14.61	NA	9.12	3.71	NA	27.44	090
61533		A	Implant brain electrodes	19.68	NA	11.53	4.92	NA	36.13	090
61534		A	Removal of brain lesion	20.94	NA	12.08	5.33	NA	38.35	090
61535		A	Remove brain electrodes	11.61	NA	7.42	2.92	NA	21.95	090
61536		A	Removal of brain lesion	35.47	NA	19.78	8.68	NA	63.93	090
61537		A	Removal of brain tissue	24.96	NA	14.74	6.75	NA	46.45	090
61538		A	Removal of brain tissue	26.77	NA	15.31	6.75	NA	48.83	090
61539		A	Removal of brain tissue	32.03	NA	17.76	8.22	NA	58.01	090
61540		A	Removal of brain tissue	29.96	NA	17.24	8.22	NA	55.42	090
61541		A	Incision of brain tissue	28.81	NA	16.20	6.53	NA	51.54	090
61542		A	Removal of brain tissue	30.97	NA	17.82	7.95	NA	56.74	090
61543		A	Removal of brain tissue	29.18	NA	16.38	7.49	NA	53.05	090
61544		A	Remove & treat brain lesion	25.46	NA	13.82	5.92	NA	45.20	090
61545		A	Excision of brain tumor	43.73	NA	24.21	9.92	NA	77.86	090
61546		A	Removal of pituitary gland	31.25	NA	17.49	7.47	NA	56.21	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
61548		A	Removal of pituitary gland	21.50	NA	12.78	3.34	NA	37.62	090
61550		A	Release of skull seams	14.63	NA	6.93	0.98	NA	22.54	090
61552		A	Release of skull seams	19.53	NA	9.11	1.06	NA	29.70	090
61556		A	Incise skull/sutures	22.23	NA	11.36	4.60	NA	38.19	090
61557		A	Incise skull/sutures	22.35	NA	13.62	5.74	NA	41.71	090
61558		A	Excision of skull/sutures	25.54	NA	14.19	1.35	NA	41.08	090
61559		A	Excision of skull/sutures	32.74	NA	19.31	8.40	NA	60.45	090
61563		A	Excision of skull tumor	26.79	NA	15.24	5.11	NA	47.14	090
61564		A	Excision of skull tumor	33.78	NA	18.28	8.67	NA	60.73	090
61566		A	Removal of brain tissue	30.95	NA	17.77	6.75	NA	55.47	090
61567		A	Incision of brain tissue	35.45	NA	20.67	6.49	NA	62.61	090
61570		A	Remove foreign body, brain	24.56	NA	13.91	5.32	NA	43.79	090
61571		A	Incise skull for brain wound	26.35	NA	15.14	6.72	NA	48.21	090
61575		A	Skull base/brainstem surgery	34.31	NA	19.63	5.10	NA	59.04	090
61576		A	Skull base/brainstem surgery	52.35	NA	34.73	5.51	NA	92.59	090
61580		A	Craniofacial approach, skull	30.30	NA	25.58	3.33	NA	59.21	090
61581		A	Craniofacial approach, skull	34.55	NA	23.44	3.87	NA	61.86	090
61582		A	Craniofacial approach, skull	31.61	NA	27.30	6.91	NA	65.82	090
61583		A	Craniofacial approach, skull	36.16	NA	25.11	8.32	NA	69.59	090
61584		A	Orbitocranial approach/skull	34.60	NA	24.52	7.69	NA	66.81	090
61585		A	Orbitocranial approach/skull	38.55	NA	26.49	6.96	NA	72.00	090
61586		A	Resect nasopharynx, skull	25.06	NA	22.58	4.32	NA	51.96	090
61590		A	Infratemporal approach/skull	41.72	NA	28.62	5.18	NA	75.52	090
61591		A	Infratemporal approach/skull	43.61	NA	29.52	5.48	NA	78.61	090
61592		A	Orbitocranial approach/skull	39.58	NA	26.50	9.31	NA	75.39	090
61595		A	Transtemporal approach/skull	29.53	NA	22.35	3.86	NA	55.74	090
61596		A	Transcochlear approach/skull	35.58	NA	24.44	3.36	NA	63.38	090
61597		A	Transcondylar approach/skull	37.90	NA	22.99	8.31	NA	69.20	090
61598		A	Transpetrosal approach/skull	33.36	NA	23.23	5.53	NA	62.12	090
61600		A	Resect/excise cranial lesion	25.81	NA	19.77	3.62	NA	49.20	090
61601		A	Resect/excise cranial lesion	27.85	NA	20.49	6.34	NA	54.68	090
61605		A	Resect/excise cranial lesion	29.29	NA	21.96	2.81	NA	54.06	090
61606		A	Resect/excise cranial lesion	38.77	NA	25.15	8.57	NA	72.49	090
61607		A	Resect/excise cranial lesion	36.22	NA	23.78	6.69	NA	66.69	090
61608		A	Resect/excise cranial lesion	42.04	NA	26.58	9.93	NA	78.55	090
61609		A	Transect artery, sinus	9.88	NA	4.85	2.53	NA	17.26	ZZZ
61610		A	Transect artery, sinus	29.63	NA	13.14	7.60	NA	50.37	ZZZ

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
61611		A	Transect artery, sinus	7.41	NA	3.82	1.87	NA	13.10	ZZZ
61612		A	Transect artery, sinus	27.84	NA	13.31	4.28	NA	45.43	ZZZ
61613		A	Remove aneurysm, sinus	40.80	NA	26.26	8.34	NA	75.40	090
61615		A	Resect/excise lesion, skull	32.02	NA	22.72	4.65	NA	59.39	090
61616		A	Resect/excise lesion, skull	43.27	NA	28.65	7.89	NA	79.81	090
61618		A	Repair dura	16.96	NA	10.44	3.62	NA	31.02	090
61619		A	Repair dura	20.68	NA	12.24	3.89	NA	36.81	090
61623		A	Endovasc tempory vessel occl	9.95	NA	4.08	1.05	NA	15.08	000
61624		A	Transcath occlusion, cns	20.12	NA	6.89	1.92	NA	28.93	000
61626		A	Transcath occlusion, non-cns	16.60	NA	5.51	1.24	NA	23.35	000
61680		A	Intracranial vessel surgery	30.66	NA	17.43	7.60	NA	55.69	090
61682		A	Intracranial vessel surgery	61.48	NA	32.21	15.50	NA	109.19	090
61684		A	Intracranial vessel surgery	39.75	NA	22.00	10.20	NA	71.95	090
61686		A	Intracranial vessel surgery	64.39	NA	34.72	16.15	NA	115.26	090
61690		A	Intracranial vessel surgery	29.27	NA	16.72	6.87	NA	52.86	090
61692		A	Intracranial vessel surgery	51.79	NA	27.47	13.29	NA	92.55	090
61697		A	Brain aneurysm repr, complx	50.44	NA	28.01	12.44	NA	90.89	090
61698		A	Brain aneurysm repr, complx	48.34	NA	26.69	12.08	NA	87.11	090
61700		A	Brain aneurysm repr, simple	50.44	NA	27.80	12.59	NA	90.83	090
61702		A	Inner skull vessel surgery	48.34	NA	26.03	10.32	NA	84.69	090
61703		A	Clamp neck artery	17.44	NA	10.46	3.94	NA	31.84	090
61705		A	Revise circulation to head	36.15	NA	19.25	8.76	NA	64.16	090
61708		A	Revise circulation to head	35.25	NA	15.15	2.49	NA	52.89	090
61710		A	Revise circulation to head	29.63	NA	13.64	4.47	NA	47.74	090
61711		A	Fusion of skull arteries	36.28	NA	19.80	9.16	NA	65.24	090
61720		A	Incise skull/brain surgery	16.74	NA	9.97	2.72	NA	29.43	090
61735		A	Incise skull/brain surgery	20.40	NA	12.16	2.69	NA	35.25	090
61750		A	Incise skull/brain biopsy	18.17	NA	10.61	4.50	NA	33.28	090
61751		A	Brain biopsy w/ct/mr guide	17.59	NA	10.82	4.39	NA	32.80	090
61760		A	Implant brain electrodes	22.24	NA	8.71	5.07	NA	36.02	090
61770		A	Incise skull for treatment	21.41	NA	12.25	3.51	NA	37.17	090
61790		A	Treat trigeminal nerve	10.84	NA	5.91	2.68	NA	19.43	090
61791		A	Treat trigeminal tract	14.59	NA	8.91	3.07	NA	26.57	090
61793		A	Focus radiation beam	17.21	NA	10.12	4.24	NA	31.57	090
61795		A	Brain surgery using computer	4.03	NA	2.03	0.77	NA	6.83	ZZZ
61850		A	Implant neuroelectrodes	12.37	NA	7.67	3.18	NA	23.22	090
61860		A	Implant neuroelectrodes	20.84	NA	12.06	4.90	NA	37.80	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
61863		A	Implant neuroelectrode	18.97	NA	11.77	5.21	NA	35.95	090
61864		A	Implant neuroelectrde, add'l	4.49	NA	2.28	5.21	NA	11.98	ZZZ
61867		A	Implant neuroelectrode	31.29	NA	18.02	5.21	NA	54.52	090
61868		A	Implant neuroelectrde, add'l	7.91	NA	4.01	5.21	NA	17.13	ZZZ
61870		A	Implant neuroelectrodes	14.92	NA	9.70	3.83	NA	28.45	090
61875		A	Implant neuroelectrodes	15.04	NA	8.57	2.92	NA	26.53	090
61880		A	Revise/remove neuroelectrode	6.28	NA	4.57	1.58	NA	12.43	090
61885		A	Insrt/redo neurostim 1 array	5.84	NA	5.30	1.42	NA	12.56	090
61886		A	Implant neurostim arrays	7.99	NA	6.35	1.92	NA	16.26	090
61888		A	Revise/remove neuroreceiver	5.06	NA	3.67	1.23	NA	9.96	010
62000		A	Treat skull fracture	12.51	NA	5.51	1.04	NA	19.06	090
62005		A	Treat skull fracture	16.15	NA	8.79	3.74	NA	28.68	090
62010		A	Treatment of head injury	19.78	NA	11.71	4.80	NA	36.29	090
62100		A	Repair brain fluid leakage	22.00	NA	12.78	4.71	NA	39.49	090
62115		A	Reduction of skull defect	21.63	NA	11.64	5.46	NA	38.73	090
62116		A	Reduction of skull defect	23.55	NA	13.36	6.05	NA	42.96	090
62117		A	Reduction of skull defect	26.56	NA	15.37	4.48	NA	46.41	090
62120		A	Repair skull cavity lesion	23.31	NA	18.48	2.96	NA	44.75	090
62121		A	Incise skull repair	21.55	NA	15.45	4.08	NA	41.08	090
62140		A	Repair of skull defect	13.49	NA	8.32	3.22	NA	25.03	090
62141		A	Repair of skull defect	14.89	NA	9.04	3.49	NA	27.42	090
62142		A	Remove skull plate/flap	10.77	NA	6.99	2.55	NA	20.31	090
62143		A	Replace skull plate/flap	13.03	NA	8.04	3.18	NA	24.25	090
62145		A	Repair of skull & brain	18.79	NA	10.89	4.30	NA	33.98	090
62146		A	Repair of skull with graft	16.10	NA	9.63	3.52	NA	29.25	090
62147		A	Repair of skull with graft	19.31	NA	11.30	4.20	NA	34.81	090
62148		A	Retr bone flap to fix skull	2.00	NA	0.66	0.47	NA	3.33	ZZZ
62160		A	Neuroendoscopy add-on	3.00	NA	1.53	0.75	NA	5.28	ZZZ
62161		A	Dissect brain w/scope	19.97	NA	12.09	5.02	NA	37.08	090
62162		A	Remove colloid cyst w/scope	25.21	NA	14.85	5.85	NA	45.91	090
62163		A	Neuroendoscopy w/fb removal	15.48	NA	9.92	3.97	NA	29.37	090
62164		A	Remove brain tumor w/scope	27.46	NA	14.95	5.31	NA	47.72	090
62165		A	Remove pituit tumor w/scope	21.97	NA	13.38	2.95	NA	38.30	090
62180		A	Establish brain cavity shunt	21.03	NA	12.28	4.77	NA	38.08	090
62190		A	Establish brain cavity shunt	11.05	NA	7.08	2.76	NA	20.89	090
62192		A	Establish brain cavity shunt	12.23	NA	7.62	2.93	NA	22.78	090
62194		A	Replace/irrigate catheter	5.02	NA	2.43	0.89	NA	8.34	010

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
62200		A	Establish brain cavity shunt	18.29	NA	10.84	4.49	NA	33.62	090
62201		A	Brain cavity shunt w/scope	14.84	NA	9.44	3.41	NA	27.69	090
62220		A	Establish brain cavity shunt	12.98	NA	7.98	3.06	NA	24.02	090
62223		A	Establish brain cavity shunt	12.85	NA	8.24	3.02	NA	24.11	090
62225		A	Replace/irrigate catheter	5.40	NA	4.09	1.33	NA	10.82	090
62230		A	Replace/revise brain shunt	10.52	NA	6.48	2.54	NA	19.54	090
62252		A	Csf shunt reprogram	0.74	1.47	NA	0.20	2.41	NA	XXX
62252	26	A	Csf shunt reprogram	0.74	0.37	0.37	0.18	1.29	1.29	XXX
62252	TC	A	Csf shunt reprogram	0.00	1.10	NA	0.02	1.12	NA	XXX
62256		A	Remove brain cavity shunt	6.59	NA	4.69	1.65	NA	12.93	090
62258		A	Replace brain cavity shunt	14.52	NA	8.71	3.56	NA	26.79	090
62263		A	Epidural lysis mult sessions	6.13	12.69	3.19	0.42	19.24	9.74	010
62264		A	Epidural lysis on single day	4.42	7.73	1.42	0.27	12.42	6.11	010
62268		A	Drain spinal cord cyst	4.73	11.53	2.14	0.43	16.69	7.30	000
62269		A	Needle biopsy, spinal cord	5.01	14.68	1.97	0.39	20.08	7.37	000
62270		A	Spinal fluid tap, diagnostic	1.13	2.99	0.56	0.08	4.20	1.77	000
62272		A	Drain cerebro spinal fluid	1.35	3.61	0.71	0.17	5.13	2.23	000
62273		A	Inject epidural patch	2.15	2.71	0.71	0.14	5.00	3.00	000
62280		A	Treat spinal cord lesion	2.63	6.93	1.01	0.31	9.87	3.95	010
62281		A	Treat spinal cord lesion	2.66	5.65	0.89	0.18	8.49	3.73	010
62282		A	Treat spinal canal lesion	2.33	8.36	0.92	0.19	10.88	3.44	010
62284		A	Injection for myelogram	1.54	4.96	0.68	0.13	6.63	2.35	000
62287		A	Percutaneous diskectomy	8.07	NA	5.55	0.64	NA	14.26	090
62290		A	Inject for spine disk x-ray	3.00	7.13	1.38	0.25	10.38	4.63	000
62291		A	Inject for spine disk x-ray	2.91	5.93	1.23	0.26	9.10	4.40	000
62292		A	Injection into disk lesion	7.85	NA	4.47	0.81	NA	13.13	090
62294		A	Injection into spinal artery	11.81	NA	5.58	1.23	NA	18.62	090
62310		A	Inject spine c/t	1.91	4.81	0.65	0.12	6.84	2.68	000
62311		A	Inject spine l/s (cd)	1.54	4.92	0.59	0.10	6.56	2.23	000
62318		A	Inject spine w/cath, c/t	2.04	5.72	0.65	0.13	7.89	2.82	000
62319		A	Inject spine w/cath l/s (cd)	1.87	4.98	0.61	0.12	6.97	2.60	000
62350		A	Implant spinal canal cath	6.86	NA	3.94	0.98	NA	11.78	090
62351		A	Implant spinal canal cath	9.99	NA	7.12	2.17	NA	19.28	090
62355		A	Remove spinal canal catheter	5.44	NA	3.16	0.74	NA	9.34	090
62360		A	Insert spine infusion device	2.62	NA	2.68	0.36	NA	5.66	090
62361		A	Implant spine infusion pump	5.41	NA	3.92	0.77	NA	10.10	090
62362		A	Implant spine infusion pump	7.03	NA	4.36	1.15	NA	12.54	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
62365		A	Remove spine infusion device	5.41	NA	3.58	0.83	NA	9.82	090
62367		A	Analyze spine infusion pump	0.48	0.13	0.13	0.03	0.64	0.64	XXX
62368		A	Analyze spine infusion pump	0.75	0.19	0.19	0.06	1.00	1.00	XXX
63001		A	Removal of spinal lamina	15.80	NA	9.51	3.65	NA	28.96	090
63003		A	Removal of spinal lamina	15.93	NA	9.86	3.63	NA	29.42	090
63005		A	Removal of spinal lamina	14.90	NA	9.97	3.27	NA	28.14	090
63011		A	Removal of spinal lamina	14.50	NA	8.27	3.31	NA	26.08	090
63012		A	Removal of spinal lamina	15.38	NA	10.12	3.41	NA	28.91	090
63015		A	Removal of spinal lamina	19.32	NA	11.87	4.64	NA	35.83	090
63016		A	Removal of spinal lamina	19.17	NA	11.78	4.45	NA	35.40	090
63017		A	Removal of spinal lamina	15.92	NA	10.39	3.56	NA	29.87	090
63020		A	Neck spine disk surgery	14.79	NA	9.67	3.60	NA	28.06	090
63030		A	Low back disk surgery	11.98	NA	8.42	2.91	NA	23.31	090
63035		A	Spinal disk surgery add-on	3.15	NA	1.59	0.77	NA	5.51	ZZZ
63040		A	Laminotomy, single cervical	18.78	NA	11.50	4.49	NA	34.77	090
63042		A	Laminotomy, single lumbar	17.44	NA	11.34	4.08	NA	32.86	090
63043		C	Laminotomy, add'l cervical	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
63044		C	Laminotomy, add'l lumbar	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
63045		A	Removal of spinal lamina	16.48	NA	10.35	3.89	NA	30.72	090
63046		A	Removal of spinal lamina	15.78	NA	10.18	3.47	NA	29.43	090
63047		A	Removal of spinal lamina	14.59	NA	9.89	3.15	NA	27.63	090
63048		A	Remove spinal lamina add-on	3.26	NA	1.66	0.71	NA	5.63	ZZZ
63050		A	Cervical laminoplasty	20.75	NA	11.84	4.64	NA	37.23	090
63051		A	C-laminoplasty w/graft/plate	24.25	NA	13.47	4.64	NA	42.36	090
63055		A	Decompress spinal cord	21.96	NA	13.13	5.13	NA	40.22	090
63056		A	Decompress spinal cord	20.33	NA	12.56	4.57	NA	37.46	090
63057		A	Decompress spine cord add-on	5.25	NA	2.63	1.18	NA	9.06	ZZZ
63064		A	Decompress spinal cord	24.57	NA	14.42	5.45	NA	44.44	090
63066		A	Decompress spine cord add-on	3.26	NA	1.66	0.67	NA	5.59	ZZZ
63075		A	Neck spine disk surgery	19.38	NA	12.08	4.49	NA	35.95	090
63076		A	Neck spine disk surgery	4.04	NA	2.05	0.93	NA	7.02	ZZZ
63077		A	Spine disk surgery, thorax	21.41	NA	12.79	3.70	NA	37.90	090
63078		A	Spine disk surgery, thorax	3.28	NA	1.64	0.63	NA	5.55	ZZZ
63081		A	Removal of vertebral body	23.69	NA	14.32	5.36	NA	43.37	090
63082		A	Remove vertebral body add-on	4.36	NA	2.22	1.00	NA	7.58	ZZZ
63085		A	Removal of vertebral body	26.88	NA	15.47	4.18	NA	46.53	090
63086		A	Remove vertebral body add-on	3.19	NA	1.59	0.55	NA	5.33	ZZZ

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
63087		A	Removal of vertebral body	35.52	NA	19.45	5.65	NA	60.62	090
63088		A	Remove vertebral body add-on	4.32	NA	2.17	0.78	NA	7.27	ZZZ
63090		A	Removal of vertebral body	28.12	NA	16.03	4.06	NA	48.21	090
63091		A	Remove vertebral body add-on	3.03	NA	1.46	0.47	NA	4.96	ZZZ
63101		A	Removal of vertebral body	31.95	NA	19.27	5.45	NA	56.67	090
63102		A	Removal of vertebral body	31.95	NA	19.27	5.45	NA	56.67	090
63103		A	Remove vertebral body add-on	4.82	NA	2.50	0.67	NA	7.99	ZZZ
63170		A	Incise spinal cord tract(s)	19.80	NA	11.86	4.81	NA	36.47	090
63172		A	Drainage of spinal cyst	17.63	NA	10.64	4.37	NA	32.64	090
63173		A	Drainage of spinal cyst	21.96	NA	12.80	5.64	NA	40.40	090
63180		A	Revise spinal cord ligaments	18.24	NA	10.98	3.92	NA	33.14	090
63182		A	Revise spinal cord ligaments	20.47	NA	10.95	5.25	NA	36.67	090
63185		A	Incise spinal column/nerves	15.02	NA	8.09	2.66	NA	25.77	090
63190		A	Incise spinal column/nerves	17.42	NA	10.13	3.21	NA	30.76	090
63191		A	Incise spinal column/nerves	17.51	NA	10.47	6.29	NA	34.27	090
63194		A	Incise spinal column & cord	19.16	NA	11.71	3.23	NA	34.10	090
63195		A	Incise spinal column & cord	18.81	NA	11.04	4.83	NA	34.68	090
63196		A	Incise spinal column & cord	22.27	NA	13.38	5.72	NA	41.37	090
63197		A	Incise spinal column & cord	21.08	NA	12.20	5.33	NA	38.61	090
63198		A	Incise spinal column & cord	25.34	NA	8.43	6.40	NA	40.17	090
63199		A	Incise spinal column & cord	26.85	NA	15.03	1.40	NA	43.28	090
63200		A	Release of spinal cord	19.15	NA	11.29	4.73	NA	35.17	090
63250		A	Revise spinal cord vessels	40.70	NA	19.92	8.93	NA	69.55	090
63251		A	Revise spinal cord vessels	41.14	NA	22.58	9.92	NA	73.64	090
63252		A	Revise spinal cord vessels	41.13	NA	22.23	10.07	NA	73.43	090
63265		A	Excise intraspinal lesion	21.53	NA	12.76	5.28	NA	39.57	090
63266		A	Excise intraspinal lesion	22.27	NA	13.17	5.37	NA	40.81	090
63267		A	Excise intraspinal lesion	17.92	NA	11.07	4.26	NA	33.25	090
63268		A	Excise intraspinal lesion	18.49	NA	10.36	3.61	NA	32.46	090
63270		A	Excise intraspinal lesion	26.76	NA	15.46	6.56	NA	48.78	090
63271		A	Excise intraspinal lesion	26.88	NA	15.56	6.47	NA	48.91	090
63272		A	Excise intraspinal lesion	25.28	NA	14.68	6.04	NA	46.00	090
63273		A	Excise intraspinal lesion	24.25	NA	14.33	5.69	NA	44.27	090
63275		A	Biopsy/excise spinal tumor	23.64	NA	13.76	5.61	NA	43.01	090
63276		A	Biopsy/excise spinal tumor	23.41	NA	13.67	5.60	NA	42.68	090
63277		A	Biopsy/excise spinal tumor	20.80	NA	12.51	4.86	NA	38.17	090
63278		A	Biopsy/excise spinal tumor	20.53	NA	12.38	4.40	NA	37.31	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
63280		A	Biopsy/excise spinal tumor	28.31	NA	16.30	7.01	NA	51.62	090
63281		A	Biopsy/excise spinal tumor	28.01	NA	16.16	6.90	NA	51.07	090
63282		A	Biopsy/excise spinal tumor	26.35	NA	15.32	6.40	NA	48.07	090
63283		A	Biopsy/excise spinal tumor	24.96	NA	14.65	6.22	NA	45.83	090
63285		A	Biopsy/excise spinal tumor	35.95	NA	19.93	8.98	NA	64.86	090
63286		A	Biopsy/excise spinal tumor	35.58	NA	19.89	8.87	NA	64.34	090
63287		A	Biopsy/excise spinal tumor	36.64	NA	20.41	8.81	NA	65.86	090
63290		A	Biopsy/excise spinal tumor	37.32	NA	20.58	8.74	NA	66.64	090
63295		A	Repair of laminectomy defect	5.25	NA	2.14	1.03	NA	8.42	ZZZ
63300		A	Removal of vertebral body	24.39	NA	14.29	5.56	NA	44.24	090
63301		A	Removal of vertebral body	27.56	NA	15.54	4.91	NA	48.01	090
63302		A	Removal of vertebral body	27.77	NA	15.84	5.22	NA	48.83	090
63303		A	Removal of vertebral body	30.45	NA	16.90	4.49	NA	51.84	090
63304		A	Removal of vertebral body	30.28	NA	17.26	6.36	NA	53.90	090
63305		A	Removal of vertebral body	31.98	NA	18.04	5.66	NA	55.68	090
63306		A	Removal of vertebral body	32.17	NA	17.79	8.26	NA	58.22	090
63307		A	Removal of vertebral body	31.58	NA	16.80	4.43	NA	52.81	090
63308		A	Remove vertebral body add-on	5.24	NA	2.60	1.26	NA	9.10	ZZZ
63600		A	Remove spinal cord lesion	14.00	NA	5.39	1.49	NA	20.88	090
63610		A	Stimulation of spinal cord	8.72	59.68	2.25	0.86	69.26	11.83	000
63615		A	Remove lesion of spinal cord	16.26	NA	9.26	2.64	NA	28.16	090
63650		A	Implant neuroelectrodes	6.73	NA	3.17	0.54	NA	10.44	090
63655		A	Implant neuroelectrodes	10.27	NA	6.89	2.33	NA	19.49	090
63660		A	Revise/remove neuroelectrode	6.15	NA	3.61	0.79	NA	10.55	090
63685		A	Insrt/redo spine n generator	7.03	NA	4.14	1.02	NA	12.19	090
63688		A	Revise/remove neuroreceiver	5.38	NA	3.55	0.85	NA	9.78	090
63700		A	Repair of spinal herniation	16.51	NA	10.30	3.42	NA	30.23	090
63702		A	Repair of spinal herniation	18.45	NA	11.03	4.09	NA	33.57	090
63704		A	Repair of spinal herniation	21.15	NA	12.91	4.54	NA	38.60	090
63706		A	Repair of spinal herniation	24.07	NA	13.57	6.18	NA	43.82	090
63707		A	Repair spinal fluid leakage	11.24	NA	7.70	2.41	NA	21.35	090
63709		A	Repair spinal fluid leakage	14.30	NA	9.39	3.02	NA	26.71	090
63710		A	Graft repair of spine defect	14.05	NA	9.03	3.34	NA	26.42	090
63740		A	Install spinal shunt	11.34	NA	7.34	2.68	NA	21.36	090
63741		A	Install spinal shunt	8.24	NA	4.75	1.59	NA	14.58	090
63744		A	Revision of spinal shunt	8.09	NA	5.25	1.76	NA	15.10	090
63746		A	Removal of spinal shunt	6.42	NA	3.77	1.49	NA	11.68	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
64400		A	N block inj, trigeminal	1.11	1.89	0.43	0.09	3.09	1.63	000
64402		A	N block inj, facial	1.25	1.61	0.60	0.09	2.95	1.94	000
64405		A	N block inj, occipital	1.32	1.46	0.46	0.08	2.86	1.86	000
64408		A	N block inj, vagus	1.41	1.58	0.85	0.10	3.09	2.36	000
64410		A	N block inj, phrenic	1.43	2.50	0.46	0.10	4.03	1.99	000
64412		A	N block inj, spinal accessor	1.18	2.65	0.43	0.08	3.91	1.69	000
64413		A	N block inj, cervical plexus	1.40	1.84	0.50	0.09	3.33	1.99	000
64415		A	N block inj, brachial plexus	1.48	2.80	0.46	0.10	4.38	2.04	000
64416		A	N block cont infuse, b plex	3.49	NA	0.79	0.31	NA	4.59	010
64417		A	N block inj, axillary	1.44	3.03	0.49	0.11	4.58	2.04	000
64418		A	N block inj, suprascapular	1.32	2.62	0.44	0.08	4.02	1.84	000
64420		A	N block inj, intercost, sng	1.18	3.88	0.42	0.09	5.15	1.69	000
64421		A	N block inj, intercost, mlt	1.68	6.08	0.52	0.12	7.88	2.32	000
64425		A	N block inj, ilio-ing/hypogi	1.75	1.65	0.54	0.14	3.54	2.43	000
64430		A	N block inj, pudendal	1.46	2.51	0.55	0.11	4.08	2.12	000
64435		A	N block inj, paracervical	1.45	2.52	0.69	0.15	4.12	2.29	000
64445		A	N block inj, sciatic, sng	1.48	2.67	0.50	0.10	4.25	2.08	000
64446		A	N blk inj, sciatic, cont inf	3.25	NA	1.00	0.24	NA	4.49	010
64447		A	N block inj fem, single	1.50	NA	0.43	0.10	NA	2.03	000
64448		A	N block inj fem, cont inf	3.00	NA	0.81	0.21	NA	4.02	010
64449		A	N block inj, lumbar plexus	3.00	NA	0.96	0.16	NA	4.12	010
64450		A	N block, other peripheral	1.27	1.24	0.48	0.13	2.64	1.88	000
64470		A	Inj paravertebral c/t	1.85	7.23	0.71	0.13	9.21	2.69	000
64472		A	Inj paravertebral c/t add-on	1.29	2.33	0.34	0.09	3.71	1.72	ZZZ
64475		A	Inj paravertebral l/s	1.41	6.88	0.63	0.11	8.40	2.15	000
64476		A	Inj paravertebral l/s add-on	0.98	2.12	0.24	0.07	3.17	1.29	ZZZ
64479		A	Inj foramen epidural c/t	2.20	7.49	0.89	0.15	9.84	3.24	000
64480		A	Inj foramen epidural add-on	1.54	2.84	0.47	0.12	4.50	2.13	ZZZ
64483		A	Inj foramen epidural l/s	1.90	7.89	0.83	0.12	9.91	2.85	000
64484		A	Inj foramen epidural add-on	1.33	3.28	0.37	0.09	4.70	1.79	ZZZ
64505		A	N block, spenopalatine gangl	1.36	1.24	0.66	0.10	2.70	2.12	000
64508		A	N block, carotid sinus s/p	1.12	3.32	0.74	0.07	4.51	1.93	000
64510		A	N block, stellate ganglion	1.22	3.45	0.51	0.07	4.74	1.80	000
64517		A	N block inj, hypogas plxs	2.20	2.72	0.87	0.11	5.03	3.18	000
64520		A	N block, lumbar/thoracic	1.35	5.14	0.55	0.08	6.57	1.98	000
64530		A	N block inj, celiac pelus	1.58	4.45	0.65	0.10	6.13	2.33	000
64550		A	Apply neurostimulator	0.18	0.28	0.05	0.01	0.47	0.24	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
64553		A	Implant neuroelectrodes	2.31	2.83	1.85	0.19	5.33	4.35	010
64555		A	Implant neuroelectrodes	2.27	3.10	1.19	0.20	5.57	3.66	010
64560		A	Implant neuroelectrodes	2.36	2.63	1.28	0.21	5.20	3.85	010
64561		A	Implant neuroelectrodes	6.73	30.05	2.77	0.51	37.29	10.01	010
64565		A	Implant neuroelectrodes	1.76	3.28	1.26	0.13	5.17	3.15	010
64573		A	Implant neuroelectrodes	7.49	NA	5.24	1.53	NA	14.26	090
64575		A	Implant neuroelectrodes	4.34	NA	2.67	0.59	NA	7.60	090
64577		A	Implant neuroelectrodes	4.61	NA	3.28	1.04	NA	8.93	090
64580		A	Implant neuroelectrodes	4.11	NA	3.55	0.36	NA	8.02	090
64581		A	Implant neuroelectrodes	13.48	NA	5.37	1.05	NA	19.90	090
64585		A	Revise/remove neuroelectrode	2.06	11.28	2.13	0.20	13.54	4.39	010
64590		A	Insrt/redo perph n generator	2.40	7.14	2.28	0.21	9.75	4.89	010
64595		A	Revise/remove neuroreceiver	1.73	10.39	1.92	0.19	12.31	3.84	010
64600		A	Injection treatment of nerve	3.44	9.35	1.65	0.33	13.12	5.42	010
64605		A	Injection treatment of nerve	5.60	9.55	2.18	0.77	15.92	8.55	010
64610		A	Injection treatment of nerve	7.15	8.86	3.71	1.48	17.49	12.34	010
64612		A	Destroy nerve, face muscle	1.96	2.48	1.32	0.12	4.56	3.40	010
64613		A	Destroy nerve, spine muscle	1.96	2.93	1.22	0.11	5.00	3.29	010
64614		A	Destroy nerve, extrem musc	2.20	3.22	1.31	0.11	5.53	3.62	010
64620		A	Injection treatment of nerve	2.84	5.06	1.33	0.20	8.10	4.37	010
64622		A	Destr paravertebrl nerve l/s	3.00	7.76	1.37	0.21	10.97	4.58	010
64623		A	Destr paravertebral n add-on	0.99	2.96	0.22	0.07	4.02	1.28	ZZZ
64626		A	Destr paravertebrl nerve c/t	3.28	7.78	1.96	0.22	11.28	5.46	010
64627		A	Destr paravertebral n add-on	1.16	4.53	0.27	0.08	5.77	1.51	ZZZ
64630		A	Injection treatment of nerve	3.00	2.73	1.41	0.23	5.96	4.64	010
64640		A	Injection treatment of nerve	2.76	4.18	1.84	0.28	7.22	4.88	010
64680		A	Injection treatment of nerve	2.62	6.71	1.43	0.18	9.51	4.23	010
64681		A	Injection treatment of nerve	3.54	9.29	2.06	0.28	13.11	5.88	010
64702		A	Revise finger/toe nerve	4.22	NA	3.86	0.61	NA	8.69	090
64704		A	Revise hand/foot nerve	4.56	NA	3.31	0.61	NA	8.48	090
64708		A	Revise arm/leg nerve	6.11	NA	4.86	0.94	NA	11.91	090
64712		A	Revision of sciatic nerve	7.74	NA	4.96	0.99	NA	13.69	090
64713		A	Revision of arm nerve(s)	10.98	NA	5.87	1.74	NA	18.59	090
64714		A	Revise low back nerve(s)	10.31	NA	4.20	1.19	NA	15.70	090
64716		A	Revision of cranial nerve	6.30	NA	5.97	0.65	NA	12.92	090
64718		A	Revise ulnar nerve at elbow	5.98	NA	5.99	1.04	NA	13.01	090
64719		A	Revise ulnar nerve at wrist	4.84	NA	4.52	0.77	NA	10.13	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
64721		A	Carpal tunnel surgery	4.28	NA	5.36	0.72	NA	10.36	090
64722		A	Relieve pressure on nerve(s)	4.69	NA	3.04	0.52	NA	8.25	090
64726		A	Release foot/toe nerve	4.17	NA	2.79	0.55	NA	7.51	090
64727		A	Internal nerve revision	3.10	NA	1.50	0.47	NA	5.07	ZZZ
64732		A	Incision of brow nerve	4.40	NA	3.50	0.94	NA	8.84	090
64734		A	Incision of cheek nerve	4.91	NA	4.05	0.88	NA	9.84	090
64736		A	Incision of chin nerve	4.59	NA	4.02	0.52	NA	9.13	090
64738		A	Incision of jaw nerve	5.72	NA	4.61	1.07	NA	11.40	090
64740		A	Incision of tongue nerve	5.58	NA	5.12	0.69	NA	11.39	090
64742		A	Incision of facial nerve	6.21	NA	4.70	0.73	NA	11.64	090
64744		A	Incise nerve, back of head	5.23	NA	3.77	1.09	NA	10.09	090
64746		A	Incise diaphragm nerve	5.92	NA	4.50	0.82	NA	11.24	090
64752		A	Incision of vagus nerve	7.05	NA	4.28	0.92	NA	12.25	090
64755		A	Incision of stomach nerves	13.50	NA	5.63	1.81	NA	20.94	090
64760		A	Incision of vagus nerve	6.95	NA	3.45	0.78	NA	11.18	090
64761		A	Incision of pelvis nerve	6.40	NA	3.52	0.53	NA	10.45	090
64763		A	Incise hip/thigh nerve	6.92	NA	5.19	0.94	NA	13.05	090
64766		A	Incise hip/thigh nerve	8.66	NA	5.24	1.06	NA	14.96	090
64771		A	Sever cranial nerve	7.34	NA	5.55	1.22	NA	14.11	090
64772		A	Incision of spinal nerve	7.20	NA	4.92	1.29	NA	13.41	090
64774		A	Remove skin nerve lesion	5.16	NA	3.83	0.75	NA	9.74	090
64776		A	Remove digit nerve lesion	5.11	NA	3.68	0.73	NA	9.52	090
64778		A	Digit nerve surgery add-on	3.11	NA	1.50	0.45	NA	5.06	ZZZ
64782		A	Remove limb nerve lesion	6.22	NA	3.77	0.87	NA	10.86	090
64783		A	Limb nerve surgery add-on	3.71	NA	1.83	0.51	NA	6.05	ZZZ
64784		A	Remove nerve lesion	9.81	NA	6.59	1.42	NA	17.82	090
64786		A	Remove sciatic nerve lesion	15.44	NA	9.83	2.53	NA	27.80	090
64787		A	Implant nerve end	4.29	NA	2.12	0.58	NA	6.99	ZZZ
64788		A	Remove skin nerve lesion	4.60	NA	3.46	0.68	NA	8.74	090
64790		A	Removal of nerve lesion	11.29	NA	7.20	1.99	NA	20.48	090
64792		A	Removal of nerve lesion	14.90	NA	8.82	2.36	NA	26.08	090
64795		A	Biopsy of nerve	3.01	NA	1.56	0.50	NA	5.07	000
64802		A	Remove sympathetic nerves	9.14	NA	5.13	1.28	NA	15.55	090
64804		A	Remove sympathetic nerves	14.62	NA	7.16	2.09	NA	23.87	090
64809		A	Remove sympathetic nerves	13.65	NA	5.76	1.50	NA	20.91	090
64818		A	Remove sympathetic nerves	10.28	NA	5.28	1.32	NA	16.88	090
64820		A	Remove sympathetic nerves	10.35	NA	7.12	1.48	NA	18.95	090

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CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
64821		A	Remove sympathetic nerves	8.74	NA	7.34	1.24	NA	17.32	090
64822		A	Remove sympathetic nerves	8.74	NA	7.23	1.27	NA	17.24	090
64823		A	Remove sympathetic nerves	10.35	NA	8.13	1.55	NA	20.03	090
64831		A	Repair of digit nerve	9.43	NA	7.07	1.39	NA	17.89	090
64832		A	Repair nerve add-on	5.65	NA	2.93	0.84	NA	9.42	ZZZ
64834		A	Repair of hand or foot nerve	10.17	NA	7.09	1.52	NA	18.78	090
64835		A	Repair of hand or foot nerve	10.92	NA	7.69	1.67	NA	20.28	090
64836		A	Repair of hand or foot nerve	10.92	NA	7.66	1.66	NA	20.24	090
64837		A	Repair nerve add-on	6.25	NA	3.23	0.96	NA	10.44	ZZZ
64840		A	Repair of leg nerve	13.00	NA	8.25	1.36	NA	22.61	090
64856		A	Repair/transpose nerve	13.78	NA	9.18	2.08	NA	25.04	090
64857		A	Repair arm/leg nerve	14.47	NA	9.63	2.22	NA	26.32	090
64858		A	Repair sciatic nerve	16.47	NA	10.77	3.30	NA	30.54	090
64859		A	Nerve surgery	4.25	NA	2.19	0.67	NA	7.11	ZZZ
64861		A	Repair of arm nerves	19.21	NA	11.77	4.05	NA	35.03	090
64862		A	Repair of low back nerves	19.41	NA	11.93	4.28	NA	35.62	090
64864		A	Repair of facial nerve	12.53	NA	8.76	1.30	NA	22.59	090
64865		A	Repair of facial nerve	15.22	NA	13.52	1.55	NA	30.29	090
64866		A	Fusion of facial/other nerve	15.72	NA	13.16	2.03	NA	30.91	090
64868		A	Fusion of facial/other nerve	14.02	NA	11.43	1.43	NA	26.88	090
64870		A	Fusion of facial/other nerve	15.97	NA	8.72	1.30	NA	25.99	090
64872		A	Subsequent repair of nerve	1.99	NA	1.08	0.29	NA	3.36	ZZZ
64874		A	Repair & revise nerve add-on	2.98	NA	1.53	0.42	NA	4.93	ZZZ
64876		A	Repair nerve/shorten bone	3.37	NA	1.74	0.47	NA	5.58	ZZZ
64885		A	Nerve graft, head or neck	17.50	NA	11.60	1.67	NA	30.77	090
64886		A	Nerve graft, head or neck	20.72	NA	13.54	2.10	NA	36.36	090
64890		A	Nerve graft, hand or foot	15.13	NA	9.99	2.28	NA	27.40	090
64891		A	Nerve graft, hand or foot	16.12	NA	7.58	1.62	NA	25.32	090
64892		A	Nerve graft, arm or leg	14.63	NA	8.86	2.45	NA	25.94	090
64893		A	Nerve graft, arm or leg	15.58	NA	9.86	2.60	NA	28.04	090
64895		A	Nerve graft, hand or foot	19.22	NA	9.65	2.55	NA	31.42	090
64896		A	Nerve graft, hand or foot	20.46	NA	10.98	3.13	NA	34.57	090
64897		A	Nerve graft, arm or leg	18.21	NA	10.69	2.52	NA	31.42	090
64898		A	Nerve graft, arm or leg	19.47	NA	11.79	2.74	NA	34.00	090
64901		A	Nerve graft add-on	10.20	NA	5.26	1.37	NA	16.83	ZZZ
64902		A	Nerve graft add-on	11.81	NA	5.96	1.54	NA	19.31	ZZZ
64905		A	Nerve pedicle transfer	14.00	NA	8.49	1.98	NA	24.47	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
64907		A	Nerve pedicle transfer	18.80	NA	12.52	3.13	NA	34.45	090
64999		C	Nervous system surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
65091		A	Revise eye	6.45	NA	8.35	0.32	NA	15.12	090
65093		A	Revise eye with implant	6.86	NA	8.71	0.36	NA	15.93	090
65101		A	Removal of eye	7.02	NA	9.52	0.37	NA	16.91	090
65103		A	Remove eye/insert implant	7.56	NA	9.73	0.38	NA	17.67	090
65105		A	Remove eye/attach implant	8.48	NA	10.46	0.43	NA	19.37	090
65110		A	Removal of eye	13.93	NA	13.67	0.84	NA	28.44	090
65112		A	Remove eye/revise socket	16.36	NA	16.13	1.38	NA	33.87	090
65114		A	Remove eye/revise socket	17.50	NA	16.34	1.02	NA	34.86	090
65125		A	Revise ocular implant	3.12	8.80	3.60	0.18	12.10	6.90	090
65130		A	Insert ocular implant	7.14	NA	9.16	0.35	NA	16.65	090
65135		A	Insert ocular implant	7.32	NA	9.31	0.38	NA	17.01	090
65140		A	Attach ocular implant	8.01	NA	9.87	0.43	NA	18.31	090
65150		A	Revise ocular implant	6.25	NA	7.97	0.33	NA	14.55	090
65155		A	Reinsert ocular implant	8.65	NA	10.48	0.50	NA	19.63	090
65175		A	Removal of ocular implant	6.27	NA	8.48	0.34	NA	15.09	090
65205		A	Remove foreign body from eye	0.71	0.64	0.29	0.04	1.39	1.04	000
65210		A	Remove foreign body from eye	0.84	0.81	0.38	0.04	1.69	1.26	000
65220		A	Remove foreign body from eye	0.71	0.64	0.28	0.05	1.40	1.04	000
65222		A	Remove foreign body from eye	0.93	0.89	0.38	0.05	1.87	1.36	000
65235		A	Remove foreign body from eye	7.56	NA	6.74	0.39	NA	14.69	090
65260		A	Remove foreign body from eye	10.94	NA	9.65	0.57	NA	21.16	090
65265		A	Remove foreign body from eye	12.57	NA	10.62	0.63	NA	23.82	090
65270		A	Repair of eye wound	1.90	5.22	1.39	0.10	7.22	3.39	010
65272		A	Repair of eye wound	3.81	7.71	3.29	0.20	11.72	7.30	090
65273		A	Repair of eye wound	4.35	NA	3.58	0.22	NA	8.15	090
65275		A	Repair of eye wound	5.33	6.31	3.94	0.29	11.93	9.56	090
65280		A	Repair of eye wound	7.65	NA	6.23	0.38	NA	14.26	090
65285		A	Repair of eye wound	12.88	NA	9.21	0.64	NA	22.73	090
65286		A	Repair of eye wound	5.50	11.14	4.62	0.27	16.91	10.39	090
65290		A	Repair of eye socket wound	5.40	NA	4.74	0.32	NA	10.46	090
65400		A	Removal of eye lesion	6.05	8.33	6.12	0.30	14.68	12.47	090
65410		A	Biopsy of cornea	1.47	2.11	0.97	0.07	3.65	2.51	000
65420		A	Removal of eye lesion	4.16	8.85	4.44	0.21	13.22	8.81	090
65426		A	Removal of eye lesion	5.24	10.17	4.92	0.26	15.67	10.42	090
65430		A	Corneal smear	1.47	1.29	0.98	0.07	2.83	2.52	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
65435		A	Curette/treat cornea	0.92	1.00	0.71	0.05	1.97	1.68	000
65436		A	Curette/treat cornea	4.18	4.09	3.67	0.21	8.48	8.06	090
65450		A	Treatment of corneal lesion	3.27	4.07	3.94	0.16	7.50	7.37	090
65600		A	Revision of cornea	3.39	5.01	3.35	0.17	8.57	6.91	090
65710		A	Corneal transplant	12.33	NA	11.20	0.60	NA	24.13	090
65730		A	Corneal transplant	14.23	NA	12.02	0.70	NA	26.95	090
65750		A	Corneal transplant	14.98	NA	11.97	0.74	NA	27.69	090
65755		A	Corneal transplant	14.87	NA	11.89	0.73	NA	27.49	090
65760		N	Revision of cornea	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65765		N	Revision of cornea	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65767		N	Corneal tissue transplant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65770		A	Revise cornea with implant	17.53	NA	13.20	0.86	NA	31.59	090
65771		N	Radial keratotomy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65772		A	Correction of astigmatism	4.28	5.53	4.13	0.21	10.02	8.62	090
65775		A	Correction of astigmatism	5.78	NA	5.95	0.28	NA	12.01	090
65780		A	Ocular reconst, transplant	10.23	NA	10.29	0.44	NA	20.96	090
65781		A	Ocular reconst, transplant	17.64	NA	13.67	0.44	NA	31.75	090
65782		A	Ocular reconst, transplant	14.98	NA	11.99	0.44	NA	27.41	090
65800		A	Drainage of eye	1.91	1.79	1.18	0.09	3.79	3.18	000
65805		A	Drainage of eye	1.91	2.17	1.19	0.09	4.17	3.19	000
65810		A	Drainage of eye	4.86	NA	4.70	0.24	NA	9.80	090
65815		A	Drainage of eye	5.04	10.00	4.81	0.25	15.29	10.10	090
65820		A	Relieve inner eye pressure	8.12	NA	9.05	0.40	NA	17.57	090
65850		A	Incision of eye	10.50	NA	8.44	0.52	NA	19.46	090
65855		A	Laser surgery of eye	3.84	4.31	3.10	0.19	8.34	7.13	010
65860		A	Incise inner eye adhesions	3.54	4.04	2.50	0.18	7.76	6.22	090
65865		A	Incise inner eye adhesions	5.59	NA	5.62	0.28	NA	11.49	090
65870		A	Incise inner eye adhesions	6.26	NA	6.41	0.31	NA	12.98	090
65875		A	Incise inner eye adhesions	6.53	NA	6.79	0.32	NA	13.64	090
65880		A	Incise inner eye adhesions	7.08	NA	7.03	0.35	NA	14.46	090
65900		A	Remove eye lesion	10.91	NA	10.25	0.57	NA	21.73	090
65920		A	Remove implant of eye	8.39	NA	8.17	0.41	NA	16.97	090
65930		A	Remove blood clot from eye	7.43	NA	6.83	0.37	NA	14.63	090
66020		A	Injection treatment of eye	1.59	3.12	1.44	0.08	4.79	3.11	010
66030		A	Injection treatment of eye	1.25	2.96	1.28	0.06	4.27	2.59	010
66130		A	Remove eye lesion	7.68	9.62	5.61	0.38	17.68	13.67	090
66150		A	Glaucoma surgery	8.29	NA	9.40	0.46	NA	18.15	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
66155		A	Glaucoma surgery	8.28	NA	9.35	0.41	NA	18.04	090
66160		A	Glaucoma surgery	10.15	NA	10.19	0.50	NA	20.84	090
66165		A	Glaucoma surgery	8.00	NA	9.24	0.40	NA	17.64	090
66170		A	Glaucoma surgery	12.14	NA	12.22	0.59	NA	24.95	090
66172		A	Incision of eye	15.02	NA	15.20	0.74	NA	30.96	090
66180		A	Implant eye shunt	14.53	NA	10.76	0.71	NA	26.00	090
66185		A	Revise eye shunt	8.13	NA	7.38	0.40	NA	15.91	090
66220		A	Repair eye lesion	7.76	NA	7.10	0.42	NA	15.28	090
66225		A	Repair/graft eye lesion	11.03	NA	8.73	0.54	NA	20.30	090
66250		A	Follow-up surgery of eye	5.97	11.69	5.48	0.30	17.96	11.75	090
66500		A	Incision of iris	3.70	NA	4.64	0.18	NA	8.52	090
66505		A	Incision of iris	4.07	NA	4.99	0.20	NA	9.26	090
66600		A	Remove iris and lesion	8.67	NA	8.22	0.44	NA	17.33	090
66605		A	Removal of iris	12.77	NA	10.02	0.77	NA	23.56	090
66625		A	Removal of iris	5.12	NA	4.73	0.25	NA	10.10	090
66630		A	Removal of iris	6.15	NA	5.71	0.30	NA	12.16	090
66635		A	Removal of iris	6.24	NA	5.74	0.31	NA	12.29	090
66680		A	Repair iris & ciliary body	5.43	NA	5.27	0.27	NA	10.97	090
66682		A	Repair iris & ciliary body	6.20	NA	6.61	0.31	NA	13.12	090
66700		A	Destruction, ciliary body	4.77	5.24	3.93	0.24	10.25	8.94	090
66710		A	Ciliary transscleral therapy	4.77	5.17	3.84	0.23	10.17	8.84	090
66711		A	Ciliary endoscopic ablation	6.60	NA	6.47	0.30	NA	13.37	090
66720		A	Destruction, ciliary body	4.77	5.79	4.72	0.26	10.82	9.75	090
66740		A	Destruction, ciliary body	4.77	5.09	3.97	0.23	10.09	8.97	090
66761		A	Revision of iris	4.06	5.59	4.31	0.20	9.85	8.57	090
66762		A	Revision of iris	4.57	5.65	4.29	0.23	10.45	9.09	090
66770		A	Removal of inner eye lesion	5.17	6.08	4.80	0.26	11.51	10.23	090
66820		A	Incision, secondary cataract	3.88	NA	5.81	0.19	NA	9.88	090
66821		A	After cataract laser surgery	2.35	4.09	3.62	0.11	6.55	6.08	090
66825		A	Reposition intraocular lens	8.22	NA	9.06	0.40	NA	17.68	090
66830		A	Removal of lens lesion	8.19	NA	6.95	0.38	NA	15.52	090
66840		A	Removal of lens material	7.90	NA	6.86	0.38	NA	15.14	090
66850		A	Removal of lens material	9.10	NA	7.64	0.44	NA	17.18	090
66852		A	Removal of lens material	9.96	NA	8.10	0.49	NA	18.55	090
66920		A	Extraction of lens	8.85	NA	7.30	0.44	NA	16.59	090
66930		A	Extraction of lens	10.16	NA	8.14	0.48	NA	18.78	090
66940		A	Extraction of lens	8.92	NA	7.60	0.43	NA	16.95	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
66982		A	Cataract surgery, complex	13.48	NA	9.86	0.61	NA	23.95	090
66983		A	Cataract surg w/iol, 1 stage	8.98	NA	6.11	0.22	NA	15.31	090
66984		A	Cataract surg w/iol, 1 stage	10.21	NA	7.42	0.42	NA	18.05	090
66985		A	Insert lens prosthesis	8.38	NA	7.45	0.38	NA	16.21	090
66986		A	Exchange lens prosthesis	12.26	NA	9.17	0.59	NA	22.02	090
66990		A	Ophthalmic endoscope add-on	1.51	NA	0.69	0.08	NA	2.28	ZZZ
66999		C	Eye surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
67005		A	Partial removal of eye fluid	5.69	NA	4.86	0.28	NA	10.83	090
67010		A	Partial removal of eye fluid	6.86	NA	5.41	0.34	NA	12.61	090
67015		A	Release of eye fluid	6.91	NA	6.45	0.34	NA	13.70	090
67025		A	Replace eye fluid	6.83	9.22	6.22	0.34	16.39	13.39	090
67027		A	Implant eye drug system	10.83	NA	8.00	0.54	NA	19.37	090
67028		A	Injection eye drug	2.52	2.70	1.46	0.12	5.34	4.10	000
67030		A	Incise inner eye strands	4.83	NA	5.85	0.24	NA	10.92	090
67031		A	Laser surgery, eye strands	3.66	4.60	3.64	0.18	8.44	7.48	090
67036		A	Removal of inner eye fluid	11.87	NA	9.12	0.58	NA	21.57	090
67038		A	Strip retinal membrane	21.21	NA	15.49	1.04	NA	37.74	090
67039		A	Laser treatment of retina	14.50	NA	12.18	0.71	NA	27.39	090
67040		A	Laser treatment of retina	17.20	NA	13.68	0.85	NA	31.73	090
67101		A	Repair detached retina	7.52	9.12	6.53	0.37	17.01	14.42	090
67105		A	Repair detached retina	7.40	8.08	6.15	0.37	15.85	13.92	090
67107		A	Repair detached retina	14.82	NA	11.30	0.73	NA	26.85	090
67108		A	Repair detached retina	20.79	NA	14.42	1.02	NA	36.23	090
67110		A	Repair detached retina	8.80	10.23	7.39	0.44	19.47	16.63	090
67112		A	Rerepair detached retina	16.83	NA	11.81	0.83	NA	29.47	090
67115		A	Release encircling material	4.98	NA	5.08	0.25	NA	10.31	090
67120		A	Remove eye implant material	5.97	8.58	5.53	0.30	14.85	11.80	090
67121		A	Remove eye implant material	10.65	NA	8.53	0.53	NA	19.71	090
67141		A	Treatment of retina	5.19	5.85	4.86	0.26	11.30	10.31	090
67145		A	Treatment of retina	5.36	5.72	4.93	0.27	11.35	10.56	090
67208		A	Treatment of retinal lesion	6.69	6.12	5.51	0.33	13.14	12.53	090
67210		A	Treatment of retinal lesion	8.81	6.57	5.88	0.44	15.82	15.13	090
67218		A	Treatment of retinal lesion	18.50	NA	12.15	0.92	NA	31.57	090
67220		A	Treatment of choroid lesion	13.11	10.42	9.01	0.65	24.18	22.77	090
67221		R	Ocular photodynamic ther	4.00	4.33	1.80	0.20	8.53	6.00	000
67225		A	Eye photodynamic ther add-on	0.47	0.25	0.21	0.02	0.74	0.70	ZZZ
67227		A	Treatment of retinal lesion	6.57	6.58	5.52	0.33	13.48	12.42	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
67228		A	Treatment of retinal lesion	12.72	11.48	8.54	0.63	24.83	21.89	090
67250		A	Reinforce eye wall	8.65	NA	9.17	0.47	NA	18.29	090
67255		A	Reinforce/graft eye wall	8.89	NA	9.89	0.44	NA	19.22	090
67299		C	Eye surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
67311		A	Revise eye muscle	6.64	NA	6.02	0.37	NA	13.03	090
67312		A	Revise two eye muscles	8.53	NA	6.75	0.43	NA	15.71	090
67314		A	Revise eye muscle	7.51	NA	6.55	0.39	NA	14.45	090
67316		A	Revise two eye muscles	9.65	NA	7.50	0.49	NA	17.64	090
67318		A	Revise eye muscle(s)	7.84	NA	6.93	0.41	NA	15.18	090
67320		A	Revise eye muscle(s) add-on	4.32	NA	1.95	0.23	NA	6.50	ZZZ
67331		A	Eye surgery follow-up add-on	4.05	NA	1.83	0.21	NA	6.09	ZZZ
67332		A	Rerevise eye muscles add-on	4.48	NA	2.02	0.24	NA	6.74	ZZZ
67334		A	Revise eye muscle w/suture	3.97	NA	1.79	0.20	NA	5.96	ZZZ
67335		A	Eye suture during surgery	2.49	NA	1.12	0.13	NA	3.74	ZZZ
67340		A	Revise eye muscle add-on	4.92	NA	2.20	0.25	NA	7.37	ZZZ
67343		A	Release eye tissue	7.34	NA	6.51	0.37	NA	14.22	090
67345		A	Destroy nerve of eye muscle	2.96	2.58	2.01	0.17	5.71	5.14	010
67350		A	Biopsy eye muscle	2.87	NA	1.87	0.16	NA	4.90	000
67399		C	Eye muscle surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
67400		A	Explore/biopsy eye socket	9.75	NA	11.26	0.57	NA	21.58	090
67405		A	Explore/drain eye socket	7.92	NA	9.77	0.46	NA	18.15	090
67412		A	Explore/treat eye socket	9.49	NA	10.93	0.53	NA	20.95	090
67413		A	Explore/treat eye socket	9.99	NA	10.77	0.54	NA	21.30	090
67414		A	Explr/decompress eye socket	11.11	NA	12.04	0.66	NA	23.81	090
67415		A	Aspiration, orbital contents	1.76	NA	0.76	0.10	NA	2.62	000
67420		A	Explore/treat eye socket	20.03	NA	17.39	1.22	NA	38.64	090
67430		A	Explore/treat eye socket	13.37	NA	14.89	0.91	NA	29.17	090
67440		A	Explore/drain eye socket	13.07	NA	14.26	0.77	NA	28.10	090
67445		A	Explr/decompress eye socket	14.40	NA	13.91	0.93	NA	29.24	090
67450		A	Explore/biopsy eye socket	13.49	NA	14.69	0.73	NA	28.91	090
67500		A	Inject/treat eye socket	0.79	0.67	0.29	0.06	1.52	1.14	000
67505		A	Inject/treat eye socket	0.82	0.69	0.31	0.05	1.56	1.18	000
67515		A	Inject/treat eye socket	0.61	0.59	0.38	0.03	1.23	1.02	000
67550		A	Insert eye socket implant	10.17	NA	11.30	0.73	NA	22.20	090
67560		A	Revise eye socket implant	10.58	NA	11.37	0.59	NA	22.54	090
67570		A	Decompress optic nerve	13.56	NA	13.58	0.79	NA	27.93	090
67599		C	Orbit surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
67700		A	Drainage of eyelid abscess	1.35	6.02	1.27	0.07	7.44	2.69	010
67710		A	Incision of eyelid	1.02	5.37	1.21	0.05	6.44	2.28	010
67715		A	Incision of eyelid fold	1.22	5.37	1.29	0.06	6.65	2.57	010
67800		A	Remove eyelid lesion	1.38	1.62	1.04	0.07	3.07	2.49	010
67801		A	Remove eyelid lesions	1.88	1.96	1.26	0.09	3.93	3.23	010
67805		A	Remove eyelid lesions	2.22	2.52	1.65	0.11	4.85	3.98	010
67808		A	Remove eyelid lesion(s)	3.79	NA	3.77	0.21	NA	7.77	090
67810		A	Biopsy of eyelid	1.48	3.33	0.68	0.07	4.88	2.23	000
67820		A	Revise eyelashes	0.89	0.60	0.56	0.04	1.53	1.49	000
67825		A	Revise eyelashes	1.38	1.73	1.41	0.07	3.18	2.86	010
67830		A	Revise eyelashes	1.70	5.53	1.50	0.09	7.32	3.29	010
67835		A	Revise eyelashes	5.55	NA	4.62	0.29	NA	10.46	090
67840		A	Remove eyelid lesion	2.04	5.47	1.65	0.10	7.61	3.79	010
67850		A	Treat eyelid lesion	1.69	3.37	1.47	0.08	5.14	3.24	010
67875		A	Closure of eyelid by suture	1.35	3.30	0.94	0.08	4.73	2.37	000
67880		A	Revision of eyelid	3.79	6.61	3.80	0.20	10.60	7.79	090
67882		A	Revision of eyelid	5.06	7.63	4.81	0.27	12.96	10.14	090
67900		A	Repair brow defect	6.13	9.06	5.25	0.38	15.57	11.76	090
67901		A	Repair eyelid defect	6.96	NA	5.40	0.51	NA	12.87	090
67902		A	Repair eyelid defect	7.02	NA	5.46	0.45	NA	12.93	090
67903		A	Repair eyelid defect	6.36	9.56	5.51	0.47	16.39	12.34	090
67904		A	Repair eyelid defect	6.25	9.63	5.23	0.41	16.29	11.89	090
67906		A	Repair eyelid defect	6.78	5.37	5.03	0.46	12.61	12.27	090
67908		A	Repair eyelid defect	5.12	6.63	5.34	0.29	12.04	10.75	090
67909		A	Revise eyelid defect	5.39	8.03	4.95	0.31	13.73	10.65	090
67911		A	Revise eyelid defect	5.26	NA	4.78	0.31	NA	10.35	090
67912		A	Correction eyelid w/implant	5.67	18.93	5.53	0.28	24.88	11.48	090
67914		A	Repair eyelid defect	3.67	6.34	3.05	0.21	10.22	6.93	090
67915		A	Repair eyelid defect	3.18	5.98	2.80	0.17	9.33	6.15	090
67916		A	Repair eyelid defect	5.30	8.05	4.76	0.30	13.65	10.36	090
67917		A	Repair eyelid defect	6.01	8.46	5.07	0.36	14.83	11.44	090
67921		A	Repair eyelid defect	3.39	6.19	2.89	0.18	9.76	6.46	090
67922		A	Repair eyelid defect	3.06	5.91	2.75	0.15	9.12	5.96	090
67923		A	Repair eyelid defect	5.87	8.12	4.97	0.32	14.31	11.16	090
67924		A	Repair eyelid defect	5.78	8.92	4.68	0.32	15.02	10.78	090
67930		A	Repair eyelid wound	3.60	5.71	2.17	0.21	9.52	5.98	010
67935		A	Repair eyelid wound	6.21	8.52	4.41	0.39	15.12	11.01	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
67938		A	Remove eyelid foreign body	1.33	5.38	1.26	0.07	6.78	2.66	010
67950		A	Revision of eyelid	5.81	8.63	5.21	0.36	14.80	11.38	090
67961		A	Revision of eyelid	5.68	8.68	5.03	0.33	14.69	11.04	090
67966		A	Revision of eyelid	6.56	9.13	5.56	0.37	16.06	12.49	090
67971		A	Reconstruction of eyelid	9.78	NA	7.28	0.53	NA	17.59	090
67973		A	Reconstruction of eyelid	12.85	NA	9.31	0.75	NA	22.91	090
67974		A	Reconstruction of eyelid	12.82	NA	9.23	0.75	NA	22.80	090
67975		A	Reconstruction of eyelid	9.12	NA	6.95	0.50	NA	16.57	090
67999		C	Revision of eyelid	0.00	0.00	0.00	0.00	0.00	0.00	YYY
68020		A	Incise/drain eyelid lining	1.37	1.41	1.21	0.07	2.85	2.65	010
68040		A	Treatment of eyelid lesions	0.85	0.71	0.43	0.04	1.60	1.32	000
68100		A	Biopsy of eyelid lining	1.35	3.25	0.95	0.07	4.67	2.37	000
68110		A	Remove eyelid lining lesion	1.77	4.10	1.65	0.09	5.96	3.51	010
68115		A	Remove eyelid lining lesion	2.36	5.96	1.91	0.12	8.44	4.39	010
68130		A	Remove eyelid lining lesion	4.92	8.71	4.60	0.25	13.88	9.77	090
68135		A	Remove eyelid lining lesion	1.84	1.81	1.65	0.09	3.74	3.58	010
68200		A	Treat eyelid by injection	0.49	0.54	0.33	0.02	1.05	0.84	000
68320		A	Revise/graft eyelid lining	5.36	11.28	5.52	0.28	16.92	11.16	090
68325		A	Revise/graft eyelid lining	7.35	NA	6.54	0.44	NA	14.33	090
68326		A	Revise/graft eyelid lining	7.14	NA	6.41	0.38	NA	13.93	090
68328		A	Revise/graft eyelid lining	8.17	NA	7.29	0.54	NA	16.00	090
68330		A	Revise eyelid lining	4.82	9.41	4.72	0.25	14.48	9.79	090
68335		A	Revise/graft eyelid lining	7.18	NA	6.38	0.36	NA	13.92	090
68340		A	Separate eyelid adhesions	4.16	8.87	4.10	0.21	13.24	8.47	090
68360		A	Revise eyelid lining	4.36	8.04	4.18	0.22	12.62	8.76	090
68362		A	Revise eyelid lining	7.33	NA	6.40	0.36	NA	14.09	090
68371		A	Harvest eye tissue, alograft	4.89	NA	4.73	0.44	NA	10.06	010
68399		C	Eyelid lining surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
68400		A	Incise/drain tear gland	1.69	5.90	1.82	0.09	7.68	3.60	010
68420		A	Incise/drain tear sac	2.30	6.19	2.10	0.12	8.61	4.52	010
68440		A	Incise tear duct opening	0.94	2.08	1.27	0.05	3.07	2.26	010
68500		A	Removal of tear gland	11.00	NA	9.73	0.55	NA	21.28	090
68505		A	Partial removal, tear gland	10.92	NA	10.65	0.57	NA	22.14	090
68510		A	Biopsy of tear gland	4.60	7.33	2.09	0.24	12.17	6.93	000
68520		A	Removal of tear sac	7.50	NA	7.42	0.41	NA	15.33	090
68525		A	Biopsy of tear sac	4.42	NA	2.02	0.23	NA	6.67	000
68530		A	Clearance of tear duct	3.65	8.17	2.64	0.20	12.02	6.49	010

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
68540		A	Remove tear gland lesion	10.58	NA	9.39	0.61	NA	20.58	090
68550		A	Remove tear gland lesion	13.24	NA	11.35	0.79	NA	25.38	090
68700		A	Repair tear ducts	6.59	NA	5.98	0.35	NA	12.92	090
68705		A	Revise tear duct opening	2.06	4.17	1.79	0.10	6.33	3.95	010
68720		A	Create tear sac drain	8.95	NA	7.86	0.49	NA	17.30	090
68745		A	Create tear duct drain	8.62	NA	7.86	0.51	NA	16.99	090
68750		A	Create tear duct drain	8.65	NA	8.27	0.47	NA	17.39	090
68760		A	Close tear duct opening	1.73	3.54	1.63	0.09	5.36	3.45	010
68761		A	Close tear duct opening	1.36	2.27	1.32	0.07	3.70	2.75	010
68770		A	Close tear system fistula	7.01	3.18	3.18	0.35	10.54	10.54	090
68801		A	Dilate tear duct opening	0.94	1.94	1.48	0.05	2.93	2.47	010
68810		A	Probe nasolacrimal duct	1.90	3.66	2.67	0.11	5.67	4.68	010
68811		A	Probe nasolacrimal duct	2.35	NA	2.41	0.14	NA	4.90	010
68815		A	Probe nasolacrimal duct	3.20	8.24	2.81	0.18	11.62	6.19	010
68840		A	Explore/irrigate tear ducts	1.25	1.60	1.12	0.06	2.91	2.43	010
68850		A	Injection for tear sac x-ray	0.80	0.88	0.68	0.04	1.72	1.52	000
68899		C	Tear duct system surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69000		A	Drain external ear lesion	1.45	2.88	1.36	0.12	4.45	2.93	010
69005		A	Drain external ear lesion	2.11	2.93	1.83	0.18	5.22	4.12	010
69020		A	Drain outer ear canal lesion	1.48	3.99	2.06	0.12	5.59	3.66	010
69090		N	Pierce earlobes	0.00	0.00	0.00	0.00	0.00	0.00	XXX
69100		A	Biopsy of external ear	0.81	1.71	0.39	0.04	2.56	1.24	000
69105		A	Biopsy of external ear canal	0.85	2.34	0.77	0.07	3.26	1.69	000
69110		A	Remove external ear, partial	3.43	6.74	4.47	0.30	10.47	8.20	090
69120		A	Removal of external ear	4.04	NA	6.18	0.38	NA	10.60	090
69140		A	Remove ear canal lesion(s)	7.96	NA	13.28	0.67	NA	21.91	090
69145		A	Remove ear canal lesion(s)	2.62	5.78	3.30	0.22	8.62	6.14	090
69150		A	Extensive ear canal surgery	13.41	NA	13.40	1.25	NA	28.06	090
69155		A	Extensive ear/neck surgery	20.77	NA	19.54	1.98	NA	42.29	090
69200		A	Clear outer ear canal	0.77	2.38	0.55	0.06	3.21	1.38	000
69205		A	Clear outer ear canal	1.20	NA	1.36	0.10	NA	2.66	010
69210		A	Remove impacted ear wax	0.61	0.63	0.23	0.05	1.29	0.89	000
69220		A	Clean out mastoid cavity	0.83	2.36	0.73	0.07	3.26	1.63	000
69222		A	Clean out mastoid cavity	1.40	3.85	2.06	0.12	5.37	3.58	010
69300		R	Revise external ear	6.35	NA	4.22	0.72	NA	11.29	YYY
69310		A	Rebuild outer ear canal	10.77	NA	16.28	0.86	NA	27.91	090
69320		A	Rebuild outer ear canal	16.93	NA	21.84	1.40	NA	40.17	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
69399		C	Outer ear surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69400		A	Inflate middle ear canal	0.83	2.16	0.67	0.07	3.06	1.57	000
69401		A	Inflate middle ear canal	0.63	1.24	0.65	0.05	1.92	1.33	000
69405		A	Catheterize middle ear canal	2.63	3.50	2.31	0.22	6.35	5.16	010
69410		A	Inset middle ear (baffle)	0.33	2.10	0.48	0.03	2.46	0.84	000
69420		A	Incision of eardrum	1.33	3.15	1.59	0.11	4.59	3.03	010
69421		A	Incision of eardrum	1.73	NA	2.16	0.15	NA	4.04	010
69424		A	Remove ventilating tube	0.85	2.18	0.68	0.07	3.10	1.60	000
69433		A	Create eardrum opening	1.52	3.09	1.64	0.13	4.74	3.29	010
69436		A	Create eardrum opening	1.96	NA	2.29	0.19	NA	4.44	010
69440		A	Exploration of middle ear	7.56	NA	8.77	0.61	NA	16.94	090
69450		A	Eardrum revision	5.56	NA	7.03	0.45	NA	13.04	090
69501		A	Mastoidectomy	9.06	NA	9.00	0.77	NA	18.83	090
69502		A	Mastoidectomy	12.36	NA	11.59	1.00	NA	24.95	090
69505		A	Remove mastoid structures	12.97	NA	17.19	1.08	NA	31.24	090
69511		A	Extensive mastoid surgery	13.50	NA	17.47	1.09	NA	32.06	090
69530		A	Extensive mastoid surgery	19.16	NA	21.63	1.52	NA	42.31	090
69535		A	Remove part of temporal bone	36.09	NA	31.96	2.86	NA	70.91	090
69540		A	Remove ear lesion	1.20	3.74	1.97	0.10	5.04	3.27	010
69550		A	Remove ear lesion	10.97	NA	14.86	0.90	NA	26.73	090
69552		A	Remove ear lesion	19.43	NA	20.67	1.57	NA	41.67	090
69554		A	Remove ear lesion	33.11	NA	30.33	2.89	NA	66.33	090
69601		A	Mastoid surgery revision	13.22	NA	12.67	1.05	NA	26.94	090
69602		A	Mastoid surgery revision	13.56	NA	13.23	1.10	NA	27.89	090
69603		A	Mastoid surgery revision	14.00	NA	18.36	1.15	NA	33.51	090
69604		A	Mastoid surgery revision	14.00	NA	13.69	1.12	NA	28.81	090
69605		A	Mastoid surgery revision	18.46	NA	20.95	1.49	NA	40.90	090
69610		A	Repair of eardrum	4.42	5.55	3.27	0.36	10.33	8.05	010
69620		A	Repair of eardrum	5.88	11.12	6.29	0.47	17.47	12.64	090
69631		A	Repair eardrum structures	9.85	NA	11.20	0.80	NA	21.85	090
69632		A	Rebuild eardrum structures	12.73	NA	13.47	1.04	NA	27.24	090
69633		A	Rebuild eardrum structures	12.08	NA	13.05	0.98	NA	26.11	090
69635		A	Repair eardrum structures	13.31	NA	16.74	1.09	NA	31.14	090
69636		A	Rebuild eardrum structures	15.20	NA	19.30	1.24	NA	35.74	090
69637		A	Rebuild eardrum structures	15.09	NA	19.22	1.23	NA	35.54	090
69641		A	Revise middle ear & mastoid	12.69	NA	12.78	1.04	NA	26.51	090
69642		A	Revise middle ear & mastoid	16.81	NA	16.28	1.37	NA	34.46	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
69643		A	Revise middle ear & mastoid	15.30	NA	14.82	1.24	NA	31.36	090
69644		A	Revise middle ear & mastoid	16.94	NA	20.40	1.37	NA	38.71	090
69645		A	Revise middle ear & mastoid	16.36	NA	20.02	1.33	NA	37.71	090
69646		A	Revise middle ear & mastoid	17.96	NA	20.76	1.46	NA	40.18	090
69650		A	Release middle ear bone	9.65	NA	9.91	0.78	NA	20.34	090
69660		A	Revise middle ear bone	11.88	NA	11.18	0.96	NA	24.02	090
69661		A	Revise middle ear bone	15.72	NA	14.70	1.27	NA	31.69	090
69662		A	Revise middle ear bone	15.42	NA	13.75	1.25	NA	30.42	090
69666		A	Repair middle ear structures	9.74	NA	9.97	0.79	NA	20.50	090
69667		A	Repair middle ear structures	9.75	NA	9.98	0.79	NA	20.52	090
69670		A	Remove mastoid air cells	11.49	NA	11.71	0.92	NA	24.12	090
69676		A	Remove middle ear nerve	9.51	NA	10.75	0.80	NA	21.06	090
69700		A	Close mastoid fistula	8.22	NA	9.24	0.67	NA	18.13	090
69710		N	Implant/replace hearing aid	0.00	0.00	0.00	0.00	0.00	0.00	XXX
69711		A	Remove/repair hearing aid	10.42	NA	10.79	0.83	NA	22.04	090
69714		A	Implant temple bone w/stimul	13.98	NA	12.66	1.13	NA	27.77	090
69715		A	Temple bne implnt w/stimulat	16.22	NA	15.03	1.47	NA	34.72	090
69717		A	Temple bone implant revision	14.96	NA	14.47	0.90	NA	30.33	090
69718		A	Revise temple bone implant	18.47	NA	15.30	3.18	NA	36.95	090
69720		A	Release facial nerve	14.36	NA	14.52	1.18	NA	30.06	090
69725		A	Release facial nerve	25.34	NA	20.13	2.42	NA	47.89	090
69740		A	Repair facial nerve	15.94	NA	13.41	1.27	NA	30.62	090
69745		A	Repair facial nerve	16.66	NA	14.97	1.14	NA	32.77	090
69799		C	Middle ear surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69801		A	Incise inner ear	8.55	NA	9.46	0.69	NA	18.70	090
69802		A	Incise inner ear	13.08	NA	12.32	1.06	NA	26.46	090
69805		A	Explore inner ear	13.80	NA	11.88	1.12	NA	26.80	090
69806		A	Explore inner ear	12.33	NA	11.04	1.01	NA	24.38	090
69820		A	Establish inner ear window	10.32	NA	11.22	0.90	NA	22.44	090
69840		A	Revise inner ear window	10.24	NA	13.17	0.79	NA	24.20	090
69905		A	Remove inner ear	11.08	NA	11.35	1.02	NA	23.45	090
69910		A	Remove inner ear & mastoid	13.61	NA	11.92	1.06	NA	26.59	090
69915		A	Incise inner ear nerve	21.20	NA	16.46	1.67	NA	39.33	090
69930		A	Implant cochlear device	16.78	NA	14.75	1.36	NA	32.89	090
69949		C	Inner ear surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69950		A	Incise inner ear nerve	25.60	NA	18.90	2.26	NA	46.76	090
69955		A	Release facial nerve	27.00	NA	21.38	2.46	NA	50.84	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
69960		A	Release inner ear canal	27.00	NA	20.05	2.15	NA	49.20	090
69970		A	Remove inner ear lesion	29.99	NA	23.27	2.59	NA	55.85	090
69979		C	Temporal bone surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69990		R	Microsurgery add-on	3.46	NA	1.79	0.83	NA	6.08	ZZZ
70010		A	Contrast x-ray of brain	1.19	4.72	NA	0.28	6.19	NA	XXX
70010	26	A	Contrast x-ray of brain	1.19	0.39	0.39	0.06	1.64	1.64	XXX
70010	TC	A	Contrast x-ray of brain	0.00	4.33	NA	0.22	4.55	NA	XXX
70015		A	Contrast x-ray of brain	1.19	1.74	NA	0.16	3.09	NA	XXX
70015	26	A	Contrast x-ray of brain	1.19	0.39	0.39	0.08	1.66	1.66	XXX
70015	TC	A	Contrast x-ray of brain	0.00	1.35	NA	0.08	1.43	NA	XXX
70030		A	X-ray eye for foreign body	0.17	0.48	NA	0.03	0.68	NA	XXX
70030	26	A	X-ray eye for foreign body	0.17	0.06	0.06	0.01	0.24	0.24	XXX
70030	TC	A	X-ray eye for foreign body	0.00	0.42	NA	0.02	0.44	NA	XXX
70100		A	X-ray exam of jaw	0.18	0.58	NA	0.03	0.79	NA	XXX
70100	26	A	X-ray exam of jaw	0.18	0.06	0.06	0.01	0.25	0.25	XXX
70100	TC	A	X-ray exam of jaw	0.00	0.52	NA	0.02	0.54	NA	XXX
70110		A	X-ray exam of jaw	0.25	0.70	NA	0.05	1.00	NA	XXX
70110	26	A	X-ray exam of jaw	0.25	0.08	0.08	0.01	0.34	0.34	XXX
70110	TC	A	X-ray exam of jaw	0.00	0.62	NA	0.04	0.66	NA	XXX
70120		A	X-ray exam of mastoids	0.18	0.68	NA	0.05	0.91	NA	XXX
70120	26	A	X-ray exam of mastoids	0.18	0.06	0.06	0.01	0.25	0.25	XXX
70120	TC	A	X-ray exam of mastoids	0.00	0.62	NA	0.04	0.66	NA	XXX
70130		A	X-ray exam of mastoids	0.34	0.89	NA	0.07	1.30	NA	XXX
70130	26	A	X-ray exam of mastoids	0.34	0.11	0.11	0.02	0.47	0.47	XXX
70130	TC	A	X-ray exam of mastoids	0.00	0.78	NA	0.05	0.83	NA	XXX
70134		A	X-ray exam of middle ear	0.34	0.84	NA	0.07	1.25	NA	XXX
70134	26	A	X-ray exam of middle ear	0.34	0.11	0.11	0.02	0.47	0.47	XXX
70134	TC	A	X-ray exam of middle ear	0.00	0.73	NA	0.05	0.78	NA	XXX
70140		A	X-ray exam of facial bones	0.19	0.68	NA	0.05	0.92	NA	XXX
70140	26	A	X-ray exam of facial bones	0.19	0.06	0.06	0.01	0.26	0.26	XXX
70140	TC	A	X-ray exam of facial bones	0.00	0.62	NA	0.04	0.66	NA	XXX
70150		A	X-ray exam of facial bones	0.26	0.86	NA	0.06	1.18	NA	XXX
70150	26	A	X-ray exam of facial bones	0.26	0.08	0.08	0.01	0.35	0.35	XXX
70150	TC	A	X-ray exam of facial bones	0.00	0.78	NA	0.05	0.83	NA	XXX
70160		A	X-ray exam of nasal bones	0.17	0.58	NA	0.03	0.78	NA	XXX
70160	26	A	X-ray exam of nasal bones	0.17	0.06	0.06	0.01	0.24	0.24	XXX
70160	TC	A	X-ray exam of nasal bones	0.00	0.52	NA	0.02	0.54	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
70170		A	X-ray exam of tear duct	0.30	1.05	NA	0.07	1.42	NA	XXX
70170	26	A	X-ray exam of tear duct	0.30	0.10	0.10	0.01	0.41	0.41	XXX
70170	TC	A	X-ray exam of tear duct	0.00	0.95	NA	0.06	1.01	NA	XXX
70190		A	X-ray exam of eye sockets	0.21	0.69	NA	0.05	0.95	NA	XXX
70190	26	A	X-ray exam of eye sockets	0.21	0.07	0.07	0.01	0.29	0.29	XXX
70190	TC	A	X-ray exam of eye sockets	0.00	0.62	NA	0.04	0.66	NA	XXX
70200		A	X-ray exam of eye sockets	0.28	0.87	NA	0.06	1.21	NA	XXX
70200	26	A	X-ray exam of eye sockets	0.28	0.09	0.09	0.01	0.38	0.38	XXX
70200	TC	A	X-ray exam of eye sockets	0.00	0.78	NA	0.05	0.83	NA	XXX
70210		A	X-ray exam of sinuses	0.17	0.68	NA	0.05	0.90	NA	XXX
70210	26	A	X-ray exam of sinuses	0.17	0.06	0.06	0.01	0.24	0.24	XXX
70210	TC	A	X-ray exam of sinuses	0.00	0.62	NA	0.04	0.66	NA	XXX
70220		A	X-ray exam of sinuses	0.25	0.86	NA	0.06	1.17	NA	XXX
70220	26	A	X-ray exam of sinuses	0.25	0.08	0.08	0.01	0.34	0.34	XXX
70220	TC	A	X-ray exam of sinuses	0.00	0.78	NA	0.05	0.83	NA	XXX
70240		A	X-ray exam, pituitary saddle	0.19	0.48	NA	0.03	0.70	NA	XXX
70240	26	A	X-ray exam, pituitary saddle	0.19	0.06	0.06	0.01	0.26	0.26	XXX
70240	TC	A	X-ray exam, pituitary saddle	0.00	0.42	NA	0.02	0.44	NA	XXX
70250		A	X-ray exam of skull	0.24	0.70	NA	0.05	0.99	NA	XXX
70250	26	A	X-ray exam of skull	0.24	0.08	0.08	0.01	0.33	0.33	XXX
70250	TC	A	X-ray exam of skull	0.00	0.62	NA	0.04	0.66	NA	XXX
70260		A	X-ray exam of skull	0.34	1.00	NA	0.08	1.42	NA	XXX
70260	26	A	X-ray exam of skull	0.34	0.11	0.11	0.02	0.47	0.47	XXX
70260	TC	A	X-ray exam of skull	0.00	0.89	NA	0.06	0.95	NA	XXX
70300		A	X-ray exam of teeth	0.10	0.31	NA	0.03	0.44	NA	XXX
70300	26	A	X-ray exam of teeth	0.10	0.05	0.05	0.01	0.16	0.16	XXX
70300	TC	A	X-ray exam of teeth	0.00	0.26	NA	0.02	0.28	NA	XXX
70310		A	X-ray exam of teeth	0.16	0.50	NA	0.03	0.69	NA	XXX
70310	26	A	X-ray exam of teeth	0.16	0.08	0.08	0.01	0.25	0.25	XXX
70310	TC	A	X-ray exam of teeth	0.00	0.42	NA	0.02	0.44	NA	XXX
70320		A	Full mouth x-ray of teeth	0.22	0.86	NA	0.06	1.14	NA	XXX
70320	26	A	Full mouth x-ray of teeth	0.22	0.08	0.08	0.01	0.31	0.31	XXX
70320	TC	A	Full mouth x-ray of teeth	0.00	0.78	NA	0.05	0.83	NA	XXX
70328		A	X-ray exam of jaw joint	0.18	0.55	NA	0.03	0.76	NA	XXX
70328	26	A	X-ray exam of jaw joint	0.18	0.06	0.06	0.01	0.25	0.25	XXX
70328	TC	A	X-ray exam of jaw joint	0.00	0.49	NA	0.02	0.51	NA	XXX
70330		A	X-ray exam of jaw joints	0.24	0.92	NA	0.06	1.22	NA	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
70330	26	A	X-ray exam of jaw joints	0.24	0.08	0.08	0.01	0.33	0.33	XXX
70330	TC	A	X-ray exam of jaw joints	0.00	0.84	NA	0.05	0.89	NA	XXX
70332		A	X-ray exam of jaw joint	0.54	2.30	NA	0.15	2.99	NA	XXX
70332	26	A	X-ray exam of jaw joint	0.54	0.20	0.20	0.03	0.77	0.77	XXX
70332	TC	A	X-ray exam of jaw joint	0.00	2.10	NA	0.12	2.22	NA	XXX
70336		A	Magnetic image, jaw joint	1.48	11.69	NA	0.66	13.83	NA	XXX
70336	26	A	Magnetic image, jaw joint	1.48	0.49	0.49	0.07	2.04	2.04	XXX
70336	TC	A	Magnetic image, jaw joint	0.00	11.20	NA	0.59	11.79	NA	XXX
70350		A	X-ray head for orthodontia	0.17	0.45	NA	0.03	0.65	NA	XXX
70350	26	A	X-ray head for orthodontia	0.17	0.07	0.07	0.01	0.25	0.25	XXX
70350	TC	A	X-ray head for orthodontia	0.00	0.38	NA	0.02	0.40	NA	XXX
70355		A	Panoramic x-ray of jaws	0.20	0.64	NA	0.05	0.89	NA	XXX
70355	26	A	Panoramic x-ray of jaws	0.20	0.07	0.07	0.01	0.28	0.28	XXX
70355	TC	A	Panoramic x-ray of jaws	0.00	0.57	NA	0.04	0.61	NA	XXX
70360		A	X-ray exam of neck	0.17	0.48	NA	0.03	0.68	NA	XXX
70360	26	A	X-ray exam of neck	0.17	0.06	0.06	0.01	0.24	0.24	XXX
70360	TC	A	X-ray exam of neck	0.00	0.42	NA	0.02	0.44	NA	XXX
70370		A	Throat x-ray & fluoroscopy	0.32	1.41	NA	0.08	1.81	NA	XXX
70370	26	A	Throat x-ray & fluoroscopy	0.32	0.10	0.10	0.01	0.43	0.43	XXX
70370	TC	A	Throat x-ray & fluoroscopy	0.00	1.31	NA	0.07	1.38	NA	XXX
70371		A	Speech evaluation, complex	0.84	2.38	NA	0.16	3.38	NA	XXX
70371	26	A	Speech evaluation, complex	0.84	0.28	0.28	0.04	1.16	1.16	XXX
70371	TC	A	Speech evaluation, complex	0.00	2.10	NA	0.12	2.22	NA	XXX
70373		A	Contrast x-ray of larynx	0.44	1.92	NA	0.13	2.49	NA	XXX
70373	26	A	Contrast x-ray of larynx	0.44	0.14	0.14	0.02	0.60	0.60	XXX
70373	TC	A	Contrast x-ray of larynx	0.00	1.78	NA	0.11	1.89	NA	XXX
70380		A	X-ray exam of salivary gland	0.17	0.73	NA	0.05	0.95	NA	XXX
70380	26	A	X-ray exam of salivary gland	0.17	0.06	0.06	0.01	0.24	0.24	XXX
70380	TC	A	X-ray exam of salivary gland	0.00	0.67	NA	0.04	0.71	NA	XXX
70390		A	X-ray exam of salivary duct	0.38	1.90	NA	0.13	2.41	NA	XXX
70390	26	A	X-ray exam of salivary duct	0.38	0.12	0.12	0.02	0.52	0.52	XXX
70390	TC	A	X-ray exam of salivary duct	0.00	1.78	NA	0.11	1.89	NA	XXX
70450		A	Ct head/brain w/o dye	0.85	5.00	NA	0.29	6.14	NA	XXX
70450	26	A	Ct head/brain w/o dye	0.85	0.28	0.28	0.04	1.17	1.17	XXX
70450	TC	A	Ct head/brain w/o dye	0.00	4.72	NA	0.25	4.97	NA	XXX
70460		A	Ct head/brain w/dye	1.13	6.03	NA	0.35	7.51	NA	XXX
70460	26	A	Ct head/brain w/dye	1.13	0.37	0.37	0.05	1.55	1.55	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
70460	TC	A	Ct head/brain w/dye	0.00	5.66	NA	0.30	5.96	NA	XXX
70470		A	Ct head/brain w/o & w/dye	1.27	7.49	NA	0.43	9.19	NA	XXX
70470	26	A	Ct head/brain w/o & w/dye	1.27	0.42	0.42	0.06	1.75	1.75	XXX
70470	TC	A	Ct head/brain w/o & w/dye	0.00	7.07	NA	0.37	7.44	NA	XXX
70480		A	Ct orbit/ear/fossa w/o dye	1.28	5.14	NA	0.31	6.73	NA	XXX
70480	26	A	Ct orbit/ear/fossa w/o dye	1.28	0.42	0.42	0.06	1.76	1.76	XXX
70480	TC	A	Ct orbit/ear/fossa w/o dye	0.00	4.72	NA	0.25	4.97	NA	XXX
70481		A	Ct orbit/ear/fossa w/dye	1.38	6.11	NA	0.36	7.85	NA	XXX
70481	26	A	Ct orbit/ear/fossa w/dye	1.38	0.45	0.45	0.06	1.89	1.89	XXX
70481	TC	A	Ct orbit/ear/fossa w/dye	0.00	5.66	NA	0.30	5.96	NA	XXX
70482		A	Ct orbit/ear/fossa w/o&w/dye	1.45	7.55	NA	0.43	9.43	NA	XXX
70482	26	A	Ct orbit/ear/fossa w/o&w/dye	1.45	0.48	0.48	0.06	1.99	1.99	XXX
70482	TC	A	Ct orbit/ear/fossa w/o&w/dye	0.00	7.07	NA	0.37	7.44	NA	XXX
70486		A	Ct maxillofacial w/o dye	1.14	5.09	NA	0.30	6.53	NA	XXX
70486	26	A	Ct maxillofacial w/o dye	1.14	0.37	0.37	0.05	1.56	1.56	XXX
70486	TC	A	Ct maxillofacial w/o dye	0.00	4.72	NA	0.25	4.97	NA	XXX
70487		A	Ct maxillofacial w/dye	1.30	6.09	NA	0.36	7.75	NA	XXX
70487	26	A	Ct maxillofacial w/dye	1.30	0.43	0.43	0.06	1.79	1.79	XXX
70487	TC	A	Ct maxillofacial w/dye	0.00	5.66	NA	0.30	5.96	NA	XXX
70488		A	Ct maxillofacial w/o & w/dye	1.42	7.53	NA	0.43	9.38	NA	XXX
70488	26	A	Ct maxillofacial w/o & w/dye	1.42	0.46	0.46	0.06	1.94	1.94	XXX
70488	TC	A	Ct maxillofacial w/o & w/dye	0.00	7.07	NA	0.37	7.44	NA	XXX
70490		A	Ct soft tissue neck w/o dye	1.28	5.14	NA	0.31	6.73	NA	XXX
70490	26	A	Ct soft tissue neck w/o dye	1.28	0.42	0.42	0.06	1.76	1.76	XXX
70490	TC	A	Ct soft tissue neck w/o dye	0.00	4.72	NA	0.25	4.97	NA	XXX
70491		A	Ct soft tissue neck w/dye	1.38	6.11	NA	0.36	7.85	NA	XXX
70491	26	A	Ct soft tissue neck w/dye	1.38	0.45	0.45	0.06	1.89	1.89	XXX
70491	TC	A	Ct soft tissue neck w/dye	0.00	5.66	NA	0.30	5.96	NA	XXX
70492		A	Ct sft tsue nck w/o & w/dye	1.45	7.54	NA	0.43	9.42	NA	XXX
70492	26	A	Ct sft tsue nck w/o & w/dye	1.45	0.47	0.47	0.06	1.98	1.98	XXX
70492	TC	A	Ct sft tsue nck w/o & w/dye	0.00	7.07	NA	0.37	7.44	NA	XXX
70496		A	Ct angiography, head	1.75	11.17	NA	0.66	13.58	NA	XXX
70496	26	A	Ct angiography, head	1.75	0.57	0.57	0.08	2.40	2.40	XXX
70496	TC	A	Ct angiography, head	0.00	10.60	NA	0.58	11.18	NA	XXX
70498		A	Ct angiography, neck	1.75	11.17	NA	0.66	13.58	NA	XXX
70498	26	A	Ct angiography, neck	1.75	0.57	0.57	0.08	2.40	2.40	XXX
70498	TC	A	Ct angiography, neck	0.00	10.60	NA	0.58	11.18	NA	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
70540		A	Mri orbit/face/neck w/o dye	1.35	11.64	NA	0.45	13.44	NA	XXX
70540	26	A	Mri orbit/face/neck w/o dye	1.35	0.44	0.44	0.06	1.85	1.85	XXX
70540	TC	A	Mri orbit/face/neck w/o dye	0.00	11.20	NA	0.39	11.59	NA	XXX
70542		A	Mri orbit/face/neck w/dye	1.62	13.97	NA	0.54	16.13	NA	XXX
70542	26	A	Mri orbit/face/neck w/dye	1.62	0.53	0.53	0.07	2.22	2.22	XXX
70542	TC	A	Mri orbit/face/neck w/dye	0.00	13.44	NA	0.47	13.91	NA	XXX
70543		A	Mri orbt/fac/nck w/o & w/dye	2.15	25.59	NA	0.94	28.68	NA	XXX
70543	26	A	Mri orbt/fac/nck w/o & w/dye	2.15	0.71	0.71	0.10	2.96	2.96	XXX
70543	TC	A	Mri orbt/fac/nck w/o & w/dye	0.00	24.88	NA	0.84	25.72	NA	XXX
70544		A	Mr angiography head w/o dye	1.20	11.60	NA	0.64	13.44	NA	XXX
70544	26	A	Mr angiography head w/o dye	1.20	0.40	0.40	0.05	1.65	1.65	XXX
70544	TC	A	Mr angiography head w/o dye	0.00	11.20	NA	0.59	11.79	NA	XXX
70545		A	Mr angiography head w/dye	1.20	11.59	NA	0.64	13.43	NA	XXX
70545	26	A	Mr angiography head w/dye	1.20	0.39	0.39	0.05	1.64	1.64	XXX
70545	TC	A	Mr angiography head w/dye	0.00	11.20	NA	0.59	11.79	NA	XXX
70546		A	Mr angiograph head w/o&w/dye	1.80	23.00	NA	0.67	25.47	NA	XXX
70546	26	A	Mr angiograph head w/o&w/dye	1.80	0.59	0.59	0.08	2.47	2.47	XXX
70546	TC	A	Mr angiograph head w/o&w/dye	0.00	22.41	NA	0.59	23.00	NA	XXX
70547		A	Mr angiography neck w/o dye	1.20	11.59	NA	0.64	13.43	NA	XXX
70547	26	A	Mr angiography neck w/o dye	1.20	0.39	0.39	0.05	1.64	1.64	XXX
70547	TC	A	Mr angiography neck w/o dye	0.00	11.20	NA	0.59	11.79	NA	XXX
70548		A	Mr angiography neck w/dye	1.20	11.59	NA	0.64	13.43	NA	XXX
70548	26	A	Mr angiography neck w/dye	1.20	0.39	0.39	0.05	1.64	1.64	XXX
70548	TC	A	Mr angiography neck w/dye	0.00	11.20	NA	0.59	11.79	NA	XXX
70549		A	Mr angiograph neck w/o&w/dye	1.80	23.00	NA	0.67	25.47	NA	XXX
70549	26	A	Mr angiograph neck w/o&w/dye	1.80	0.59	0.59	0.08	2.47	2.47	XXX
70549	TC	A	Mr angiograph neck w/o&w/dye	0.00	22.41	NA	0.59	23.00	NA	XXX
70551		A	Mri brain w/o dye	1.48	11.69	NA	0.66	13.83	NA	XXX
70551	26	A	Mri brain w/o dye	1.48	0.49	0.49	0.07	2.04	2.04	XXX
70551	TC	A	Mri brain w/o dye	0.00	11.20	NA	0.59	11.79	NA	XXX
70552		A	Mri brain w/dye	1.78	14.03	NA	0.78	16.59	NA	XXX
70552	26	A	Mri brain w/dye	1.78	0.59	0.59	0.08	2.45	2.45	XXX
70552	TC	A	Mri brain w/dye	0.00	13.44	NA	0.70	14.14	NA	XXX
70553		A	Mri brain w/o & w/dye	2.36	25.66	NA	1.42	29.44	NA	XXX
70553	26	A	Mri brain w/o & w/dye	2.36	0.78	0.78	0.11	3.25	3.25	XXX
70553	TC	A	Mri brain w/o & w/dye	0.00	24.88	NA	1.31	26.19	NA	XXX
70557		C	Mri brain w/o dye	0.00	0.00	0.00	0.00	0.00	0.00	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
70557	26	A	Mri brain w/o dye	2.90	1.13	1.13	0.08	4.11	4.11	XXX
70557	TC	C	Mri brain w/o dye	0.00	0.00	0.00	0.00	0.00	0.00	XXX
70558		C	Mri brain w/dye	0.00	0.00	0.00	0.00	0.00	0.00	XXX
70558	26	A	Mri brain w/dye	3.20	1.24	1.24	0.10	4.54	4.54	XXX
70558	TC	C	Mri brain w/dye	0.00	0.00	0.00	0.00	0.00	0.00	XXX
70559		C	Mri brain w/o & w/dye	0.00	0.00	0.00	0.00	0.00	0.00	XXX
70559	26	A	Mri brain w/o & w/dye	3.20	1.24	1.24	0.12	4.56	4.56	XXX
70559	TC	C	Mri brain w/o & w/dye	0.00	0.00	0.00	0.00	0.00	0.00	XXX
71010		A	Chest x-ray	0.18	0.53	NA	0.03	0.74	NA	XXX
71010	26	A	Chest x-ray	0.18	0.06	0.06	0.01	0.25	0.25	XXX
71010	TC	A	Chest x-ray	0.00	0.47	NA	0.02	0.49	NA	XXX
71015		A	Chest x-ray	0.21	0.59	NA	0.03	0.83	NA	XXX
71015	26	A	Chest x-ray	0.21	0.07	0.07	0.01	0.29	0.29	XXX
71015	TC	A	Chest x-ray	0.00	0.52	NA	0.02	0.54	NA	XXX
71020		A	Chest x-ray	0.22	0.69	NA	0.05	0.96	NA	XXX
71020	26	A	Chest x-ray	0.22	0.07	0.07	0.01	0.30	0.30	XXX
71020	TC	A	Chest x-ray	0.00	0.62	NA	0.04	0.66	NA	XXX
71021		A	Chest x-ray	0.27	0.82	NA	0.06	1.15	NA	XXX
71021	26	A	Chest x-ray	0.27	0.09	0.09	0.01	0.37	0.37	XXX
71021	TC	A	Chest x-ray	0.00	0.73	NA	0.05	0.78	NA	XXX
71022		A	Chest x-ray	0.31	0.83	NA	0.06	1.20	NA	XXX
71022	26	A	Chest x-ray	0.31	0.10	0.10	0.01	0.42	0.42	XXX
71022	TC	A	Chest x-ray	0.00	0.73	NA	0.05	0.78	NA	XXX
71023		A	Chest x-ray and fluoroscopy	0.38	0.91	NA	0.07	1.36	NA	XXX
71023	26	A	Chest x-ray and fluoroscopy	0.38	0.13	0.13	0.02	0.53	0.53	XXX
71023	TC	A	Chest x-ray and fluoroscopy	0.00	0.78	NA	0.05	0.83	NA	XXX
71030		A	Chest x-ray	0.31	0.88	NA	0.06	1.25	NA	XXX
71030	26	A	Chest x-ray	0.31	0.10	0.10	0.01	0.42	0.42	XXX
71030	TC	A	Chest x-ray	0.00	0.78	NA	0.05	0.83	NA	XXX
71034		A	Chest x-ray and fluoroscopy	0.46	1.60	NA	0.10	2.16	NA	XXX
71034	26	A	Chest x-ray and fluoroscopy	0.46	0.16	0.16	0.02	0.64	0.64	XXX
71034	TC	A	Chest x-ray and fluoroscopy	0.00	1.44	NA	0.08	1.52	NA	XXX
71035		A	Chest x-ray	0.18	0.58	NA	0.03	0.79	NA	XXX
71035	26	A	Chest x-ray	0.18	0.06	0.06	0.01	0.25	0.25	XXX
71035	TC	A	Chest x-ray	0.00	0.52	NA	0.02	0.54	NA	XXX
71040		A	Contrast x-ray of bronchi	0.58	1.65	NA	0.11	2.34	NA	XXX
71040	26	A	Contrast x-ray of bronchi	0.58	0.19	0.19	0.03	0.80	0.80	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
71040	TC	A	Contrast x-ray of bronchi	0.00	1.46	NA	0.08	1.54	NA	XXX
71060		A	Contrast x-ray of bronchi	0.74	2.44	NA	0.17	3.35	NA	XXX
71060	26	A	Contrast x-ray of bronchi	0.74	0.24	0.24	0.04	1.02	1.02	XXX
71060	TC	A	Contrast x-ray of bronchi	0.00	2.20	NA	0.13	2.33	NA	XXX
71090		A	X-ray & pacemaker insertion	0.54	1.89	NA	0.13	2.56	NA	XXX
71090	26	A	X-ray & pacemaker insertion	0.54	0.21	0.21	0.02	0.77	0.77	XXX
71090	TC	A	X-ray & pacemaker insertion	0.00	1.68	NA	0.11	1.79	NA	XXX
71100		A	X-ray exam of ribs	0.22	0.64	NA	0.05	0.91	NA	XXX
71100	26	A	X-ray exam of ribs	0.22	0.07	0.07	0.01	0.30	0.30	XXX
71100	TC	A	X-ray exam of ribs	0.00	0.57	NA	0.04	0.61	NA	XXX
71101		A	X-ray exam of ribs/chest	0.27	0.76	NA	0.05	1.08	NA	XXX
71101	26	A	X-ray exam of ribs/chest	0.27	0.09	0.09	0.01	0.37	0.37	XXX
71101	TC	A	X-ray exam of ribs/chest	0.00	0.67	NA	0.04	0.71	NA	XXX
71110		A	X-ray exam of ribs	0.27	0.87	NA	0.06	1.20	NA	XXX
71110	26	A	X-ray exam of ribs	0.27	0.09	0.09	0.01	0.37	0.37	XXX
71110	TC	A	X-ray exam of ribs	0.00	0.78	NA	0.05	0.83	NA	XXX
71111		A	X-ray exam of ribs/chest	0.32	0.99	NA	0.07	1.38	NA	XXX
71111	26	A	X-ray exam of ribs/chest	0.32	0.10	0.10	0.01	0.43	0.43	XXX
71111	TC	A	X-ray exam of ribs/chest	0.00	0.89	NA	0.06	0.95	NA	XXX
71120		A	X-ray exam of breastbone	0.20	0.72	NA	0.05	0.97	NA	XXX
71120	26	A	X-ray exam of breastbone	0.20	0.07	0.07	0.01	0.28	0.28	XXX
71120	TC	A	X-ray exam of breastbone	0.00	0.65	NA	0.04	0.69	NA	XXX
71130		A	X-ray exam of breastbone	0.22	0.78	NA	0.05	1.05	NA	XXX
71130	26	A	X-ray exam of breastbone	0.22	0.07	0.07	0.01	0.30	0.30	XXX
71130	TC	A	X-ray exam of breastbone	0.00	0.71	NA	0.04	0.75	NA	XXX
71250		A	Ct thorax w/o dye	1.16	6.29	NA	0.36	7.81	NA	XXX
71250	26	A	Ct thorax w/o dye	1.16	0.38	0.38	0.05	1.59	1.59	XXX
71250	TC	A	Ct thorax w/o dye	0.00	5.91	NA	0.31	6.22	NA	XXX
71260		A	Ct thorax w/dye	1.24	7.48	NA	0.43	9.15	NA	XXX
71260	26	A	Ct thorax w/dye	1.24	0.41	0.41	0.06	1.71	1.71	XXX
71260	TC	A	Ct thorax w/dye	0.00	7.07	NA	0.37	7.44	NA	XXX
71270		A	Ct thorax w/o & w/dye	1.38	9.30	NA	0.52	11.20	NA	XXX
71270	26	A	Ct thorax w/o & w/dye	1.38	0.45	0.45	0.06	1.89	1.89	XXX
71270	TC	A	Ct thorax w/o & w/dye	0.00	8.85	NA	0.46	9.31	NA	XXX
71275		A	Ct angiography, chest	1.92	13.01	NA	0.48	15.41	NA	XXX
71275	26	A	Ct angiography, chest	1.92	0.63	0.63	0.09	2.64	2.64	XXX
71275	TC	A	Ct angiography, chest	0.00	12.38	NA	0.39	12.77	NA	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
71550		A	Mri chest w/o dye	1.46	11.68	NA	0.51	13.65	NA	XXX
71550	26	A	Mri chest w/o dye	1.46	0.48	0.48	0.06	2.00	2.00	XXX
71550	TC	A	Mri chest w/o dye	0.00	11.20	NA	0.45	11.65	NA	XXX
71551		A	Mri chest w/dye	1.73	14.01	NA	0.60	16.34	NA	XXX
71551	26	A	Mri chest w/dye	1.73	0.57	0.57	0.08	2.38	2.38	XXX
71551	TC	A	Mri chest w/dye	0.00	13.44	NA	0.52	13.96	NA	XXX
71552		A	Mri chest w/o & w/dye	2.26	25.62	NA	0.78	28.66	NA	XXX
71552	26	A	Mri chest w/o & w/dye	2.26	0.74	0.74	0.10	3.10	3.10	XXX
71552	TC	A	Mri chest w/o & w/dye	0.00	24.88	NA	0.68	25.56	NA	XXX
71555		R	Mri angio chest w or w/o dye	1.81	11.80	NA	0.67	14.28	NA	XXX
71555	26	R	Mri angio chest w or w/o dye	1.81	0.60	0.60	0.08	2.49	2.49	XXX
71555	TC	R	Mri angio chest w or w/o dye	0.00	11.20	NA	0.59	11.79	NA	XXX
72010		A	X-ray exam of spine	0.45	1.17	NA	0.08	1.70	NA	XXX
72010	26	A	X-ray exam of spine	0.45	0.15	0.15	0.02	0.62	0.62	XXX
72010	TC	A	X-ray exam of spine	0.00	1.02	NA	0.06	1.08	NA	XXX
72020		A	X-ray exam of spine	0.15	0.47	NA	0.03	0.65	NA	XXX
72020	26	A	X-ray exam of spine	0.15	0.05	0.05	0.01	0.21	0.21	XXX
72020	TC	A	X-ray exam of spine	0.00	0.42	NA	0.02	0.44	NA	XXX
72040		A	X-ray exam of neck spine	0.22	0.67	NA	0.05	0.94	NA	XXX
72040	26	A	X-ray exam of neck spine	0.22	0.07	0.07	0.01	0.30	0.30	XXX
72040	TC	A	X-ray exam of neck spine	0.00	0.60	NA	0.04	0.64	NA	XXX
72050		A	X-ray exam of neck spine	0.31	0.99	NA	0.07	1.37	NA	XXX
72050	26	A	X-ray exam of neck spine	0.31	0.10	0.10	0.01	0.42	0.42	XXX
72050	TC	A	X-ray exam of neck spine	0.00	0.89	NA	0.06	0.95	NA	XXX
72052		A	X-ray exam of neck spine	0.36	1.25	NA	0.08	1.69	NA	XXX
72052	26	A	X-ray exam of neck spine	0.36	0.12	0.12	0.02	0.50	0.50	XXX
72052	TC	A	X-ray exam of neck spine	0.00	1.13	NA	0.06	1.19	NA	XXX
72069		A	X-ray exam of trunk spine	0.22	0.57	NA	0.03	0.82	NA	XXX
72069	26	A	X-ray exam of trunk spine	0.22	0.08	0.08	0.01	0.31	0.31	XXX
72069	TC	A	X-ray exam of trunk spine	0.00	0.49	NA	0.02	0.51	NA	XXX
72070		A	X-ray exam of thoracic spine	0.22	0.72	NA	0.05	0.99	NA	XXX
72070	26	A	X-ray exam of thoracic spine	0.22	0.07	0.07	0.01	0.30	0.30	XXX
72070	TC	A	X-ray exam of thoracic spine	0.00	0.65	NA	0.04	0.69	NA	XXX
72072		A	X-ray exam of thoracic spine	0.22	0.80	NA	0.06	1.08	NA	XXX
72072	26	A	X-ray exam of thoracic spine	0.22	0.07	0.07	0.01	0.30	0.30	XXX
72072	TC	A	X-ray exam of thoracic spine	0.00	0.73	NA	0.05	0.78	NA	XXX
72074		A	X-ray exam of thoracic spine	0.22	0.98	NA	0.07	1.27	NA	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
72074	26	A	X-ray exam of thoracic spine	0.22	0.07	0.07	0.01	0.30	0.30	XXX
72074	TC	A	X-ray exam of thoracic spine	0.00	0.91	NA	0.06	0.97	NA	XXX
72080		A	X-ray exam of trunk spine	0.22	0.74	NA	0.05	1.01	NA	XXX
72080	26	A	X-ray exam of trunk spine	0.22	0.07	0.07	0.01	0.30	0.30	XXX
72080	TC	A	X-ray exam of trunk spine	0.00	0.67	NA	0.04	0.71	NA	XXX
72090		A	X-ray exam of trunk spine	0.28	0.76	NA	0.05	1.09	NA	XXX
72090	26	A	X-ray exam of trunk spine	0.28	0.09	0.09	0.01	0.38	0.38	XXX
72090	TC	A	X-ray exam of trunk spine	0.00	0.67	NA	0.04	0.71	NA	XXX
72100		A	X-ray exam of lower spine	0.22	0.74	NA	0.05	1.01	NA	XXX
72100	26	A	X-ray exam of lower spine	0.22	0.07	0.07	0.01	0.30	0.30	XXX
72100	TC	A	X-ray exam of lower spine	0.00	0.67	NA	0.04	0.71	NA	XXX
72110		A	X-ray exam of lower spine	0.31	1.01	NA	0.07	1.39	NA	XXX
72110	26	A	X-ray exam of lower spine	0.31	0.10	0.10	0.01	0.42	0.42	XXX
72110	TC	A	X-ray exam of lower spine	0.00	0.91	NA	0.06	0.97	NA	XXX
72114		A	X-ray exam of lower spine	0.36	1.31	NA	0.08	1.75	NA	XXX
72114	26	A	X-ray exam of lower spine	0.36	0.12	0.12	0.02	0.50	0.50	XXX
72114	TC	A	X-ray exam of lower spine	0.00	1.19	NA	0.06	1.25	NA	XXX
72120		A	X-ray exam of lower spine	0.22	0.96	NA	0.07	1.25	NA	XXX
72120	26	A	X-ray exam of lower spine	0.22	0.07	0.07	0.01	0.30	0.30	XXX
72120	TC	A	X-ray exam of lower spine	0.00	0.89	NA	0.06	0.95	NA	XXX
72125		A	Ct neck spine w/o dye	1.16	6.29	NA	0.36	7.81	NA	XXX
72125	26	A	Ct neck spine w/o dye	1.16	0.38	0.38	0.05	1.59	1.59	XXX
72125	TC	A	Ct neck spine w/o dye	0.00	5.91	NA	0.31	6.22	NA	XXX
72126		A	Ct neck spine w/dye	1.22	7.47	NA	0.42	9.11	NA	XXX
72126	26	A	Ct neck spine w/dye	1.22	0.40	0.40	0.05	1.67	1.67	XXX
72126	TC	A	Ct neck spine w/dye	0.00	7.07	NA	0.37	7.44	NA	XXX
72127		A	Ct neck spine w/o & w/dye	1.27	9.27	NA	0.52	11.06	NA	XXX
72127	26	A	Ct neck spine w/o & w/dye	1.27	0.42	0.42	0.06	1.75	1.75	XXX
72127	TC	A	Ct neck spine w/o & w/dye	0.00	8.85	NA	0.46	9.31	NA	XXX
72128		A	Ct chest spine w/o dye	1.16	6.29	NA	0.36	7.81	NA	XXX
72128	26	A	Ct chest spine w/o dye	1.16	0.38	0.38	0.05	1.59	1.59	XXX
72128	TC	A	Ct chest spine w/o dye	0.00	5.91	NA	0.31	6.22	NA	XXX
72129		A	Ct chest spine w/dye	1.22	7.47	NA	0.43	9.12	NA	XXX
72129	26	A	Ct chest spine w/dye	1.22	0.40	0.40	0.06	1.68	1.68	XXX
72129	TC	A	Ct chest spine w/dye	0.00	7.07	NA	0.37	7.44	NA	XXX
72130		A	Ct chest spine w/o & w/dye	1.27	9.27	NA	0.52	11.06	NA	XXX
72130	26	A	Ct chest spine w/o & w/dye	1.27	0.42	0.42	0.06	1.75	1.75	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
72130	TC	A	Ct chest spine w/o & w/dye	0.00	8.85	NA	0.46	9.31	NA	XXX
72131		A	Ct lumbar spine w/o dye	1.16	6.29	NA	0.36	7.81	NA	XXX
72131	26	A	Ct lumbar spine w/o dye	1.16	0.38	0.38	0.05	1.59	1.59	XXX
72131	TC	A	Ct lumbar spine w/o dye	0.00	5.91	NA	0.31	6.22	NA	XXX
72132		A	Ct lumbar spine w/dye	1.22	7.47	NA	0.42	9.11	NA	XXX
72132	26	A	Ct lumbar spine w/dye	1.22	0.40	0.40	0.05	1.67	1.67	XXX
72132	TC	A	Ct lumbar spine w/dye	0.00	7.07	NA	0.37	7.44	NA	XXX
72133		A	Ct lumbar spine w/o & w/dye	1.27	9.27	NA	0.52	11.06	NA	XXX
72133	26	A	Ct lumbar spine w/o & w/dye	1.27	0.42	0.42	0.06	1.75	1.75	XXX
72133	TC	A	Ct lumbar spine w/o & w/dye	0.00	8.85	NA	0.46	9.31	NA	XXX
72141		A	Mri neck spine w/o dye	1.60	11.73	NA	0.66	13.99	NA	XXX
72141	26	A	Mri neck spine w/o dye	1.60	0.53	0.53	0.07	2.20	2.20	XXX
72141	TC	A	Mri neck spine w/o dye	0.00	11.20	NA	0.59	11.79	NA	XXX
72142		A	Mri neck spine w/dye	1.92	14.08	NA	0.79	16.79	NA	XXX
72142	26	A	Mri neck spine w/dye	1.92	0.64	0.64	0.09	2.65	2.65	XXX
72142	TC	A	Mri neck spine w/dye	0.00	13.44	NA	0.70	14.14	NA	XXX
72146		A	Mri chest spine w/o dye	1.60	12.97	NA	0.71	15.28	NA	XXX
72146	26	A	Mri chest spine w/o dye	1.60	0.53	0.53	0.07	2.20	2.20	XXX
72146	TC	A	Mri chest spine w/o dye	0.00	12.44	NA	0.64	13.08	NA	XXX
72147		A	Mri chest spine w/dye	1.92	14.07	NA	0.79	16.78	NA	XXX
72147	26	A	Mri chest spine w/dye	1.92	0.63	0.63	0.09	2.64	2.64	XXX
72147	TC	A	Mri chest spine w/dye	0.00	13.44	NA	0.70	14.14	NA	XXX
72148		A	Mri lumbar spine w/o dye	1.48	12.93	NA	0.71	15.12	NA	XXX
72148	26	A	Mri lumbar spine w/o dye	1.48	0.49	0.49	0.07	2.04	2.04	XXX
72148	TC	A	Mri lumbar spine w/o dye	0.00	12.44	NA	0.64	13.08	NA	XXX
72149		A	Mri lumbar spine w/dye	1.78	14.04	NA	0.78	16.60	NA	XXX
72149	26	A	Mri lumbar spine w/dye	1.78	0.60	0.60	0.08	2.46	2.46	XXX
72149	TC	A	Mri lumbar spine w/dye	0.00	13.44	NA	0.70	14.14	NA	XXX
72156		A	Mri neck spine w/o & w/dye	2.57	25.73	NA	1.43	29.73	NA	XXX
72156	26	A	Mri neck spine w/o & w/dye	2.57	0.85	0.85	0.12	3.54	3.54	XXX
72156	TC	A	Mri neck spine w/o & w/dye	0.00	24.88	NA	1.31	26.19	NA	XXX
72157		A	Mri chest spine w/o & w/dye	2.57	25.72	NA	1.42	29.71	NA	XXX
72157	26	A	Mri chest spine w/o & w/dye	2.57	0.84	0.84	0.11	3.52	3.52	XXX
72157	TC	A	Mri chest spine w/o & w/dye	0.00	24.88	NA	1.31	26.19	NA	XXX
72158		A	Mri lumbar spine w/o & w/dye	2.36	25.66	NA	1.42	29.44	NA	XXX
72158	26	A	Mri lumbar spine w/o & w/dye	2.36	0.78	0.78	0.11	3.25	3.25	XXX
72158	TC	A	Mri lumbar spine w/o & w/dye	0.00	24.88	NA	1.31	26.19	NA	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
72159		N	Mr angio spine w/o&w/dye	+1.80	12.92	12.92	0.74	15.46	15.46	XXX
72159	26	N	Mr angio spine w/o&w/dye	+1.80	0.69	0.69	0.10	2.59	2.59	XXX
72159	TC	N	Mr angio spine w/o&w/dye	+0.00	12.23	12.23	0.64	12.87	12.87	XXX
72170		A	X-ray exam of pelvis	0.17	0.58	NA	0.03	0.78	NA	XXX
72170	26	A	X-ray exam of pelvis	0.17	0.06	0.06	0.01	0.24	0.24	XXX
72170	TC	A	X-ray exam of pelvis	0.00	0.52	NA	0.02	0.54	NA	XXX
72190		A	X-ray exam of pelvis	0.21	0.74	NA	0.05	1.00	NA	XXX
72190	26	A	X-ray exam of pelvis	0.21	0.07	0.07	0.01	0.29	0.29	XXX
72190	TC	A	X-ray exam of pelvis	0.00	0.67	NA	0.04	0.71	NA	XXX
72191		A	Ct angiograph pelv w/o&w/dye	1.81	12.63	NA	0.47	14.91	NA	XXX
72191	26	A	Ct angiograph pelv w/o&w/dye	1.81	0.60	0.60	0.08	2.49	2.49	XXX
72191	TC	A	Ct angiograph pelv w/o&w/dye	0.00	12.03	NA	0.39	12.42	NA	XXX
72192		A	Ct pelvis w/o dye	1.09	6.27	NA	0.36	7.72	NA	XXX
72192	26	A	Ct pelvis w/o dye	1.09	0.36	0.36	0.05	1.50	1.50	XXX
72192	TC	A	Ct pelvis w/o dye	0.00	5.91	NA	0.31	6.22	NA	XXX
72193		A	Ct pelvis w/dye	1.16	7.22	NA	0.41	8.79	NA	XXX
72193	26	A	Ct pelvis w/dye	1.16	0.38	0.38	0.05	1.59	1.59	XXX
72193	TC	A	Ct pelvis w/dye	0.00	6.84	NA	0.36	7.20	NA	XXX
72194		A	Ct pelvis w/o & w/dye	1.22	8.89	NA	0.48	10.59	NA	XXX
72194	26	A	Ct pelvis w/o & w/dye	1.22	0.40	0.40	0.05	1.67	1.67	XXX
72194	TC	A	Ct pelvis w/o & w/dye	0.00	8.49	NA	0.43	8.92	NA	XXX
72195		A	Mri pelvis w/o dye	1.46	11.68	NA	0.52	13.66	NA	XXX
72195	26	A	Mri pelvis w/o dye	1.46	0.48	0.48	0.07	2.01	2.01	XXX
72195	TC	A	Mri pelvis w/o dye	0.00	11.20	NA	0.45	11.65	NA	XXX
72196		A	Mri pelvis w/dye	1.73	14.01	NA	0.60	16.34	NA	XXX
72196	26	A	Mri pelvis w/dye	1.73	0.57	0.57	0.08	2.38	2.38	XXX
72196	TC	A	Mri pelvis w/dye	0.00	13.44	NA	0.52	13.96	NA	XXX
72197		A	Mri pelvis w/o & w/dye	2.26	25.62	NA	1.02	28.90	NA	XXX
72197	26	A	Mri pelvis w/o & w/dye	2.26	0.74	0.74	0.10	3.10	3.10	XXX
72197	TC	A	Mri pelvis w/o & w/dye	0.00	24.88	NA	0.92	25.80	NA	XXX
72198		A	Mr angio pelvis w/o & w/dye	1.80	11.79	NA	0.67	14.26	NA	XXX
72198	26	A	Mr angio pelvis w/o & w/dye	1.80	0.59	0.59	0.08	2.47	2.47	XXX
72198	TC	A	Mr angio pelvis w/o & w/dye	0.00	11.20	NA	0.59	11.79	NA	XXX
72200		A	X-ray exam sacroiliac joints	0.17	0.58	NA	0.03	0.78	NA	XXX
72200	26	A	X-ray exam sacroiliac joints	0.17	0.06	0.06	0.01	0.24	0.24	XXX
72200	TC	A	X-ray exam sacroiliac joints	0.00	0.52	NA	0.02	0.54	NA	XXX
72202		A	X-ray exam sacroiliac joints	0.19	0.68	NA	0.05	0.92	NA	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
72202	26	A	X-ray exam sacroiliac joints	0.19	0.06	0.06	0.01	0.26	0.26	XXX
72202	TC	A	X-ray exam sacroiliac joints	0.00	0.62	NA	0.04	0.66	NA	XXX
72220		A	X-ray exam of tailbone	0.17	0.63	NA	0.05	0.85	NA	XXX
72220	26	A	X-ray exam of tailbone	0.17	0.06	0.06	0.01	0.24	0.24	XXX
72220	TC	A	X-ray exam of tailbone	0.00	0.57	NA	0.04	0.61	NA	XXX
72240		A	Contrast x-ray of neck spine	0.91	5.04	NA	0.29	6.24	NA	XXX
72240	26	A	Contrast x-ray of neck spine	0.91	0.29	0.29	0.04	1.24	1.24	XXX
72240	TC	A	Contrast x-ray of neck spine	0.00	4.75	NA	0.25	5.00	NA	XXX
72255		A	Contrast x-ray, thorax spine	0.91	4.60	NA	0.26	5.77	NA	XXX
72255	26	A	Contrast x-ray, thorax spine	0.91	0.27	0.27	0.04	1.22	1.22	XXX
72255	TC	A	Contrast x-ray, thorax spine	0.00	4.33	NA	0.22	4.55	NA	XXX
72265		A	Contrast x-ray, lower spine	0.83	4.32	NA	0.26	5.41	NA	XXX
72265	26	A	Contrast x-ray, lower spine	0.83	0.25	0.25	0.04	1.12	1.12	XXX
72265	TC	A	Contrast x-ray, lower spine	0.00	4.07	NA	0.22	4.29	NA	XXX
72270		A	Contrast x-ray, spine	1.33	6.52	NA	0.39	8.24	NA	XXX
72270	26	A	Contrast x-ray, spine	1.33	0.42	0.42	0.06	1.81	1.81	XXX
72270	TC	A	Contrast x-ray, spine	0.00	6.10	NA	0.33	6.43	NA	XXX
72275		A	Epidurography	0.76	2.30	NA	0.26	3.32	NA	XXX
72275	26	A	Epidurography	0.76	0.20	0.20	0.04	1.00	1.00	XXX
72275	TC	A	Epidurography	0.00	2.10	NA	0.22	2.32	NA	XXX
72285		A	X-ray c/t spine disk	1.16	8.74	NA	0.50	10.40	NA	XXX
72285	26	A	X-ray c/t spine disk	1.16	0.36	0.36	0.07	1.59	1.59	XXX
72285	TC	A	X-ray c/t spine disk	0.00	8.38	NA	0.43	8.81	NA	XXX
72295		A	X-ray of lower spine disk	0.83	8.13	NA	0.46	9.42	NA	XXX
72295	26	A	X-ray of lower spine disk	0.83	0.27	0.27	0.06	1.16	1.16	XXX
72295	TC	A	X-ray of lower spine disk	0.00	7.86	NA	0.40	8.26	NA	XXX
73000		A	X-ray exam of collar bone	0.16	0.57	NA	0.03	0.76	NA	XXX
73000	26	A	X-ray exam of collar bone	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73000	TC	A	X-ray exam of collar bone	0.00	0.52	NA	0.02	0.54	NA	XXX
73010		A	X-ray exam of shoulder blade	0.17	0.58	NA	0.03	0.78	NA	XXX
73010	26	A	X-ray exam of shoulder blade	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73010	TC	A	X-ray exam of shoulder blade	0.00	0.52	NA	0.02	0.54	NA	XXX
73020		A	X-ray exam of shoulder	0.15	0.52	NA	0.03	0.70	NA	XXX
73020	26	A	X-ray exam of shoulder	0.15	0.05	0.05	0.01	0.21	0.21	XXX
73020	TC	A	X-ray exam of shoulder	0.00	0.47	NA	0.02	0.49	NA	XXX
73030		A	X-ray exam of shoulder	0.18	0.63	NA	0.05	0.86	NA	XXX
73030	26	A	X-ray exam of shoulder	0.18	0.06	0.06	0.01	0.25	0.25	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
73030	TC	A	X-ray exam of shoulder	0.00	0.57	NA	0.04	0.61	NA	XXX
73040		A	Contrast x-ray of shoulder	0.54	2.28	NA	0.14	2.96	NA	XXX
73040	26	A	Contrast x-ray of shoulder	0.54	0.18	0.18	0.02	0.74	0.74	XXX
73040	TC	A	Contrast x-ray of shoulder	0.00	2.10	NA	0.12	2.22	NA	XXX
73050		A	X-ray exam of shoulders	0.20	0.74	NA	0.05	0.99	NA	XXX
73050	26	A	X-ray exam of shoulders	0.20	0.07	0.07	0.01	0.28	0.28	XXX
73050	TC	A	X-ray exam of shoulders	0.00	0.67	NA	0.04	0.71	NA	XXX
73060		A	X-ray exam of humerus	0.17	0.63	NA	0.05	0.85	NA	XXX
73060	26	A	X-ray exam of humerus	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73060	TC	A	X-ray exam of humerus	0.00	0.57	NA	0.04	0.61	NA	XXX
73070		A	X-ray exam of elbow	0.15	0.57	NA	0.03	0.75	NA	XXX
73070	26	A	X-ray exam of elbow	0.15	0.05	0.05	0.01	0.21	0.21	XXX
73070	TC	A	X-ray exam of elbow	0.00	0.52	NA	0.02	0.54	NA	XXX
73080		A	X-ray exam of elbow	0.17	0.63	NA	0.05	0.85	NA	XXX
73080	26	A	X-ray exam of elbow	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73080	TC	A	X-ray exam of elbow	0.00	0.57	NA	0.04	0.61	NA	XXX
73085		A	Contrast x-ray of elbow	0.54	2.29	NA	0.15	2.98	NA	XXX
73085	26	A	Contrast x-ray of elbow	0.54	0.19	0.19	0.03	0.76	0.76	XXX
73085	TC	A	Contrast x-ray of elbow	0.00	2.10	NA	0.12	2.22	NA	XXX
73090		A	X-ray exam of forearm	0.16	0.57	NA	0.03	0.76	NA	XXX
73090	26	A	X-ray exam of forearm	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73090	TC	A	X-ray exam of forearm	0.00	0.52	NA	0.02	0.54	NA	XXX
73092		A	X-ray exam of arm, infant	0.16	0.54	NA	0.03	0.73	NA	XXX
73092	26	A	X-ray exam of arm, infant	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73092	TC	A	X-ray exam of arm, infant	0.00	0.49	NA	0.02	0.51	NA	XXX
73100		A	X-ray exam of wrist	0.16	0.54	NA	0.03	0.73	NA	XXX
73100	26	A	X-ray exam of wrist	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73100	TC	A	X-ray exam of wrist	0.00	0.49	NA	0.02	0.51	NA	XXX
73110		A	X-ray exam of wrist	0.17	0.59	NA	0.03	0.79	NA	XXX
73110	26	A	X-ray exam of wrist	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73110	TC	A	X-ray exam of wrist	0.00	0.53	NA	0.02	0.55	NA	XXX
73115		A	Contrast x-ray of wrist	0.54	1.76	NA	0.13	2.43	NA	XXX
73115	26	A	Contrast x-ray of wrist	0.54	0.18	0.18	0.03	0.75	0.75	XXX
73115	TC	A	Contrast x-ray of wrist	0.00	1.58	NA	0.10	1.68	NA	XXX
73120		A	X-ray exam of hand	0.16	0.54	NA	0.03	0.73	NA	XXX
73120	26	A	X-ray exam of hand	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73120	TC	A	X-ray exam of hand	0.00	0.49	NA	0.02	0.51	NA	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
73130		A	X-ray exam of hand	0.17	0.59	NA	0.03	0.79	NA	XXX
73130	26	A	X-ray exam of hand	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73130	TC	A	X-ray exam of hand	0.00	0.53	NA	0.02	0.55	NA	XXX
73140		A	X-ray exam of finger(s)	0.13	0.46	NA	0.03	0.62	NA	XXX
73140	26	A	X-ray exam of finger(s)	0.13	0.04	0.04	0.01	0.18	0.18	XXX
73140	TC	A	X-ray exam of finger(s)	0.00	0.42	NA	0.02	0.44	NA	XXX
73200		A	Ct upper extremity w/o dye	1.09	5.32	NA	0.30	6.71	NA	XXX
73200	26	A	Ct upper extremity w/o dye	1.09	0.36	0.36	0.05	1.50	1.50	XXX
73200	TC	A	Ct upper extremity w/o dye	0.00	4.96	NA	0.25	5.21	NA	XXX
73201		A	Ct upper extremity w/dye	1.16	6.29	NA	0.36	7.81	NA	XXX
73201	26	A	Ct upper extremity w/dye	1.16	0.38	0.38	0.05	1.59	1.59	XXX
73201	TC	A	Ct upper extremity w/dye	0.00	5.91	NA	0.31	6.22	NA	XXX
73202		A	Ct uppr extremity w/o&w/dye	1.22	7.82	NA	0.45	9.49	NA	XXX
73202	26	A	Ct uppr extremity w/o&w/dye	1.22	0.40	0.40	0.06	1.68	1.68	XXX
73202	TC	A	Ct uppr extremity w/o&w/dye	0.00	7.42	NA	0.39	7.81	NA	XXX
73206		A	Ct angio upr extrm w/o&w/dye	1.81	11.55	NA	0.47	13.83	NA	XXX
73206	26	A	Ct angio upr extrm w/o&w/dye	1.81	0.59	0.59	0.08	2.48	2.48	XXX
73206	TC	A	Ct angio upr extrm w/o&w/dye	0.00	10.96	NA	0.39	11.35	NA	XXX
73218		A	Mri upper extremity w/o dye	1.35	11.64	NA	0.45	13.44	NA	XXX
73218	26	A	Mri upper extremity w/o dye	1.35	0.44	0.44	0.06	1.85	1.85	XXX
73218	TC	A	Mri upper extremity w/o dye	0.00	11.20	NA	0.39	11.59	NA	XXX
73219		A	Mri upper extremity w/dye	1.62	13.98	NA	0.54	16.14	NA	XXX
73219	26	A	Mri upper extremity w/dye	1.62	0.54	0.54	0.07	2.23	2.23	XXX
73219	TC	A	Mri upper extremity w/dye	0.00	13.44	NA	0.47	13.91	NA	XXX
73220		A	Mri uppr extremity w/o&w/dye	2.15	25.59	NA	0.94	28.68	NA	XXX
73220	26	A	Mri uppr extremity w/o&w/dye	2.15	0.71	0.71	0.10	2.96	2.96	XXX
73220	TC	A	Mri uppr extremity w/o&w/dye	0.00	24.88	NA	0.84	25.72	NA	XXX
73221		A	Mri joint upr extrem w/o dye	1.35	11.64	NA	0.45	13.44	NA	XXX
73221	26	A	Mri joint upr extrem w/o dye	1.35	0.44	0.44	0.06	1.85	1.85	XXX
73221	TC	A	Mri joint upr extrem w/o dye	0.00	11.20	NA	0.39	11.59	NA	XXX
73222		A	Mri joint upr extrem w/dye	1.62	13.97	NA	0.54	16.13	NA	XXX
73222	26	A	Mri joint upr extrem w/dye	1.62	0.53	0.53	0.07	2.22	2.22	XXX
73222	TC	A	Mri joint upr extrem w/dye	0.00	13.44	NA	0.47	13.91	NA	XXX
73223		A	Mri joint upr extr w/o&w/dye	2.15	25.59	NA	0.94	28.68	NA	XXX
73223	26	A	Mri joint upr extr w/o&w/dye	2.15	0.71	0.71	0.10	2.96	2.96	XXX
73223	TC	A	Mri joint upr extr w/o&w/dye	0.00	24.88	NA	0.84	25.72	NA	XXX
73225		N	Mr angio upr extr w/o&w/dye	+1.73	11.68	11.68	0.69	14.10	14.10	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
73225	26	N	Mr angio upr extr w/o&w/dye	+1.73	0.67	0.67	0.10	2.50	2.50	XXX
73225	TC	N	Mr angio upr extr w/o&w/dye	+0.00	11.01	11.01	0.59	11.60	11.60	XXX
73500		A	X-ray exam of hip	0.17	0.53	NA	0.03	0.73	NA	XXX
73500	26	A	X-ray exam of hip	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73500	TC	A	X-ray exam of hip	0.00	0.47	NA	0.02	0.49	NA	XXX
73510		A	X-ray exam of hip	0.21	0.64	NA	0.05	0.90	NA	XXX
73510	26	A	X-ray exam of hip	0.21	0.07	0.07	0.01	0.29	0.29	XXX
73510	TC	A	X-ray exam of hip	0.00	0.57	NA	0.04	0.61	NA	XXX
73520		A	X-ray exam of hips	0.26	0.76	NA	0.05	1.07	NA	XXX
73520	26	A	X-ray exam of hips	0.26	0.09	0.09	0.01	0.36	0.36	XXX
73520	TC	A	X-ray exam of hips	0.00	0.67	NA	0.04	0.71	NA	XXX
73525		A	Contrast x-ray of hip	0.54	2.28	NA	0.15	2.97	NA	XXX
73525	26	A	Contrast x-ray of hip	0.54	0.18	0.18	0.03	0.75	0.75	XXX
73525	TC	A	Contrast x-ray of hip	0.00	2.10	NA	0.12	2.22	NA	XXX
73530		A	X-ray exam of hip	0.29	0.62	NA	0.03	0.94	NA	XXX
73530	26	A	X-ray exam of hip	0.29	0.10	0.10	0.01	0.40	0.40	XXX
73530	TC	A	X-ray exam of hip	0.00	0.52	NA	0.02	0.54	NA	XXX
73540		A	X-ray exam of pelvis & hips	0.20	0.64	NA	0.05	0.89	NA	XXX
73540	26	A	X-ray exam of pelvis & hips	0.20	0.07	0.07	0.01	0.28	0.28	XXX
73540	TC	A	X-ray exam of pelvis & hips	0.00	0.57	NA	0.04	0.61	NA	XXX
73542		A	X-ray exam, sacroiliac joint	0.59	2.26	NA	0.16	3.01	NA	XXX
73542	26	A	X-ray exam, sacroiliac joint	0.59	0.16	0.16	0.04	0.79	0.79	XXX
73542	TC	A	X-ray exam, sacroiliac joint	0.00	2.10	NA	0.12	2.22	NA	XXX
73550		A	X-ray exam of thigh	0.17	0.63	NA	0.05	0.85	NA	XXX
73550	26	A	X-ray exam of thigh	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73550	TC	A	X-ray exam of thigh	0.00	0.57	NA	0.04	0.61	NA	XXX
73560		A	X-ray exam of knee, 1 or 2	0.17	0.58	NA	0.03	0.78	NA	XXX
73560	26	A	X-ray exam of knee, 1 or 2	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73560	TC	A	X-ray exam of knee, 1 or 2	0.00	0.52	NA	0.02	0.54	NA	XXX
73562		A	X-ray exam of knee, 3	0.18	0.63	NA	0.05	0.86	NA	XXX
73562	26	A	X-ray exam of knee, 3	0.18	0.06	0.06	0.01	0.25	0.25	XXX
73562	TC	A	X-ray exam of knee, 3	0.00	0.57	NA	0.04	0.61	NA	XXX
73564		A	X-ray exam, knee, 4 or more	0.22	0.69	NA	0.05	0.96	NA	XXX
73564	26	A	X-ray exam, knee, 4 or more	0.22	0.07	0.07	0.01	0.30	0.30	XXX
73564	TC	A	X-ray exam, knee, 4 or more	0.00	0.62	NA	0.04	0.66	NA	XXX
73565		A	X-ray exam of knees	0.17	0.55	NA	0.03	0.75	NA	XXX
73565	26	A	X-ray exam of knees	0.17	0.06	0.06	0.01	0.24	0.24	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
73565	TC	A	X-ray exam of knees	0.00	0.49	NA	0.02	0.51	NA	XXX
73580		A	Contrast x-ray of knee joint	0.54	2.79	NA	0.17	3.50	NA	XXX
73580	26	A	Contrast x-ray of knee joint	0.54	0.17	0.17	0.03	0.74	0.74	XXX
73580	TC	A	Contrast x-ray of knee joint	0.00	2.62	NA	0.14	2.76	NA	XXX
73590		A	X-ray exam of lower leg	0.17	0.58	NA	0.03	0.78	NA	XXX
73590	26	A	X-ray exam of lower leg	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73590	TC	A	X-ray exam of lower leg	0.00	0.52	NA	0.02	0.54	NA	XXX
73592		A	X-ray exam of leg, infant	0.16	0.54	NA	0.03	0.73	NA	XXX
73592	26	A	X-ray exam of leg, infant	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73592	TC	A	X-ray exam of leg, infant	0.00	0.49	NA	0.02	0.51	NA	XXX
73600		A	X-ray exam of ankle	0.16	0.54	NA	0.03	0.73	NA	XXX
73600	26	A	X-ray exam of ankle	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73600	TC	A	X-ray exam of ankle	0.00	0.49	NA	0.02	0.51	NA	XXX
73610		A	X-ray exam of ankle	0.17	0.59	NA	0.03	0.79	NA	XXX
73610	26	A	X-ray exam of ankle	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73610	TC	A	X-ray exam of ankle	0.00	0.53	NA	0.02	0.55	NA	XXX
73615		A	Contrast x-ray of ankle	0.54	2.28	NA	0.15	2.97	NA	XXX
73615	26	A	Contrast x-ray of ankle	0.54	0.18	0.18	0.03	0.75	0.75	XXX
73615	TC	A	Contrast x-ray of ankle	0.00	2.10	NA	0.12	2.22	NA	XXX
73620		A	X-ray exam of foot	0.16	0.54	NA	0.03	0.73	NA	XXX
73620	26	A	X-ray exam of foot	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73620	TC	A	X-ray exam of foot	0.00	0.49	NA	0.02	0.51	NA	XXX
73630		A	X-ray exam of foot	0.17	0.59	NA	0.03	0.79	NA	XXX
73630	26	A	X-ray exam of foot	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73630	TC	A	X-ray exam of foot	0.00	0.53	NA	0.02	0.55	NA	XXX
73650		A	X-ray exam of heel	0.16	0.52	NA	0.03	0.71	NA	XXX
73650	26	A	X-ray exam of heel	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73650	TC	A	X-ray exam of heel	0.00	0.47	NA	0.02	0.49	NA	XXX
73660		A	X-ray exam of toe(s)	0.13	0.46	NA	0.03	0.62	NA	XXX
73660	26	A	X-ray exam of toe(s)	0.13	0.04	0.04	0.01	0.18	0.18	XXX
73660	TC	A	X-ray exam of toe(s)	0.00	0.42	NA	0.02	0.44	NA	XXX
73700		A	Ct lower extremity w/o dye	1.09	5.32	NA	0.30	6.71	NA	XXX
73700	26	A	Ct lower extremity w/o dye	1.09	0.36	0.36	0.05	1.50	1.50	XXX
73700	TC	A	Ct lower extremity w/o dye	0.00	4.96	NA	0.25	5.21	NA	XXX
73701		A	Ct lower extremity w/dye	1.16	6.29	NA	0.36	7.81	NA	XXX
73701	26	A	Ct lower extremity w/dye	1.16	0.38	0.38	0.05	1.59	1.59	XXX
73701	TC	A	Ct lower extremity w/dye	0.00	5.91	NA	0.31	6.22	NA	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
73702		A	Ct lwr extremity w/o&w/dye	1.22	7.82	NA	0.44	9.48	NA	XXX
73702	26	A	Ct lwr extremity w/o&w/dye	1.22	0.40	0.40	0.05	1.67	1.67	XXX
73702	TC	A	Ct lwr extremity w/o&w/dye	0.00	7.42	NA	0.39	7.81	NA	XXX
73706		A	Ct angio lwr extr w/o&w/dye	1.90	11.58	NA	0.48	13.96	NA	XXX
73706	26	A	Ct angio lwr extr w/o&w/dye	1.90	0.62	0.62	0.09	2.61	2.61	XXX
73706	TC	A	Ct angio lwr extr w/o&w/dye	0.00	10.96	NA	0.39	11.35	NA	XXX
73718		A	Mri lower extremity w/o dye	1.35	11.64	NA	0.45	13.44	NA	XXX
73718	26	A	Mri lower extremity w/o dye	1.35	0.44	0.44	0.06	1.85	1.85	XXX
73718	TC	A	Mri lower extremity w/o dye	0.00	11.20	NA	0.39	11.59	NA	XXX
73719		A	Mri lower extremity w/dye	1.62	13.97	NA	0.54	16.13	NA	XXX
73719	26	A	Mri lower extremity w/dye	1.62	0.53	0.53	0.07	2.22	2.22	XXX
73719	TC	A	Mri lower extremity w/dye	0.00	13.44	NA	0.47	13.91	NA	XXX
73720		A	Mri lwr extremity w/o&w/dye	2.15	25.58	NA	0.94	28.67	NA	XXX
73720	26	A	Mri lwr extremity w/o&w/dye	2.15	0.70	0.70	0.10	2.95	2.95	XXX
73720	TC	A	Mri lwr extremity w/o&w/dye	0.00	24.88	NA	0.84	25.72	NA	XXX
73721		A	Mri jnt of lwr extre w/o dye	1.35	11.64	NA	0.45	13.44	NA	XXX
73721	26	A	Mri jnt of lwr extre w/o dye	1.35	0.44	0.44	0.06	1.85	1.85	XXX
73721	TC	A	Mri jnt of lwr extre w/o dye	0.00	11.20	NA	0.39	11.59	NA	XXX
73722		A	Mri joint of lwr extr w/dye	1.62	13.97	NA	0.54	16.13	NA	XXX
73722	26	A	Mri joint of lwr extr w/dye	1.62	0.53	0.53	0.07	2.22	2.22	XXX
73722	TC	A	Mri joint of lwr extr w/dye	0.00	13.44	NA	0.47	13.91	NA	XXX
73723		A	Mri joint lwr extr w/o&w/dye	2.15	25.59	NA	0.94	28.68	NA	XXX
73723	26	A	Mri joint lwr extr w/o&w/dye	2.15	0.71	0.71	0.10	2.96	2.96	XXX
73723	TC	A	Mri joint lwr extr w/o&w/dye	0.00	24.88	NA	0.84	25.72	NA	XXX
73725		R	Mr ang lwr ext w or w/o dye	1.82	11.80	NA	0.67	14.29	NA	XXX
73725	26	R	Mr ang lwr ext w or w/o dye	1.82	0.60	0.60	0.08	2.50	2.50	XXX
73725	TC	R	Mr ang lwr ext w or w/o dye	0.00	11.20	NA	0.59	11.79	NA	XXX
74000		A	X-ray exam of abdomen	0.18	0.58	NA	0.03	0.79	NA	XXX
74000	26	A	X-ray exam of abdomen	0.18	0.06	0.06	0.01	0.25	0.25	XXX
74000	TC	A	X-ray exam of abdomen	0.00	0.52	NA	0.02	0.54	NA	XXX
74010		A	X-ray exam of abdomen	0.23	0.65	NA	0.05	0.93	NA	XXX
74010	26	A	X-ray exam of abdomen	0.23	0.08	0.08	0.01	0.32	0.32	XXX
74010	TC	A	X-ray exam of abdomen	0.00	0.57	NA	0.04	0.61	NA	XXX
74020		A	X-ray exam of abdomen	0.27	0.71	NA	0.05	1.03	NA	XXX
74020	26	A	X-ray exam of abdomen	0.27	0.09	0.09	0.01	0.37	0.37	XXX
74020	TC	A	X-ray exam of abdomen	0.00	0.62	NA	0.04	0.66	NA	XXX
74022		A	X-ray exam series, abdomen	0.32	0.83	NA	0.06	1.21	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
74022	26	A	X-ray exam series, abdomen	0.32	0.10	0.10	0.01	0.43	0.43	XXX
74022	TC	A	X-ray exam series, abdomen	0.00	0.73	NA	0.05	0.78	NA	XXX
74150		A	Ct abdomen w/o dye	1.19	6.05	NA	0.35	7.59	NA	XXX
74150	26	A	Ct abdomen w/o dye	1.19	0.39	0.39	0.05	1.63	1.63	XXX
74150	TC	A	Ct abdomen w/o dye	0.00	5.66	NA	0.30	5.96	NA	XXX
74160		A	Ct abdomen w/dye	1.27	7.26	NA	0.42	8.95	NA	XXX
74160	26	A	Ct abdomen w/dye	1.27	0.42	0.42	0.06	1.75	1.75	XXX
74160	TC	A	Ct abdomen w/dye	0.00	6.84	NA	0.36	7.20	NA	XXX
74170		A	Ct abdomen w/o & w/dye	1.40	8.95	NA	0.49	10.84	NA	XXX
74170	26	A	Ct abdomen w/o & w/dye	1.40	0.46	0.46	0.06	1.92	1.92	XXX
74170	TC	A	Ct abdomen w/o & w/dye	0.00	8.49	NA	0.43	8.92	NA	XXX
74175		A	Ct angio abdom w/o & w/dye	1.90	12.65	NA	0.47	15.02	NA	XXX
74175	26	A	Ct angio abdom w/o & w/dye	1.90	0.62	0.62	0.08	2.60	2.60	XXX
74175	TC	A	Ct angio abdom w/o & w/dye	0.00	12.03	NA	0.39	12.42	NA	XXX
74181		A	Mri abdomen w/o dye	1.46	11.68	NA	0.51	13.65	NA	XXX
74181	26	A	Mri abdomen w/o dye	1.46	0.48	0.48	0.06	2.00	2.00	XXX
74181	TC	A	Mri abdomen w/o dye	0.00	11.20	NA	0.45	11.65	NA	XXX
74182		A	Mri abdomen w/dye	1.73	14.01	NA	0.60	16.34	NA	XXX
74182	26	A	Mri abdomen w/dye	1.73	0.57	0.57	0.08	2.38	2.38	XXX
74182	TC	A	Mri abdomen w/dye	0.00	13.44	NA	0.52	13.96	NA	XXX
74183		A	Mri abdomen w/o & w/dye	2.26	25.62	NA	1.02	28.90	NA	XXX
74183	26	A	Mri abdomen w/o & w/dye	2.26	0.74	0.74	0.10	3.10	3.10	XXX
74183	TC	A	Mri abdomen w/o & w/dye	0.00	24.88	NA	0.92	25.80	NA	XXX
74185		R	Mri angio, abdom w orw/o dye	1.80	11.79	NA	0.67	14.26	NA	XXX
74185	26	R	Mri angio, abdom w orw/o dye	1.80	0.59	0.59	0.08	2.47	2.47	XXX
74185	TC	R	Mri angio, abdom w orw/o dye	0.00	11.20	NA	0.59	11.79	NA	XXX
74190		A	X-ray exam of peritoneum	0.48	1.47	NA	0.09	2.04	NA	XXX
74190	26	A	X-ray exam of peritoneum	0.48	0.16	0.16	0.02	0.66	0.66	XXX
74190	TC	A	X-ray exam of peritoneum	0.00	1.31	NA	0.07	1.38	NA	XXX
74210		A	Contrst x-ray exam of throat	0.36	1.31	NA	0.08	1.75	NA	XXX
74210	26	A	Contrst x-ray exam of throat	0.36	0.12	0.12	0.02	0.50	0.50	XXX
74210	TC	A	Contrst x-ray exam of throat	0.00	1.19	NA	0.06	1.25	NA	XXX
74220		A	Contrast x-ray, esophagus	0.46	1.34	NA	0.08	1.88	NA	XXX
74220	26	A	Contrast x-ray, esophagus	0.46	0.15	0.15	0.02	0.63	0.63	XXX
74220	TC	A	Contrast x-ray, esophagus	0.00	1.19	NA	0.06	1.25	NA	XXX
74230		A	Cine/vid x-ray, throat/esoph	0.53	1.48	NA	0.09	2.10	NA	XXX
74230	26	A	Cine/vid x-ray, throat/esoph	0.53	0.17	0.17	0.02	0.72	0.72	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
74230	TC	A	Cine/vid x-ray, throat/esoph	0.00	1.31	NA	0.07	1.38	NA	XXX
74235		A	Remove esophagus obstruction	1.19	3.01	NA	0.20	4.40	NA	XXX
74235	26	A	Remove esophagus obstruction	1.19	0.39	0.39	0.06	1.64	1.64	XXX
74235	TC	A	Remove esophagus obstruction	0.00	2.62	NA	0.14	2.76	NA	XXX
74240		A	X-ray exam, upper gi tract	0.69	1.69	NA	0.11	2.49	NA	XXX
74240	26	A	X-ray exam, upper gi tract	0.69	0.23	0.23	0.03	0.95	0.95	XXX
74240	TC	A	X-ray exam, upper gi tract	0.00	1.46	NA	0.08	1.54	NA	XXX
74241		A	X-ray exam, upper gi tract	0.69	1.72	NA	0.11	2.52	NA	XXX
74241	26	A	X-ray exam, upper gi tract	0.69	0.23	0.23	0.03	0.95	0.95	XXX
74241	TC	A	X-ray exam, upper gi tract	0.00	1.49	NA	0.08	1.57	NA	XXX
74245		A	X-ray exam, upper gi tract	0.91	2.68	NA	0.17	3.76	NA	XXX
74245	26	A	X-ray exam, upper gi tract	0.91	0.30	0.30	0.04	1.25	1.25	XXX
74245	TC	A	X-ray exam, upper gi tract	0.00	2.38	NA	0.13	2.51	NA	XXX
74246		A	Contrst x-ray uppr gi tract	0.69	1.87	NA	0.13	2.69	NA	XXX
74246	26	A	Contrst x-ray uppr gi tract	0.69	0.23	0.23	0.03	0.95	0.95	XXX
74246	TC	A	Contrst x-ray uppr gi tract	0.00	1.64	NA	0.10	1.74	NA	XXX
74247		A	Contrst x-ray uppr gi tract	0.69	1.91	NA	0.14	2.74	NA	XXX
74247	26	A	Contrst x-ray uppr gi tract	0.69	0.23	0.23	0.03	0.95	0.95	XXX
74247	TC	A	Contrst x-ray uppr gi tract	0.00	1.68	NA	0.11	1.79	NA	XXX
74249		A	Contrst x-ray uppr gi tract	0.91	2.87	NA	0.18	3.96	NA	XXX
74249	26	A	Contrst x-ray uppr gi tract	0.91	0.30	0.30	0.04	1.25	1.25	XXX
74249	TC	A	Contrst x-ray uppr gi tract	0.00	2.57	NA	0.14	2.71	NA	XXX
74250		A	X-ray exam of small bowel	0.47	1.46	NA	0.09	2.02	NA	XXX
74250	26	A	X-ray exam of small bowel	0.47	0.15	0.15	0.02	0.64	0.64	XXX
74250	TC	A	X-ray exam of small bowel	0.00	1.31	NA	0.07	1.38	NA	XXX
74251		A	X-ray exam of small bowel	0.69	1.54	NA	0.10	2.33	NA	XXX
74251	26	A	X-ray exam of small bowel	0.69	0.23	0.23	0.03	0.95	0.95	XXX
74251	TC	A	X-ray exam of small bowel	0.00	1.31	NA	0.07	1.38	NA	XXX
74260		A	X-ray exam of small bowel	0.50	1.65	NA	0.10	2.25	NA	XXX
74260	26	A	X-ray exam of small bowel	0.50	0.16	0.16	0.02	0.68	0.68	XXX
74260	TC	A	X-ray exam of small bowel	0.00	1.49	NA	0.08	1.57	NA	XXX
74270		A	Contrast x-ray exam of colon	0.69	1.93	NA	0.14	2.76	NA	XXX
74270	26	A	Contrast x-ray exam of colon	0.69	0.23	0.23	0.03	0.95	0.95	XXX
74270	TC	A	Contrast x-ray exam of colon	0.00	1.70	NA	0.11	1.81	NA	XXX
74280		A	Contrast x-ray exam of colon	0.99	2.55	NA	0.17	3.71	NA	XXX
74280	26	A	Contrast x-ray exam of colon	0.99	0.32	0.32	0.04	1.35	1.35	XXX
74280	TC	A	Contrast x-ray exam of colon	0.00	2.23	NA	0.13	2.36	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
74283		A	Contrast x-ray exam of colon	2.02	3.22	NA	0.23	5.47	NA	XXX
74283	26	A	Contrast x-ray exam of colon	2.02	0.66	0.66	0.09	2.77	2.77	XXX
74283	TC	A	Contrast x-ray exam of colon	0.00	2.56	NA	0.14	2.70	NA	XXX
74290		A	Contrast x-ray, gallbladder	0.32	0.83	NA	0.06	1.21	NA	XXX
74290	26	A	Contrast x-ray, gallbladder	0.32	0.10	0.10	0.01	0.43	0.43	XXX
74290	TC	A	Contrast x-ray, gallbladder	0.00	0.73	NA	0.05	0.78	NA	XXX
74291		A	Contrast x-rays, gallbladder	0.20	0.49	NA	0.03	0.72	NA	XXX
74291	26	A	Contrast x-rays, gallbladder	0.20	0.07	0.07	0.01	0.28	0.28	XXX
74291	TC	A	Contrast x-rays, gallbladder	0.00	0.42	NA	0.02	0.44	NA	XXX
74300		C	X-ray bile ducts/pancreas	0.00	0.00	0.00	0.00	0.00	0.00	XXX
74300	26	A	X-ray bile ducts/pancreas	0.36	0.12	0.12	0.02	0.50	0.50	XXX
74300	TC	C	X-ray bile ducts/pancreas	0.00	0.00	0.00	0.00	0.00	0.00	XXX
74301		C	X-rays at surgery add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
74301	26	A	X-rays at surgery add-on	0.21	0.07	0.07	0.01	0.29	0.29	ZZZ
74301	TC	C	X-rays at surgery add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
74305		A	X-ray bile ducts/pancreas	0.42	0.92	NA	0.07	1.41	NA	XXX
74305	26	A	X-ray bile ducts/pancreas	0.42	0.14	0.14	0.02	0.58	0.58	XXX
74305	TC	A	X-ray bile ducts/pancreas	0.00	0.78	NA	0.05	0.83	NA	XXX
74320		A	Contrast x-ray of bile ducts	0.54	3.33	NA	0.19	4.06	NA	XXX
74320	26	A	Contrast x-ray of bile ducts	0.54	0.18	0.18	0.02	0.74	0.74	XXX
74320	TC	A	Contrast x-ray of bile ducts	0.00	3.15	NA	0.17	3.32	NA	XXX
74327		A	X-ray bile stone removal	0.70	1.99	NA	0.14	2.83	NA	XXX
74327	26	A	X-ray bile stone removal	0.70	0.23	0.23	0.03	0.96	0.96	XXX
74327	TC	A	X-ray bile stone removal	0.00	1.76	NA	0.11	1.87	NA	XXX
74328		A	X-ray bile duct endoscopy	0.70	3.38	NA	0.20	4.28	NA	XXX
74328	26	A	X-ray bile duct endoscopy	0.70	0.23	0.23	0.03	0.96	0.96	XXX
74328	TC	A	X-ray bile duct endoscopy	0.00	3.15	NA	0.17	3.32	NA	XXX
74329		A	X-ray for pancreas endoscopy	0.70	3.38	NA	0.20	4.28	NA	XXX
74329	26	A	X-ray for pancreas endoscopy	0.70	0.23	0.23	0.03	0.96	0.96	XXX
74329	TC	A	X-ray for pancreas endoscopy	0.00	3.15	NA	0.17	3.32	NA	XXX
74330		A	X-ray bile/panc endoscopy	0.90	3.44	NA	0.21	4.55	NA	XXX
74330	26	A	X-ray bile/panc endoscopy	0.90	0.29	0.29	0.04	1.23	1.23	XXX
74330	TC	A	X-ray bile/panc endoscopy	0.00	3.15	NA	0.17	3.32	NA	XXX
74340		A	X-ray guide for GI tube	0.54	2.80	NA	0.16	3.50	NA	XXX
74340	26	A	X-ray guide for GI tube	0.54	0.18	0.18	0.02	0.74	0.74	XXX
74340	TC	A	X-ray guide for GI tube	0.00	2.62	NA	0.14	2.76	NA	XXX
74350		A	X-ray guide, stomach tube	0.76	3.40	NA	0.20	4.36	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
74350	26	A	X-ray guide, stomach tube	0.76	0.25	0.25	0.03	1.04	1.04	XXX
74350	TC	A	X-ray guide, stomach tube	0.00	3.15	NA	0.17	3.32	NA	XXX
74355		A	X-ray guide, intestinal tube	0.76	2.87	NA	0.17	3.80	NA	XXX
74355	26	A	X-ray guide, intestinal tube	0.76	0.25	0.25	0.03	1.04	1.04	XXX
74355	TC	A	X-ray guide, intestinal tube	0.00	2.62	NA	0.14	2.76	NA	XXX
74360		A	X-ray guide, GI dilation	0.54	3.34	NA	0.20	4.08	NA	XXX
74360	26	A	X-ray guide, GI dilation	0.54	0.19	0.19	0.03	0.76	0.76	XXX
74360	TC	A	X-ray guide, GI dilation	0.00	3.15	NA	0.17	3.32	NA	XXX
74363		A	X-ray, bile duct dilation	0.88	6.39	NA	0.37	7.64	NA	XXX
74363	26	A	X-ray, bile duct dilation	0.88	0.29	0.29	0.04	1.21	1.21	XXX
74363	TC	A	X-ray, bile duct dilation	0.00	6.10	NA	0.33	6.43	NA	XXX
74400		A	Contrst x-ray, urinary tract	0.49	1.84	NA	0.13	2.46	NA	XXX
74400	26	A	Contrst x-ray, urinary tract	0.49	0.16	0.16	0.02	0.67	0.67	XXX
74400	TC	A	Contrst x-ray, urinary tract	0.00	1.68	NA	0.11	1.79	NA	XXX
74410		A	Contrst x-ray, urinary tract	0.49	2.11	NA	0.13	2.73	NA	XXX
74410	26	A	Contrst x-ray, urinary tract	0.49	0.16	0.16	0.02	0.67	0.67	XXX
74410	TC	A	Contrst x-ray, urinary tract	0.00	1.95	NA	0.11	2.06	NA	XXX
74415		A	Contrst x-ray, urinary tract	0.49	2.28	NA	0.14	2.91	NA	XXX
74415	26	A	Contrst x-ray, urinary tract	0.49	0.16	0.16	0.02	0.67	0.67	XXX
74415	TC	A	Contrst x-ray, urinary tract	0.00	2.12	NA	0.12	2.24	NA	XXX
74420		A	Contrst x-ray, urinary tract	0.36	2.74	NA	0.16	3.26	NA	XXX
74420	26	A	Contrst x-ray, urinary tract	0.36	0.12	0.12	0.02	0.50	0.50	XXX
74420	TC	A	Contrst x-ray, urinary tract	0.00	2.62	NA	0.14	2.76	NA	XXX
74425		A	Contrst x-ray, urinary tract	0.36	1.43	NA	0.09	1.88	NA	XXX
74425	26	A	Contrst x-ray, urinary tract	0.36	0.12	0.12	0.02	0.50	0.50	XXX
74425	TC	A	Contrst x-ray, urinary tract	0.00	1.31	NA	0.07	1.38	NA	XXX
74430		A	Contrast x-ray, bladder	0.32	1.15	NA	0.08	1.55	NA	XXX
74430	26	A	Contrast x-ray, bladder	0.32	0.10	0.10	0.02	0.44	0.44	XXX
74430	TC	A	Contrast x-ray, bladder	0.00	1.05	NA	0.06	1.11	NA	XXX
74440		A	X-ray, male genital tract	0.38	1.25	NA	0.08	1.71	NA	XXX
74440	26	A	X-ray, male genital tract	0.38	0.12	0.12	0.02	0.52	0.52	XXX
74440	TC	A	X-ray, male genital tract	0.00	1.13	NA	0.06	1.19	NA	XXX
74445		A	X-ray exam of penis	1.14	1.50	NA	0.13	2.77	NA	XXX
74445	26	A	X-ray exam of penis	1.14	0.37	0.37	0.07	1.58	1.58	XXX
74445	TC	A	X-ray exam of penis	0.00	1.13	NA	0.06	1.19	NA	XXX
74450		A	X-ray, urethra/bladder	0.33	1.57	NA	0.10	2.00	NA	XXX
74450	26	A	X-ray, urethra/bladder	0.33	0.11	0.11	0.02	0.46	0.46	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
74450	TC	A	X-ray, urethra/bladder	0.00	1.46	NA	0.08	1.54	NA	XXX
74455		A	X-ray, urethra/bladder	0.33	1.69	NA	0.12	2.14	NA	XXX
74455	26	A	X-ray, urethra/bladder	0.33	0.11	0.11	0.02	0.46	0.46	XXX
74455	TC	A	X-ray, urethra/bladder	0.00	1.58	NA	0.10	1.68	NA	XXX
74470		A	X-ray exam of kidney lesion	0.54	1.43	NA	0.09	2.06	NA	XXX
74470	26	A	X-ray exam of kidney lesion	0.54	0.18	0.18	0.02	0.74	0.74	XXX
74470	TC	A	X-ray exam of kidney lesion	0.00	1.25	NA	0.07	1.32	NA	XXX
74475		A	X-ray control, cath insert	0.54	4.25	NA	0.24	5.03	NA	XXX
74475	26	A	X-ray control, cath insert	0.54	0.18	0.18	0.02	0.74	0.74	XXX
74475	TC	A	X-ray control, cath insert	0.00	4.07	NA	0.22	4.29	NA	XXX
74480		A	X-ray control, cath insert	0.54	4.25	NA	0.24	5.03	NA	XXX
74480	26	A	X-ray control, cath insert	0.54	0.18	0.18	0.02	0.74	0.74	XXX
74480	TC	A	X-ray control, cath insert	0.00	4.07	NA	0.22	4.29	NA	XXX
74485		A	X-ray guide, GU dilation	0.54	3.32	NA	0.20	4.06	NA	XXX
74485	26	A	X-ray guide, GU dilation	0.54	0.17	0.17	0.03	0.74	0.74	XXX
74485	TC	A	X-ray guide, GU dilation	0.00	3.15	NA	0.17	3.32	NA	XXX
74710		A	X-ray measurement of pelvis	0.34	1.16	NA	0.08	1.58	NA	XXX
74710	26	A	X-ray measurement of pelvis	0.34	0.11	0.11	0.02	0.47	0.47	XXX
74710	TC	A	X-ray measurement of pelvis	0.00	1.05	NA	0.06	1.11	NA	XXX
74740		A	X-ray, female genital tract	0.38	1.44	NA	0.09	1.91	NA	XXX
74740	26	A	X-ray, female genital tract	0.38	0.13	0.13	0.02	0.53	0.53	XXX
74740	TC	A	X-ray, female genital tract	0.00	1.31	NA	0.07	1.38	NA	XXX
74742		A	X-ray, fallopian tube	0.61	3.35	NA	0.20	4.16	NA	XXX
74742	26	A	X-ray, fallopian tube	0.61	0.20	0.20	0.03	0.84	0.84	XXX
74742	TC	A	X-ray, fallopian tube	0.00	3.15	NA	0.17	3.32	NA	XXX
74775		A	X-ray exam of perineum	0.62	1.67	NA	0.11	2.40	NA	XXX
74775	26	A	X-ray exam of perineum	0.62	0.21	0.21	0.03	0.86	0.86	XXX
74775	TC	A	X-ray exam of perineum	0.00	1.46	NA	0.08	1.54	NA	XXX
75552		A	Heart mri for morph w/o dye	1.60	11.73	NA	0.66	13.99	NA	XXX
75552	26	A	Heart mri for morph w/o dye	1.60	0.53	0.53	0.07	2.20	2.20	XXX
75552	TC	A	Heart mri for morph w/o dye	0.00	11.20	NA	0.59	11.79	NA	XXX
75553		A	Heart mri for morph w/dye	2.00	11.85	NA	0.66	14.51	NA	XXX
75553	26	A	Heart mri for morph w/dye	2.00	0.65	0.65	0.07	2.72	2.72	XXX
75553	TC	A	Heart mri for morph w/dye	0.00	11.20	NA	0.59	11.79	NA	XXX
75554		A	Cardiac MRI/function	1.83	11.84	NA	0.66	14.33	NA	XXX
75554	26	A	Cardiac MRI/function	1.83	0.64	0.64	0.07	2.54	2.54	XXX
75554	TC	A	Cardiac MRI/function	0.00	11.20	NA	0.59	11.79	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
75555		A	Cardiac MRI/limited study	1.74	11.84	NA	0.66	14.24	NA	XXX
75555	26	A	Cardiac MRI/limited study	1.74	0.64	0.64	0.07	2.45	2.45	XXX
75555	TC	A	Cardiac MRI/limited study	0.00	11.20	NA	0.59	11.79	NA	XXX
75556		N	Cardiac MRI/flow mapping	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75600		A	Contrast x-ray exam of aorta	0.49	12.79	NA	0.67	13.95	NA	XXX
75600	26	A	Contrast x-ray exam of aorta	0.49	0.19	0.19	0.02	0.70	0.70	XXX
75600	TC	A	Contrast x-ray exam of aorta	0.00	12.60	NA	0.65	13.25	NA	XXX
75605		A	Contrast x-ray exam of aorta	1.14	13.00	NA	0.70	14.84	NA	XXX
75605	26	A	Contrast x-ray exam of aorta	1.14	0.40	0.40	0.05	1.59	1.59	XXX
75605	TC	A	Contrast x-ray exam of aorta	0.00	12.60	NA	0.65	13.25	NA	XXX
75625		A	Contrast x-ray exam of aorta	1.14	12.98	NA	0.71	14.83	NA	XXX
75625	26	A	Contrast x-ray exam of aorta	1.14	0.38	0.38	0.06	1.58	1.58	XXX
75625	TC	A	Contrast x-ray exam of aorta	0.00	12.60	NA	0.65	13.25	NA	XXX
75630		A	X-ray aorta, leg arteries	1.79	13.74	NA	0.80	16.33	NA	XXX
75630	26	A	X-ray aorta, leg arteries	1.79	0.61	0.61	0.11	2.51	2.51	XXX
75630	TC	A	X-ray aorta, leg arteries	0.00	13.13	NA	0.69	13.82	NA	XXX
75635		A	Ct angio abdominal arteries	2.40	16.70	NA	0.50	19.60	NA	XXX
75635	26	A	Ct angio abdominal arteries	2.40	0.79	0.79	0.11	3.30	3.30	XXX
75635	TC	A	Ct angio abdominal arteries	0.00	15.91	NA	0.39	16.30	NA	XXX
75650		A	Artery x-rays, head & neck	1.49	13.09	NA	0.73	15.31	NA	XXX
75650	26	A	Artery x-rays, head & neck	1.49	0.49	0.49	0.08	2.06	2.06	XXX
75650	TC	A	Artery x-rays, head & neck	0.00	12.60	NA	0.65	13.25	NA	XXX
75658		A	Artery x-rays, arm	1.31	13.07	NA	0.72	15.10	NA	XXX
75658	26	A	Artery x-rays, arm	1.31	0.47	0.47	0.07	1.85	1.85	XXX
75658	TC	A	Artery x-rays, arm	0.00	12.60	NA	0.65	13.25	NA	XXX
75660		A	Artery x-rays, head & neck	1.31	13.04	NA	0.73	15.08	NA	XXX
75660	26	A	Artery x-rays, head & neck	1.31	0.44	0.44	0.08	1.83	1.83	XXX
75660	TC	A	Artery x-rays, head & neck	0.00	12.60	NA	0.65	13.25	NA	XXX
75662		A	Artery x-rays, head & neck	1.66	13.19	NA	0.73	15.58	NA	XXX
75662	26	A	Artery x-rays, head & neck	1.66	0.59	0.59	0.08	2.33	2.33	XXX
75662	TC	A	Artery x-rays, head & neck	0.00	12.60	NA	0.65	13.25	NA	XXX
75665		A	Artery x-rays, head & neck	1.31	13.04	NA	0.74	15.09	NA	XXX
75665	26	A	Artery x-rays, head & neck	1.31	0.44	0.44	0.09	1.84	1.84	XXX
75665	TC	A	Artery x-rays, head & neck	0.00	12.60	NA	0.65	13.25	NA	XXX
75671		A	Artery x-rays, head & neck	1.66	13.15	NA	0.74	15.55	NA	XXX
75671	26	A	Artery x-rays, head & neck	1.66	0.55	0.55	0.09	2.30	2.30	XXX
75671	TC	A	Artery x-rays, head & neck	0.00	12.60	NA	0.65	13.25	NA	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
75676		A	Artery x-rays, neck	1.31	13.04	NA	0.74	15.09	NA	XXX
75676	26	A	Artery x-rays, neck	1.31	0.44	0.44	0.09	1.84	1.84	XXX
75676	TC	A	Artery x-rays, neck	0.00	12.60	NA	0.65	13.25	NA	XXX
75680		A	Artery x-rays, neck	1.66	13.15	NA	0.74	15.55	NA	XXX
75680	26	A	Artery x-rays, neck	1.66	0.55	0.55	0.09	2.30	2.30	XXX
75680	TC	A	Artery x-rays, neck	0.00	12.60	NA	0.65	13.25	NA	XXX
75685		A	Artery x-rays, spine	1.31	13.03	NA	0.72	15.06	NA	XXX
75685	26	A	Artery x-rays, spine	1.31	0.43	0.43	0.07	1.81	1.81	XXX
75685	TC	A	Artery x-rays, spine	0.00	12.60	NA	0.65	13.25	NA	XXX
75705		A	Artery x-rays, spine	2.18	13.33	NA	0.78	16.29	NA	XXX
75705	26	A	Artery x-rays, spine	2.18	0.73	0.73	0.13	3.04	3.04	XXX
75705	TC	A	Artery x-rays, spine	0.00	12.60	NA	0.65	13.25	NA	XXX
75710		A	Artery x-rays, arm/leg	1.14	12.99	NA	0.72	14.85	NA	XXX
75710	26	A	Artery x-rays, arm/leg	1.14	0.39	0.39	0.07	1.60	1.60	XXX
75710	TC	A	Artery x-rays, arm/leg	0.00	12.60	NA	0.65	13.25	NA	XXX
75716		A	Artery x-rays, arms/legs	1.31	13.03	NA	0.72	15.06	NA	XXX
75716	26	A	Artery x-rays, arms/legs	1.31	0.43	0.43	0.07	1.81	1.81	XXX
75716	TC	A	Artery x-rays, arms/legs	0.00	12.60	NA	0.65	13.25	NA	XXX
75722		A	Artery x-rays, kidney	1.14	13.00	NA	0.71	14.85	NA	XXX
75722	26	A	Artery x-rays, kidney	1.14	0.40	0.40	0.06	1.60	1.60	XXX
75722	TC	A	Artery x-rays, kidney	0.00	12.60	NA	0.65	13.25	NA	XXX
75724		A	Artery x-rays, kidneys	1.49	13.16	NA	0.71	15.36	NA	XXX
75724	26	A	Artery x-rays, kidneys	1.49	0.56	0.56	0.06	2.11	2.11	XXX
75724	TC	A	Artery x-rays, kidneys	0.00	12.60	NA	0.65	13.25	NA	XXX
75726		A	Artery x-rays, abdomen	1.14	12.97	NA	0.70	14.81	NA	XXX
75726	26	A	Artery x-rays, abdomen	1.14	0.37	0.37	0.05	1.56	1.56	XXX
75726	TC	A	Artery x-rays, abdomen	0.00	12.60	NA	0.65	13.25	NA	XXX
75731		A	Artery x-rays, adrenal gland	1.14	12.97	NA	0.71	14.82	NA	XXX
75731	26	A	Artery x-rays, adrenal gland	1.14	0.37	0.37	0.06	1.57	1.57	XXX
75731	TC	A	Artery x-rays, adrenal gland	0.00	12.60	NA	0.65	13.25	NA	XXX
75733		A	Artery x-rays, adrenals	1.31	13.04	NA	0.71	15.06	NA	XXX
75733	26	A	Artery x-rays, adrenals	1.31	0.44	0.44	0.06	1.81	1.81	XXX
75733	TC	A	Artery x-rays, adrenals	0.00	12.60	NA	0.65	13.25	NA	XXX
75736		A	Artery x-rays, pelvis	1.14	12.98	NA	0.71	14.83	NA	XXX
75736	26	A	Artery x-rays, pelvis	1.14	0.38	0.38	0.06	1.58	1.58	XXX
75736	TC	A	Artery x-rays, pelvis	0.00	12.60	NA	0.65	13.25	NA	XXX
75741		A	Artery x-rays, lung	1.31	13.03	NA	0.71	15.05	NA	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
75741	26	A	Artery x-rays, lung	1.31	0.43	0.43	0.06	1.80	1.80	XXX
75741	TC	A	Artery x-rays, lung	0.00	12.60	NA	0.65	13.25	NA	XXX
75743		A	Artery x-rays, lungs	1.66	13.14	NA	0.72	15.52	NA	XXX
75743	26	A	Artery x-rays, lungs	1.66	0.54	0.54	0.07	2.27	2.27	XXX
75743	TC	A	Artery x-rays, lungs	0.00	12.60	NA	0.65	13.25	NA	XXX
75746		A	Artery x-rays, lung	1.14	12.98	NA	0.70	14.82	NA	XXX
75746	26	A	Artery x-rays, lung	1.14	0.38	0.38	0.05	1.57	1.57	XXX
75746	TC	A	Artery x-rays, lung	0.00	12.60	NA	0.65	13.25	NA	XXX
75756		A	Artery x-rays, chest	1.14	13.05	NA	0.69	14.88	NA	XXX
75756	26	A	Artery x-rays, chest	1.14	0.45	0.45	0.04	1.63	1.63	XXX
75756	TC	A	Artery x-rays, chest	0.00	12.60	NA	0.65	13.25	NA	XXX
75774		A	Artery x-ray, each vessel	0.36	12.72	NA	0.67	13.75	NA	ZZZ
75774	26	A	Artery x-ray, each vessel	0.36	0.12	0.12	0.02	0.50	0.50	ZZZ
75774	TC	A	Artery x-ray, each vessel	0.00	12.60	NA	0.65	13.25	NA	ZZZ
75790		A	Visualize A-V shunt	1.84	1.95	NA	0.18	3.97	NA	XXX
75790	26	A	Visualize A-V shunt	1.84	0.60	0.60	0.10	2.54	2.54	XXX
75790	TC	A	Visualize A-V shunt	0.00	1.35	NA	0.08	1.43	NA	XXX
75801		A	Lymph vessel x-ray, arm/leg	0.81	5.68	NA	0.36	6.85	NA	XXX
75801	26	A	Lymph vessel x-ray, arm/leg	0.81	0.27	0.27	0.07	1.15	1.15	XXX
75801	TC	A	Lymph vessel x-ray, arm/leg	0.00	5.41	NA	0.29	5.70	NA	XXX
75803		A	Lymph vessel x-ray,arms/legs	1.17	5.79	NA	0.34	7.30	NA	XXX
75803	26	A	Lymph vessel x-ray,arms/legs	1.17	0.38	0.38	0.05	1.60	1.60	XXX
75803	TC	A	Lymph vessel x-ray,arms/legs	0.00	5.41	NA	0.29	5.70	NA	XXX
75805		A	Lymph vessel x-ray, trunk	0.81	6.37	NA	0.38	7.56	NA	XXX
75805	26	A	Lymph vessel x-ray, trunk	0.81	0.27	0.27	0.05	1.13	1.13	XXX
75805	TC	A	Lymph vessel x-ray, trunk	0.00	6.10	NA	0.33	6.43	NA	XXX
75807		A	Lymph vessel x-ray, trunk	1.17	6.48	NA	0.38	8.03	NA	XXX
75807	26	A	Lymph vessel x-ray, trunk	1.17	0.38	0.38	0.05	1.60	1.60	XXX
75807	TC	A	Lymph vessel x-ray, trunk	0.00	6.10	NA	0.33	6.43	NA	XXX
75809		A	Nonvascular shunt, x-ray	0.47	0.93	NA	0.07	1.47	NA	XXX
75809	26	A	Nonvascular shunt, x-ray	0.47	0.15	0.15	0.02	0.64	0.64	XXX
75809	TC	A	Nonvascular shunt, x-ray	0.00	0.78	NA	0.05	0.83	NA	XXX
75810		A	Vein x-ray, spleen/liver	1.14	12.97	NA	0.70	14.81	NA	XXX
75810	26	A	Vein x-ray, spleen/liver	1.14	0.37	0.37	0.05	1.56	1.56	XXX
75810	TC	A	Vein x-ray, spleen/liver	0.00	12.60	NA	0.65	13.25	NA	XXX
75820		A	Vein x-ray, arm/leg	0.70	1.18	NA	0.10	1.98	NA	XXX
75820	26	A	Vein x-ray, arm/leg	0.70	0.23	0.23	0.04	0.97	0.97	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
75820	TC	A	Vein x-ray, arm/leg	0.00	0.95	NA	0.06	1.01	NA	XXX
75822		A	Vein x-ray, arms/legs	1.06	1.83	NA	0.13	3.02	NA	XXX
75822	26	A	Vein x-ray, arms/legs	1.06	0.35	0.35	0.05	1.46	1.46	XXX
75822	TC	A	Vein x-ray, arms/legs	0.00	1.48	NA	0.08	1.56	NA	XXX
75825		A	Vein x-ray, trunk	1.14	12.97	NA	0.72	14.83	NA	XXX
75825	26	A	Vein x-ray, trunk	1.14	0.37	0.37	0.07	1.58	1.58	XXX
75825	TC	A	Vein x-ray, trunk	0.00	12.60	NA	0.65	13.25	NA	XXX
75827		A	Vein x-ray, chest	1.14	12.97	NA	0.71	14.82	NA	XXX
75827	26	A	Vein x-ray, chest	1.14	0.37	0.37	0.06	1.57	1.57	XXX
75827	TC	A	Vein x-ray, chest	0.00	12.60	NA	0.65	13.25	NA	XXX
75831		A	Vein x-ray, kidney	1.14	12.97	NA	0.72	14.83	NA	XXX
75831	26	A	Vein x-ray, kidney	1.14	0.37	0.37	0.07	1.58	1.58	XXX
75831	TC	A	Vein x-ray, kidney	0.00	12.60	NA	0.65	13.25	NA	XXX
75833		A	Vein x-ray, kidneys	1.49	13.09	NA	0.74	15.32	NA	XXX
75833	26	A	Vein x-ray, kidneys	1.49	0.49	0.49	0.09	2.07	2.07	XXX
75833	TC	A	Vein x-ray, kidneys	0.00	12.60	NA	0.65	13.25	NA	XXX
75840		A	Vein x-ray, adrenal gland	1.14	12.98	NA	0.72	14.84	NA	XXX
75840	26	A	Vein x-ray, adrenal gland	1.14	0.38	0.38	0.07	1.59	1.59	XXX
75840	TC	A	Vein x-ray, adrenal gland	0.00	12.60	NA	0.65	13.25	NA	XXX
75842		A	Vein x-ray, adrenal glands	1.49	13.08	NA	0.72	15.29	NA	XXX
75842	26	A	Vein x-ray, adrenal glands	1.49	0.48	0.48	0.07	2.04	2.04	XXX
75842	TC	A	Vein x-ray, adrenal glands	0.00	12.60	NA	0.65	13.25	NA	XXX
75860		A	Vein x-ray, neck	1.14	12.99	NA	0.70	14.83	NA	XXX
75860	26	A	Vein x-ray, neck	1.14	0.39	0.39	0.05	1.58	1.58	XXX
75860	TC	A	Vein x-ray, neck	0.00	12.60	NA	0.65	13.25	NA	XXX
75870		A	Vein x-ray, skull	1.14	12.99	NA	0.70	14.83	NA	XXX
75870	26	A	Vein x-ray, skull	1.14	0.39	0.39	0.05	1.58	1.58	XXX
75870	TC	A	Vein x-ray, skull	0.00	12.60	NA	0.65	13.25	NA	XXX
75872		A	Vein x-ray, skull	1.14	12.97	NA	0.78	14.89	NA	XXX
75872	26	A	Vein x-ray, skull	1.14	0.37	0.37	0.13	1.64	1.64	XXX
75872	TC	A	Vein x-ray, skull	0.00	12.60	NA	0.65	13.25	NA	XXX
75880		A	Vein x-ray, eye socket	0.70	1.18	NA	0.09	1.97	NA	XXX
75880	26	A	Vein x-ray, eye socket	0.70	0.23	0.23	0.03	0.96	0.96	XXX
75880	TC	A	Vein x-ray, eye socket	0.00	0.95	NA	0.06	1.01	NA	XXX
75885		A	Vein x-ray, liver	1.44	13.07	NA	0.72	15.23	NA	XXX
75885	26	A	Vein x-ray, liver	1.44	0.47	0.47	0.07	1.98	1.98	XXX
75885	TC	A	Vein x-ray, liver	0.00	12.60	NA	0.65	13.25	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
75887		A	Vein x-ray, liver	1.44	13.07	NA	0.71	15.22	NA	XXX
75887	26	A	Vein x-ray, liver	1.44	0.47	0.47	0.06	1.97	1.97	XXX
75887	TC	A	Vein x-ray, liver	0.00	12.60	NA	0.65	13.25	NA	XXX
75889		A	Vein x-ray, liver	1.14	12.97	NA	0.70	14.81	NA	XXX
75889	26	A	Vein x-ray, liver	1.14	0.37	0.37	0.05	1.56	1.56	XXX
75889	TC	A	Vein x-ray, liver	0.00	12.60	NA	0.65	13.25	NA	XXX
75891		A	Vein x-ray, liver	1.14	12.97	NA	0.70	14.81	NA	XXX
75891	26	A	Vein x-ray, liver	1.14	0.37	0.37	0.05	1.56	1.56	XXX
75891	TC	A	Vein x-ray, liver	0.00	12.60	NA	0.65	13.25	NA	XXX
75893		A	Venous sampling by catheter	0.54	12.78	NA	0.68	14.00	NA	XXX
75893	26	A	Venous sampling by catheter	0.54	0.18	0.18	0.03	0.75	0.75	XXX
75893	TC	A	Venous sampling by catheter	0.00	12.60	NA	0.65	13.25	NA	XXX
75894		A	X-rays, transcath therapy	1.31	24.56	NA	1.35	27.22	NA	XXX
75894	26	A	X-rays, transcath therapy	1.31	0.43	0.43	0.08	1.82	1.82	XXX
75894	TC	A	X-rays, transcath therapy	0.00	24.13	NA	1.27	25.40	NA	XXX
75896		A	X-rays, transcath therapy	1.31	21.44	NA	1.17	23.92	NA	XXX
75896	26	A	X-rays, transcath therapy	1.31	0.45	0.45	0.07	1.83	1.83	XXX
75896	TC	A	X-rays, transcath therapy	0.00	20.99	NA	1.10	22.09	NA	XXX
75898		A	Follow-up angiography	1.65	1.60	NA	0.14	3.39	NA	XXX
75898	26	A	Follow-up angiography	1.65	0.55	0.55	0.08	2.28	2.28	XXX
75898	TC	A	Follow-up angiography	0.00	1.05	NA	0.06	1.11	NA	XXX
75900		A	Arterial catheter exchange	0.49	21.13	NA	1.14	22.76	NA	XXX
75900	26	A	Arterial catheter exchange	0.49	0.16	0.16	0.03	0.68	0.68	XXX
75900	TC	A	Arterial catheter exchange	0.00	20.97	NA	1.11	22.08	NA	XXX
75901		A	Remove cva device obstruct	0.49	1.47	NA	0.85	2.81	NA	XXX
75901	26	A	Remove cva device obstruct	0.49	0.16	0.16	0.02	0.67	0.67	XXX
75901	TC	A	Remove cva device obstruct	0.00	1.31	NA	0.83	2.14	NA	XXX
75902		A	Remove cva lumen obstruct	0.39	1.44	NA	0.85	2.68	NA	XXX
75902	26	A	Remove cva lumen obstruct	0.39	0.13	0.13	0.02	0.54	0.54	XXX
75902	TC	A	Remove cva lumen obstruct	0.00	1.31	NA	0.83	2.14	NA	XXX
75940		A	X-ray placement, vein filter	0.54	12.78	NA	0.69	14.01	NA	XXX
75940	26	A	X-ray placement, vein filter	0.54	0.18	0.18	0.04	0.76	0.76	XXX
75940	TC	A	X-ray placement, vein filter	0.00	12.60	NA	0.65	13.25	NA	XXX
75945		A	Intravascular us	0.40	4.70	NA	0.28	5.38	NA	XXX
75945	26	A	Intravascular us	0.40	0.14	0.14	0.04	0.58	0.58	XXX
75945	TC	A	Intravascular us	0.00	4.56	NA	0.24	4.80	NA	XXX
75946		A	Intravascular us add-on	0.40	2.43	NA	0.18	3.01	NA	ZZZ

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
75946	26	A	Intravascular us add-on	0.40	0.14	0.14	0.05	0.59	0.59	ZZZ
75946	TC	A	Intravascular us add-on	0.00	2.29	NA	0.13	2.42	NA	ZZZ
75952		C	Endovasc repair abdom aorta	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75952	26	A	Endovasc repair abdom aorta	4.49	1.49	1.49	0.44	6.42	6.42	XXX
75952	TC	C	Endovasc repair abdom aorta	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75953		C	Abdom aneurysm endovas rpr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75953	26	A	Abdom aneurysm endovas rpr	1.36	0.45	0.45	0.13	1.94	1.94	XXX
75953	TC	C	Abdom aneurysm endovas rpr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75954		C	Iliac aneurysm endovas rpr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75954	26	A	Iliac aneurysm endovas rpr	2.25	0.78	0.78	0.15	3.18	3.18	XXX
75954	TC	C	Iliac aneurysm endovas rpr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75960		A	Transcath iv stent rs&i	0.82	15.18	NA	0.82	16.82	NA	XXX
75960	26	A	Transcath iv stent rs&i	0.82	0.28	0.28	0.05	1.15	1.15	XXX
75960	TC	A	Transcath iv stent rs&i	0.00	14.90	NA	0.77	15.67	NA	XXX
75961		A	Retrieval, broken catheter	4.24	11.89	NA	0.77	16.90	NA	XXX
75961	26	A	Retrieval, broken catheter	4.24	1.39	1.39	0.22	5.85	5.85	XXX
75961	TC	A	Retrieval, broken catheter	0.00	10.50	NA	0.55	11.05	NA	XXX
75962		A	Repair arterial blockage	0.54	15.92	NA	0.87	17.33	NA	XXX
75962	26	A	Repair arterial blockage	0.54	0.18	0.18	0.04	0.76	0.76	XXX
75962	TC	A	Repair arterial blockage	0.00	15.74	NA	0.83	16.57	NA	XXX
75964		A	Repair artery blockage, each	0.36	8.51	NA	0.46	9.33	NA	ZZZ
75964	26	A	Repair artery blockage, each	0.36	0.12	0.12	0.03	0.51	0.51	ZZZ
75964	TC	A	Repair artery blockage, each	0.00	8.39	NA	0.43	8.82	NA	ZZZ
75966		A	Repair arterial blockage	1.31	16.20	NA	0.90	18.41	NA	XXX
75966	26	A	Repair arterial blockage	1.31	0.46	0.46	0.07	1.84	1.84	XXX
75966	TC	A	Repair arterial blockage	0.00	15.74	NA	0.83	16.57	NA	XXX
75968		A	Repair artery blockage, each	0.36	8.52	NA	0.45	9.33	NA	ZZZ
75968	26	A	Repair artery blockage, each	0.36	0.13	0.13	0.02	0.51	0.51	ZZZ
75968	TC	A	Repair artery blockage, each	0.00	8.39	NA	0.43	8.82	NA	ZZZ
75970		A	Vascular biopsy	0.83	11.82	NA	0.64	13.29	NA	XXX
75970	26	A	Vascular biopsy	0.83	0.28	0.28	0.04	1.15	1.15	XXX
75970	TC	A	Vascular biopsy	0.00	11.54	NA	0.60	12.14	NA	XXX
75978		A	Repair venous blockage	0.54	15.92	NA	0.86	17.32	NA	XXX
75978	26	A	Repair venous blockage	0.54	0.18	0.18	0.03	0.75	0.75	XXX
75978	TC	A	Repair venous blockage	0.00	15.74	NA	0.83	16.57	NA	XXX
75980		A	Contrast xray exam bile duct	1.44	5.88	NA	0.35	7.67	NA	XXX
75980	26	A	Contrast xray exam bile duct	1.44	0.47	0.47	0.06	1.97	1.97	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
75980	TC	A	Contrast xray exam bile duct	0.00	5.41	NA	0.29	5.70	NA	XXX
75982		A	Contrast xray exam bile duct	1.44	6.57	NA	0.39	8.40	NA	XXX
75982	26	A	Contrast xray exam bile duct	1.44	0.47	0.47	0.06	1.97	1.97	XXX
75982	TC	A	Contrast xray exam bile duct	0.00	6.10	NA	0.33	6.43	NA	XXX
75984		A	Xray control catheter change	0.72	2.18	NA	0.14	3.04	NA	XXX
75984	26	A	Xray control catheter change	0.72	0.23	0.23	0.03	0.98	0.98	XXX
75984	TC	A	Xray control catheter change	0.00	1.95	NA	0.11	2.06	NA	XXX
75989		A	Abscess drainage under x-ray	1.19	3.54	NA	0.22	4.95	NA	XXX
75989	26	A	Abscess drainage under x-ray	1.19	0.39	0.39	0.05	1.63	1.63	XXX
75989	TC	A	Abscess drainage under x-ray	0.00	3.15	NA	0.17	3.32	NA	XXX
75992		A	Atherectomy, x-ray exam	0.54	15.93	NA	0.86	17.33	NA	XXX
75992	26	A	Atherectomy, x-ray exam	0.54	0.19	0.19	0.03	0.76	0.76	XXX
75992	TC	A	Atherectomy, x-ray exam	0.00	15.74	NA	0.83	16.57	NA	XXX
75993		A	Atherectomy, x-ray exam	0.36	8.52	NA	0.45	9.33	NA	ZZZ
75993	26	A	Atherectomy, x-ray exam	0.36	0.13	0.13	0.02	0.51	0.51	ZZZ
75993	TC	A	Atherectomy, x-ray exam	0.00	8.39	NA	0.43	8.82	NA	ZZZ
75994		A	Atherectomy, x-ray exam	1.31	16.20	NA	0.90	18.41	NA	XXX
75994	26	A	Atherectomy, x-ray exam	1.31	0.46	0.46	0.07	1.84	1.84	XXX
75994	TC	A	Atherectomy, x-ray exam	0.00	15.74	NA	0.83	16.57	NA	XXX
75995		A	Atherectomy, x-ray exam	1.31	16.21	NA	0.88	18.40	NA	XXX
75995	26	A	Atherectomy, x-ray exam	1.31	0.47	0.47	0.05	1.83	1.83	XXX
75995	TC	A	Atherectomy, x-ray exam	0.00	15.74	NA	0.83	16.57	NA	XXX
75996		A	Atherectomy, x-ray exam	0.36	8.51	NA	0.45	9.32	NA	ZZZ
75996	26	A	Atherectomy, x-ray exam	0.36	0.12	0.12	0.02	0.50	0.50	ZZZ
75996	TC	A	Atherectomy, x-ray exam	0.00	8.39	NA	0.43	8.82	NA	ZZZ
75998		A	Fluoroguide for vein device	0.38	1.44	NA	0.11	1.93	NA	ZZZ
75998	26	A	Fluoroguide for vein device	0.38	0.13	0.13	0.01	0.52	0.52	ZZZ
75998	TC	A	Fluoroguide for vein device	0.00	1.31	NA	0.10	1.41	NA	ZZZ
76000		A	Fluoroscope examination	0.17	1.36	NA	0.08	1.61	NA	XXX
76000	26	A	Fluoroscope examination	0.17	0.05	0.05	0.01	0.23	0.23	XXX
76000	TC	A	Fluoroscope examination	0.00	1.31	NA	0.07	1.38	NA	XXX
76001		A	Fluoroscope exam, extensive	0.67	2.84	NA	0.19	3.70	NA	XXX
76001	26	A	Fluoroscope exam, extensive	0.67	0.22	0.22	0.05	0.94	0.94	XXX
76001	TC	A	Fluoroscope exam, extensive	0.00	2.62	NA	0.14	2.76	NA	XXX
76003		A	Needle localization by x-ray	0.54	1.48	NA	0.10	2.12	NA	XXX
76003	26	A	Needle localization by x-ray	0.54	0.17	0.17	0.03	0.74	0.74	XXX
76003	TC	A	Needle localization by x-ray	0.00	1.31	NA	0.07	1.38	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
76005		A	Fluoroguide for spine inject	0.60	1.46	NA	0.11	2.17	NA	XXX
76005	26	A	Fluoroguide for spine inject	0.60	0.15	0.15	0.04	0.79	0.79	XXX
76005	TC	A	Fluoroguide for spine inject	0.00	1.31	NA	0.07	1.38	NA	XXX
76006		A	X-ray stress view	0.41	0.18	0.18	0.06	0.65	0.65	XXX
76010		A	X-ray, nose to rectum	0.18	0.58	NA	0.03	0.79	NA	XXX
76010	26	A	X-ray, nose to rectum	0.18	0.06	0.06	0.01	0.25	0.25	XXX
76010	TC	A	X-ray, nose to rectum	0.00	0.52	NA	0.02	0.54	NA	XXX
76012		C	Percut vertebroplasty fluor	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76012	26	A	Percut vertebroplasty fluor	1.31	0.47	0.47	0.10	1.88	1.88	XXX
76012	TC	C	Percut vertebroplasty fluor	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76013		C	Percut vertebroplasty, ct	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76013	26	A	Percut vertebroplasty, ct	1.38	0.48	0.48	0.08	1.94	1.94	XXX
76013	TC	C	Percut vertebroplasty, ct	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76020		A	X-rays for bone age	0.19	0.58	NA	0.03	0.80	NA	XXX
76020	26	A	X-rays for bone age	0.19	0.06	0.06	0.01	0.26	0.26	XXX
76020	TC	A	X-rays for bone age	0.00	0.52	NA	0.02	0.54	NA	XXX
76040		A	X-rays, bone evaluation	0.27	0.87	NA	0.06	1.20	NA	XXX
76040	26	A	X-rays, bone evaluation	0.27	0.09	0.09	0.01	0.37	0.37	XXX
76040	TC	A	X-rays, bone evaluation	0.00	0.78	NA	0.05	0.83	NA	XXX
76061		A	X-rays, bone survey	0.45	1.15	NA	0.08	1.68	NA	XXX
76061	26	A	X-rays, bone survey	0.45	0.15	0.15	0.02	0.62	0.62	XXX
76061	TC	A	X-rays, bone survey	0.00	1.00	NA	0.06	1.06	NA	XXX
76062		A	X-rays, bone survey	0.54	1.62	NA	0.10	2.26	NA	XXX
76062	26	A	X-rays, bone survey	0.54	0.18	0.18	0.02	0.74	0.74	XXX
76062	TC	A	X-rays, bone survey	0.00	1.44	NA	0.08	1.52	NA	XXX
76065		A	X-rays, bone evaluation	0.70	0.96	NA	0.08	1.74	NA	XXX
76065	26	A	X-rays, bone evaluation	0.70	0.23	0.23	0.03	0.96	0.96	XXX
76065	TC	A	X-rays, bone evaluation	0.00	0.73	NA	0.05	0.78	NA	XXX
76066		A	Joint survey, single view	0.31	1.21	NA	0.08	1.60	NA	XXX
76066	26	A	Joint survey, single view	0.31	0.10	0.10	0.02	0.43	0.43	XXX
76066	TC	A	Joint survey, single view	0.00	1.11	NA	0.06	1.17	NA	XXX
76070		A	Ct bone density, axial	0.25	3.03	NA	0.17	3.45	NA	XXX
76070	26	A	Ct bone density, axial	0.25	0.08	0.08	0.01	0.34	0.34	XXX
76070	TC	A	Ct bone density, axial	0.00	2.95	NA	0.16	3.11	NA	XXX
76071		A	Ct bone density, peripheral	0.22	3.02	NA	0.06	3.30	NA	XXX
76071	26	A	Ct bone density, peripheral	0.22	0.07	0.07	0.01	0.30	0.30	XXX
76071	TC	A	Ct bone density, peripheral	0.00	2.95	NA	0.05	3.00	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
76075		A	Dxa bone density, axial	0.30	3.19	NA	0.18	3.67	NA	XXX
76075	26	A	Dxa bone density, axial	0.30	0.10	0.10	0.01	0.41	0.41	XXX
76075	TC	A	Dxa bone density, axial	0.00	3.09	NA	0.17	3.26	NA	XXX
76076		A	Dxa bone density/peripheral	0.22	0.83	NA	0.06	1.11	NA	XXX
76076	26	A	Dxa bone density/peripheral	0.22	0.08	0.08	0.01	0.31	0.31	XXX
76076	TC	A	Dxa bone density/peripheral	0.00	0.75	NA	0.05	0.80	NA	XXX
76077		A	Dxa bone density/v-fracture	0.17	0.81	NA	0.06	1.04	NA	XXX
76077	26	A	Dxa bone density/v-fracture	0.17	0.06	0.06	0.01	0.24	0.24	XXX
76077	TC	A	Dxa bone density/v-fracture	0.00	0.75	NA	0.05	0.80	NA	XXX
76078		A	Radiographic absorptiometry	0.20	0.82	NA	0.06	1.08	NA	XXX
76078	26	A	Radiographic absorptiometry	0.20	0.07	0.07	0.01	0.28	0.28	XXX
76078	TC	A	Radiographic absorptiometry	0.00	0.75	NA	0.05	0.80	NA	XXX
76080		A	X-ray exam of fistula	0.54	1.23	NA	0.08	1.85	NA	XXX
76080	26	A	X-ray exam of fistula	0.54	0.18	0.18	0.02	0.74	0.74	XXX
76080	TC	A	X-ray exam of fistula	0.00	1.05	NA	0.06	1.11	NA	XXX
76082		A	Computer mammogram add-on	0.06	0.44	NA	0.02	0.52	NA	ZZZ
76082	26	A	Computer mammogram add-on	0.06	0.02	0.02	0.01	0.09	0.09	ZZZ
76082	TC	A	Computer mammogram add-on	0.00	0.42	NA	0.01	0.43	NA	ZZZ
76083		A	Computer mammogram add-on	0.06	0.44	NA	0.02	0.52	NA	ZZZ
76083	26	A	Computer mammogram add-on	0.06	0.02	0.02	0.01	0.09	0.09	ZZZ
76083	TC	A	Computer mammogram add-on	0.00	0.42	NA	0.01	0.43	NA	ZZZ
76086		A	X-ray of mammary duct	0.36	2.74	NA	0.16	3.26	NA	XXX
76086	26	A	X-ray of mammary duct	0.36	0.12	0.12	0.02	0.50	0.50	XXX
76086	TC	A	X-ray of mammary duct	0.00	2.62	NA	0.14	2.76	NA	XXX
76088		A	X-ray of mammary ducts	0.45	3.81	NA	0.21	4.47	NA	XXX
76088	26	A	X-ray of mammary ducts	0.45	0.15	0.15	0.02	0.62	0.62	XXX
76088	TC	A	X-ray of mammary ducts	0.00	3.66	NA	0.19	3.85	NA	XXX
76090		A	Mammogram, one breast	0.70	1.28	NA	0.09	2.07	NA	XXX
76090	26	A	Mammogram, one breast	0.70	0.23	0.23	0.03	0.96	0.96	XXX
76090	TC	A	Mammogram, one breast	0.00	1.05	NA	0.06	1.11	NA	XXX
76091		A	Mammogram, both breasts	0.87	1.59	NA	0.11	2.57	NA	XXX
76091	26	A	Mammogram, both breasts	0.87	0.28	0.28	0.04	1.19	1.19	XXX
76091	TC	A	Mammogram, both breasts	0.00	1.31	NA	0.07	1.38	NA	XXX
76092		A	Mammogram, screening	0.70	1.46	NA	0.10	2.26	NA	XXX
76092	26	A	Mammogram, screening	0.70	0.23	0.23	0.03	0.96	0.96	XXX
76092	TC	A	Mammogram, screening	0.00	1.23	NA	0.07	1.30	NA	XXX
76093		A	Magnetic image, breast	1.63	18.15	NA	0.99	20.77	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
76093	26	A	Magnetic image, breast	1.63	0.53	0.53	0.07	2.23	2.23	XXX
76093	TC	A	Magnetic image, breast	0.00	17.62	NA	0.92	18.54	NA	XXX
76094		A	Magnetic image, both breasts	1.63	24.44	NA	1.31	27.38	NA	XXX
76094	26	A	Magnetic image, both breasts	1.63	0.53	0.53	0.07	2.23	2.23	XXX
76094	TC	A	Magnetic image, both breasts	0.00	23.91	NA	1.24	25.15	NA	XXX
76095		A	Stereotactic breast biopsy	1.59	7.68	NA	0.46	9.73	NA	XXX
76095	26	A	Stereotactic breast biopsy	1.59	0.52	0.52	0.09	2.20	2.20	XXX
76095	TC	A	Stereotactic breast biopsy	0.00	7.16	NA	0.37	7.53	NA	XXX
76096		A	X-ray of needle wire, breast	0.56	1.49	NA	0.10	2.15	NA	XXX
76096	26	A	X-ray of needle wire, breast	0.56	0.18	0.18	0.03	0.77	0.77	XXX
76096	TC	A	X-ray of needle wire, breast	0.00	1.31	NA	0.07	1.38	NA	XXX
76098		A	X-ray exam, breast specimen	0.16	0.47	NA	0.03	0.66	NA	XXX
76098	26	A	X-ray exam, breast specimen	0.16	0.05	0.05	0.01	0.22	0.22	XXX
76098	TC	A	X-ray exam, breast specimen	0.00	0.42	NA	0.02	0.44	NA	XXX
76100		A	X-ray exam of body section	0.58	1.44	NA	0.10	2.12	NA	XXX
76100	26	A	X-ray exam of body section	0.58	0.19	0.19	0.03	0.80	0.80	XXX
76100	TC	A	X-ray exam of body section	0.00	1.25	NA	0.07	1.32	NA	XXX
76101		A	Complex body section x-ray	0.58	1.61	NA	0.11	2.30	NA	XXX
76101	26	A	Complex body section x-ray	0.58	0.19	0.19	0.03	0.80	0.80	XXX
76101	TC	A	Complex body section x-ray	0.00	1.42	NA	0.08	1.50	NA	XXX
76102		A	Complex body section x-rays	0.58	1.92	NA	0.14	2.64	NA	XXX
76102	26	A	Complex body section x-rays	0.58	0.19	0.19	0.03	0.80	0.80	XXX
76102	TC	A	Complex body section x-rays	0.00	1.73	NA	0.11	1.84	NA	XXX
76120		A	Cine/video x-rays	0.38	1.18	NA	0.08	1.64	NA	XXX
76120	26	A	Cine/video x-rays	0.38	0.13	0.13	0.02	0.53	0.53	XXX
76120	TC	A	Cine/video x-rays	0.00	1.05	NA	0.06	1.11	NA	XXX
76125		A	Cine/video x-rays add-on	0.27	0.87	NA	0.06	1.20	NA	ZZZ
76125	26	A	Cine/video x-rays add-on	0.27	0.09	0.09	0.01	0.37	0.37	ZZZ
76125	TC	A	Cine/video x-rays add-on	0.00	0.78	NA	0.05	0.83	NA	ZZZ
76140		I	X-ray consultation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76150		A	X-ray exam, dry process	0.00	0.42	NA	0.02	0.44	NA	XXX
76350		C	Special x-ray contrast study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76355		A	Ct scan for localization	1.21	8.66	NA	0.48	10.35	NA	XXX
76355	26	A	Ct scan for localization	1.21	0.40	0.40	0.06	1.67	1.67	XXX
76355	TC	A	Ct scan for localization	0.00	8.26	NA	0.42	8.68	NA	XXX
76360		A	Ct scan for needle biopsy	1.16	8.64	NA	0.47	10.27	NA	XXX
76360	26	A	Ct scan for needle biopsy	1.16	0.38	0.38	0.05	1.59	1.59	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
76360	TC	A	Ct scan for needle biopsy	0.00	8.26	NA	0.42	8.68	NA	XXX
76362		A	Ct guide for tissue ablation	3.99	9.56	NA	1.65	15.20	NA	XXX
76362	26	A	Ct guide for tissue ablation	3.99	1.30	1.30	0.19	5.48	5.48	XXX
76362	TC	A	Ct guide for tissue ablation	0.00	8.26	NA	1.46	9.72	NA	XXX
76370		A	Ct scan for therapy guide	0.85	3.23	NA	0.20	4.28	NA	XXX
76370	26	A	Ct scan for therapy guide	0.85	0.28	0.28	0.04	1.17	1.17	XXX
76370	TC	A	Ct scan for therapy guide	0.00	2.95	NA	0.16	3.11	NA	XXX
76375		A	3d/holograph reconstr add-on	0.16	3.59	NA	0.19	3.94	NA	XXX
76375	26	A	3d/holograph reconstr add-on	0.16	0.05	0.05	0.01	0.22	0.22	XXX
76375	TC	A	3d/holograph reconstr add-on	0.00	3.54	NA	0.18	3.72	NA	XXX
76380		A	CAT scan follow-up study	0.98	3.82	NA	0.22	5.02	NA	XXX
76380	26	A	CAT scan follow-up study	0.98	0.32	0.32	0.04	1.34	1.34	XXX
76380	TC	A	CAT scan follow-up study	0.00	3.50	NA	0.18	3.68	NA	XXX
76390		N	Mr spectroscopy	+1.40	11.48	11.48	0.66	13.54	13.54	XXX
76390	26	N	Mr spectroscopy	+1.40	0.47	0.47	0.07	1.94	1.94	XXX
76390	TC	N	Mr spectroscopy	+0.00	11.01	11.01	0.59	11.60	11.60	XXX
76393		A	Mr guidance for needle place	1.50	11.70	NA	0.64	13.84	NA	XXX
76393	26	A	Mr guidance for needle place	1.50	0.50	0.50	0.09	2.09	2.09	XXX
76393	TC	A	Mr guidance for needle place	0.00	11.20	NA	0.55	11.75	NA	XXX
76394		A	Mri for tissue ablation	4.24	12.58	NA	1.80	18.62	NA	XXX
76394	26	A	Mri for tissue ablation	4.24	1.38	1.38	0.24	5.86	5.86	XXX
76394	TC	A	Mri for tissue ablation	0.00	11.20	NA	1.56	12.76	NA	XXX
76400		A	Magnetic image, bone marrow	1.60	11.72	NA	0.66	13.98	NA	XXX
76400	26	A	Magnetic image, bone marrow	1.60	0.52	0.52	0.07	2.19	2.19	XXX
76400	TC	A	Magnetic image, bone marrow	0.00	11.20	NA	0.59	11.79	NA	XXX
76496		C	Fluoroscopic procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76496	26	C	Fluoroscopic procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76496	TC	C	Fluoroscopic procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76497		C	Ct procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76497	26	C	Ct procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76497	TC	C	Ct procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76498		C	Mri procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76498	26	C	Mri procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76498	TC	C	Mri procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76499		C	Radiographic procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76499	26	C	Radiographic procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76499	TC	C	Radiographic procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
76506		A	Echo exam of head	0.63	1.66	NA	0.13	2.42	NA	XXX
76506	26	A	Echo exam of head	0.63	0.24	0.24	0.05	0.92	0.92	XXX
76506	TC	A	Echo exam of head	0.00	1.42	NA	0.08	1.50	NA	XXX
76510		A	Ophth us, b & quant a	1.55	2.86	NA	0.10	4.51	NA	XXX
76510	26	A	Ophth us, b & quant a	1.55	0.68	0.68	0.03	2.26	2.26	XXX
76510	TC	A	Ophth us, b & quant a	0.00	2.18	NA	0.07	2.25	NA	XXX
76511		A	Ophth us, quant a only	0.94	2.43	NA	0.10	3.47	NA	XXX
76511	26	A	Ophth us, quant a only	0.94	0.40	0.40	0.03	1.37	1.37	XXX
76511	TC	A	Ophth us, quant a only	0.00	2.03	NA	0.07	2.10	NA	XXX
76512		A	Ophth us, b w/non-quant a	0.94	2.23	NA	0.12	3.29	NA	XXX
76512	26	A	Ophth us, b w/non-quant a	0.94	0.42	0.42	0.02	1.38	1.38	XXX
76512	TC	A	Ophth us, b w/non-quant a	0.00	1.81	NA	0.10	1.91	NA	XXX
76513		A	Echo exam of eye, water bath	0.66	1.81	NA	0.12	2.59	NA	XXX
76513	26	A	Echo exam of eye, water bath	0.66	0.29	0.29	0.02	0.97	0.97	XXX
76513	TC	A	Echo exam of eye, water bath	0.00	1.52	NA	0.10	1.62	NA	XXX
76514		A	Echo exam of eye, thickness	0.17	0.13	NA	0.02	0.32	NA	XXX
76514	26	A	Echo exam of eye, thickness	0.17	0.08	0.08	0.01	0.26	0.26	XXX
76514	TC	A	Echo exam of eye, thickness	0.00	0.05	NA	0.01	0.06	NA	XXX
76516		A	Echo exam of eye	0.54	1.46	NA	0.08	2.08	NA	XXX
76516	26	A	Echo exam of eye	0.54	0.24	0.24	0.01	0.79	0.79	XXX
76516	TC	A	Echo exam of eye	0.00	1.22	NA	0.07	1.29	NA	XXX
76519		A	Echo exam of eye	0.54	1.55	NA	0.08	2.17	NA	XXX
76519	26	A	Echo exam of eye	0.54	0.24	0.24	0.01	0.79	0.79	XXX
76519	TC	A	Echo exam of eye	0.00	1.31	NA	0.07	1.38	NA	XXX
76529		A	Echo exam of eye	0.57	1.37	NA	0.10	2.04	NA	XXX
76529	26	A	Echo exam of eye	0.57	0.24	0.24	0.02	0.83	0.83	XXX
76529	TC	A	Echo exam of eye	0.00	1.13	NA	0.08	1.21	NA	XXX
76536		A	Us exam of head and neck	0.56	1.60	NA	0.11	2.27	NA	XXX
76536	26	A	Us exam of head and neck	0.56	0.18	0.18	0.03	0.77	0.77	XXX
76536	TC	A	Us exam of head and neck	0.00	1.42	NA	0.08	1.50	NA	XXX
76604		A	Us exam, chest, b-scan	0.55	1.49	NA	0.09	2.13	NA	XXX
76604	26	A	Us exam, chest, b-scan	0.55	0.18	0.18	0.02	0.75	0.75	XXX
76604	TC	A	Us exam, chest, b-scan	0.00	1.31	NA	0.07	1.38	NA	XXX
76645		A	Us exam, breast(s)	0.54	1.23	NA	0.08	1.85	NA	XXX
76645	26	A	Us exam, breast(s)	0.54	0.18	0.18	0.02	0.74	0.74	XXX
76645	TC	A	Us exam, breast(s)	0.00	1.05	NA	0.06	1.11	NA	XXX
76700		A	Us exam, abdom, complete	0.81	2.24	NA	0.15	3.20	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
76700	26	A	Us exam, abdom, complete	0.81	0.27	0.27	0.04	1.12	1.12	XXX
76700	TC	A	Us exam, abdom, complete	0.00	1.97	NA	0.11	2.08	NA	XXX
76705		A	Echo exam of abdomen	0.59	1.61	NA	0.11	2.31	NA	XXX
76705	26	A	Echo exam of abdomen	0.59	0.19	0.19	0.03	0.81	0.81	XXX
76705	TC	A	Echo exam of abdomen	0.00	1.42	NA	0.08	1.50	NA	XXX
76770		A	Us exam abdo back wall, comp	0.74	2.21	NA	0.14	3.09	NA	XXX
76770	26	A	Us exam abdo back wall, comp	0.74	0.24	0.24	0.03	1.01	1.01	XXX
76770	TC	A	Us exam abdo back wall, comp	0.00	1.97	NA	0.11	2.08	NA	XXX
76775		A	Us exam abdo back wall, lim	0.58	1.61	NA	0.11	2.30	NA	XXX
76775	26	A	Us exam abdo back wall, lim	0.58	0.19	0.19	0.03	0.80	0.80	XXX
76775	TC	A	Us exam abdo back wall, lim	0.00	1.42	NA	0.08	1.50	NA	XXX
76778		A	Us exam kidney transplant	0.74	2.21	NA	0.14	3.09	NA	XXX
76778	26	A	Us exam kidney transplant	0.74	0.24	0.24	0.03	1.01	1.01	XXX
76778	TC	A	Us exam kidney transplant	0.00	1.97	NA	0.11	2.08	NA	XXX
76800		A	Us exam, spinal canal	1.13	1.76	NA	0.13	3.02	NA	XXX
76800	26	A	Us exam, spinal canal	1.13	0.34	0.34	0.05	1.52	1.52	XXX
76800	TC	A	Us exam, spinal canal	0.00	1.42	NA	0.08	1.50	NA	XXX
76801		A	Ob us < 14 wks, single fetus	0.99	2.44	NA	0.16	3.59	NA	XXX
76801	26	A	Ob us < 14 wks, single fetus	0.99	0.34	0.34	0.04	1.37	1.37	XXX
76801	TC	A	Ob us < 14 wks, single fetus	0.00	2.10	NA	0.12	2.22	NA	XXX
76802		A	Ob us < 14 wks, add'l fetus	0.83	1.34	NA	0.16	2.33	NA	ZZZ
76802	26	A	Ob us < 14 wks, add'l fetus	0.83	0.29	0.29	0.04	1.16	1.16	ZZZ
76802	TC	A	Ob us < 14 wks, add'l fetus	0.00	1.05	NA	0.12	1.17	NA	ZZZ
76805		A	Ob us >/= 14 wks, sngl fetus	0.99	2.44	NA	0.16	3.59	NA	XXX
76805	26	A	Ob us >/= 14 wks, sngl fetus	0.99	0.34	0.34	0.04	1.37	1.37	XXX
76805	TC	A	Ob us >/= 14 wks, sngl fetus	0.00	2.10	NA	0.12	2.22	NA	XXX
76810		A	Ob us >/= 14 wks, addl fetus	0.98	1.39	NA	0.26	2.63	NA	ZZZ
76810	26	A	Ob us >/= 14 wks, addl fetus	0.98	0.34	0.34	0.04	1.36	1.36	ZZZ
76810	TC	A	Ob us >/= 14 wks, addl fetus	0.00	1.05	NA	0.22	1.27	NA	ZZZ
76811		A	Ob us, detailed, sngl fetus	1.90	4.24	NA	0.52	6.66	NA	XXX
76811	26	A	Ob us, detailed, sngl fetus	1.90	0.71	0.71	0.09	2.70	2.70	XXX
76811	TC	A	Ob us, detailed, sngl fetus	0.00	3.53	NA	0.43	3.96	NA	XXX
76812		A	Ob us, detailed, addl fetus	1.78	1.71	NA	0.49	3.98	NA	ZZZ
76812	26	A	Ob us, detailed, addl fetus	1.78	0.66	0.66	0.08	2.52	2.52	ZZZ
76812	TC	A	Ob us, detailed, addl fetus	0.00	1.05	NA	0.41	1.46	NA	ZZZ
76815		A	Ob us, limited, fetus(s)	0.65	1.65	NA	0.11	2.41	NA	XXX
76815	26	A	Ob us, limited, fetus(s)	0.65	0.23	0.23	0.03	0.91	0.91	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
76815	TC	A	Ob us, limited, fetus(s)	0.00	1.42	NA	0.08	1.50	NA	XXX
76816		A	Ob us, follow-up, per fetus	0.85	1.43	NA	0.10	2.38	NA	XXX
76816	26	A	Ob us, follow-up, per fetus	0.85	0.32	0.32	0.04	1.21	1.21	XXX
76816	TC	A	Ob us, follow-up, per fetus	0.00	1.11	NA	0.06	1.17	NA	XXX
76817		A	Transvaginal us, obstetric	0.75	1.78	NA	0.09	2.62	NA	XXX
76817	26	A	Transvaginal us, obstetric	0.75	0.26	0.26	0.03	1.04	1.04	XXX
76817	TC	A	Transvaginal us, obstetric	0.00	1.52	NA	0.06	1.58	NA	XXX
76818		A	Fetal biophys profile w/nst	1.05	2.00	NA	0.15	3.20	NA	XXX
76818	26	A	Fetal biophys profile w/nst	1.05	0.39	0.39	0.05	1.49	1.49	XXX
76818	TC	A	Fetal biophys profile w/nst	0.00	1.61	NA	0.10	1.71	NA	XXX
76819		A	Fetal biophys profil w/o nst	0.77	1.89	NA	0.13	2.79	NA	XXX
76819	26	A	Fetal biophys profil w/o nst	0.77	0.28	0.28	0.03	1.08	1.08	XXX
76819	TC	A	Fetal biophys profil w/o nst	0.00	1.61	NA	0.10	1.71	NA	XXX
76820		A	Umbilical artery echo	0.50	1.80	NA	0.15	2.45	NA	XXX
76820	26	A	Umbilical artery echo	0.50	0.19	0.19	0.03	0.72	0.72	XXX
76820	TC	A	Umbilical artery echo	0.00	1.61	NA	0.12	1.73	NA	XXX
76821		A	Middle cerebral artery echo	0.70	1.88	NA	0.15	2.73	NA	XXX
76821	26	A	Middle cerebral artery echo	0.70	0.27	0.27	0.03	1.00	1.00	XXX
76821	TC	A	Middle cerebral artery echo	0.00	1.61	NA	0.12	1.73	NA	XXX
76825		A	Echo exam of fetal heart	1.67	2.57	NA	0.18	4.42	NA	XXX
76825	26	A	Echo exam of fetal heart	1.67	0.60	0.60	0.07	2.34	2.34	XXX
76825	TC	A	Echo exam of fetal heart	0.00	1.97	NA	0.11	2.08	NA	XXX
76826		A	Echo exam of fetal heart	0.83	1.00	NA	0.08	1.91	NA	XXX
76826	26	A	Echo exam of fetal heart	0.83	0.29	0.29	0.03	1.15	1.15	XXX
76826	TC	A	Echo exam of fetal heart	0.00	0.71	NA	0.05	0.76	NA	XXX
76827		A	Echo exam of fetal heart	0.58	1.93	NA	0.15	2.66	NA	XXX
76827	26	A	Echo exam of fetal heart	0.58	0.21	0.21	0.03	0.82	0.82	XXX
76827	TC	A	Echo exam of fetal heart	0.00	1.72	NA	0.12	1.84	NA	XXX
76828		A	Echo exam of fetal heart	0.56	1.33	NA	0.11	2.00	NA	XXX
76828	26	A	Echo exam of fetal heart	0.56	0.22	0.22	0.03	0.81	0.81	XXX
76828	TC	A	Echo exam of fetal heart	0.00	1.11	NA	0.08	1.19	NA	XXX
76830		A	Transvaginal us, non-ob	0.69	1.75	NA	0.13	2.57	NA	XXX
76830	26	A	Transvaginal us, non-ob	0.69	0.23	0.23	0.03	0.95	0.95	XXX
76830	TC	A	Transvaginal us, non-ob	0.00	1.52	NA	0.10	1.62	NA	XXX
76831		A	Echo exam, uterus	0.72	1.77	NA	0.13	2.62	NA	XXX
76831	26	A	Echo exam, uterus	0.72	0.25	0.25	0.03	1.00	1.00	XXX
76831	TC	A	Echo exam, uterus	0.00	1.52	NA	0.10	1.62	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
76856		A	Us exam, pelvic, complete	0.69	1.75	NA	0.13	2.57	NA	XXX
76856	26	A	Us exam, pelvic, complete	0.69	0.23	0.23	0.03	0.95	0.95	XXX
76856	TC	A	Us exam, pelvic, complete	0.00	1.52	NA	0.10	1.62	NA	XXX
76857		A	Us exam, pelvic, limited	0.38	1.83	NA	0.08	2.29	NA	XXX
76857	26	A	Us exam, pelvic, limited	0.38	0.12	0.12	0.02	0.52	0.52	XXX
76857	TC	A	Us exam, pelvic, limited	0.00	1.71	NA	0.06	1.77	NA	XXX
76870		A	Us exam, scrotum	0.64	1.73	NA	0.13	2.50	NA	XXX
76870	26	A	Us exam, scrotum	0.64	0.21	0.21	0.03	0.88	0.88	XXX
76870	TC	A	Us exam, scrotum	0.00	1.52	NA	0.10	1.62	NA	XXX
76872		A	Us, transrectal	0.69	2.24	NA	0.14	3.07	NA	XXX
76872	26	A	Us, transrectal	0.69	0.22	0.22	0.04	0.95	0.95	XXX
76872	TC	A	Us, transrectal	0.00	2.02	NA	0.10	2.12	NA	XXX
76873		A	Echograp trans r, pros study	1.55	2.60	NA	0.25	4.40	NA	XXX
76873	26	A	Echograp trans r, pros study	1.55	0.50	0.50	0.09	2.14	2.14	XXX
76873	TC	A	Echograp trans r, pros study	0.00	2.10	NA	0.16	2.26	NA	XXX
76880		A	Us exam, extremity	0.59	1.61	NA	0.11	2.31	NA	XXX
76880	26	A	Us exam, extremity	0.59	0.19	0.19	0.03	0.81	0.81	XXX
76880	TC	A	Us exam, extremity	0.00	1.42	NA	0.08	1.50	NA	XXX
76885		A	Us exam infant hips, dynamic	0.74	1.76	NA	0.13	2.63	NA	XXX
76885	26	A	Us exam infant hips, dynamic	0.74	0.24	0.24	0.03	1.01	1.01	XXX
76885	TC	A	Us exam infant hips, dynamic	0.00	1.52	NA	0.10	1.62	NA	XXX
76886		A	Us exam infant hips, static	0.62	1.62	NA	0.11	2.35	NA	XXX
76886	26	A	Us exam infant hips, static	0.62	0.20	0.20	0.03	0.85	0.85	XXX
76886	TC	A	Us exam infant hips, static	0.00	1.42	NA	0.08	1.50	NA	XXX
76930		A	Echo guide, cardiocentesis	0.67	1.77	NA	0.12	2.56	NA	XXX
76930	26	A	Echo guide, cardiocentesis	0.67	0.25	0.25	0.02	0.94	0.94	XXX
76930	TC	A	Echo guide, cardiocentesis	0.00	1.52	NA	0.10	1.62	NA	XXX
76932		A	Echo guide for heart biopsy	0.67	1.77	NA	0.12	2.56	NA	XXX
76932	26	A	Echo guide for heart biopsy	0.67	0.25	0.25	0.02	0.94	0.94	XXX
76932	TC	A	Echo guide for heart biopsy	0.00	1.52	NA	0.10	1.62	NA	XXX
76936		A	Echo guide for artery repair	1.99	6.95	NA	0.47	9.41	NA	XXX
76936	26	A	Echo guide for artery repair	1.99	0.66	0.66	0.13	2.78	2.78	XXX
76936	TC	A	Echo guide for artery repair	0.00	6.29	NA	0.34	6.63	NA	XXX
76937		A	Us guide, vascular access	0.30	0.48	NA	0.13	0.91	NA	ZZZ
76937	26	A	Us guide, vascular access	0.30	0.10	0.10	0.03	0.43	0.43	ZZZ
76937	TC	A	Us guide, vascular access	0.00	0.38	NA	0.10	0.48	NA	ZZZ
76940		A	Us guide, tissue ablation	2.00	2.17	NA	0.58	4.75	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
76940	26	A	Us guide, tissue ablation	2.00	0.65	0.65	0.29	2.94	2.94	XXX
76940	TC	A	Us guide, tissue ablation	0.00	1.52	NA	0.29	1.81	NA	XXX
76941		A	Echo guide for transfusion	1.34	2.00	NA	0.15	3.49	NA	XXX
76941	26	A	Echo guide for transfusion	1.34	0.47	0.47	0.07	1.88	1.88	XXX
76941	TC	A	Echo guide for transfusion	0.00	1.53	NA	0.08	1.61	NA	XXX
76942		A	Echo guide for biopsy	0.67	3.03	NA	0.13	3.83	NA	XXX
76942	26	A	Echo guide for biopsy	0.67	0.22	0.22	0.03	0.92	0.92	XXX
76942	TC	A	Echo guide for biopsy	0.00	2.81	NA	0.10	2.91	NA	XXX
76945		A	Echo guide, villus sampling	0.67	1.75	NA	0.12	2.54	NA	XXX
76945	26	A	Echo guide, villus sampling	0.67	0.22	0.22	0.04	0.93	0.93	XXX
76945	TC	A	Echo guide, villus sampling	0.00	1.53	NA	0.08	1.61	NA	XXX
76946		A	Echo guide for amniocentesis	0.38	1.66	NA	0.12	2.16	NA	XXX
76946	26	A	Echo guide for amniocentesis	0.38	0.14	0.14	0.02	0.54	0.54	XXX
76946	TC	A	Echo guide for amniocentesis	0.00	1.52	NA	0.10	1.62	NA	XXX
76948		A	Echo guide, ova aspiration	0.38	1.65	NA	0.12	2.15	NA	XXX
76948	26	A	Echo guide, ova aspiration	0.38	0.13	0.13	0.02	0.53	0.53	XXX
76948	TC	A	Echo guide, ova aspiration	0.00	1.52	NA	0.10	1.62	NA	XXX
76950		A	Echo guidance radiotherapy	0.58	1.50	NA	0.10	2.18	NA	XXX
76950	26	A	Echo guidance radiotherapy	0.58	0.19	0.19	0.03	0.80	0.80	XXX
76950	TC	A	Echo guidance radiotherapy	0.00	1.31	NA	0.07	1.38	NA	XXX
76965		A	Echo guidance radiotherapy	1.34	6.00	NA	0.37	7.71	NA	XXX
76965	26	A	Echo guidance radiotherapy	1.34	0.43	0.43	0.08	1.85	1.85	XXX
76965	TC	A	Echo guidance radiotherapy	0.00	5.57	NA	0.29	5.86	NA	XXX
76970		A	Ultrasound exam follow-up	0.40	1.18	NA	0.08	1.66	NA	XXX
76970	26	A	Ultrasound exam follow-up	0.40	0.13	0.13	0.02	0.55	0.55	XXX
76970	TC	A	Ultrasound exam follow-up	0.00	1.05	NA	0.06	1.11	NA	XXX
76975		A	GI endoscopic ultrasound	0.81	1.80	NA	0.14	2.75	NA	XXX
76975	26	A	GI endoscopic ultrasound	0.81	0.28	0.28	0.04	1.13	1.13	XXX
76975	TC	A	GI endoscopic ultrasound	0.00	1.52	NA	0.10	1.62	NA	XXX
76977		A	Us bone density measure	0.05	0.84	NA	0.06	0.95	NA	XXX
76977	26	A	Us bone density measure	0.05	0.02	0.02	0.01	0.08	0.08	XXX
76977	TC	A	Us bone density measure	0.00	0.82	NA	0.05	0.87	NA	XXX
76986		A	Ultrasound guide intraoper	1.20	3.02	NA	0.26	4.48	NA	XXX
76986	26	A	Ultrasound guide intraoper	1.20	0.40	0.40	0.12	1.72	1.72	XXX
76986	TC	A	Ultrasound guide intraoper	0.00	2.62	NA	0.14	2.76	NA	XXX
76999		C	Echo examination procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76999	26	C	Echo examination procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
76999	TC	C	Echo examination procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77261		A	Radiation therapy planning	1.39	0.51	0.51	0.07	1.97	1.97	XXX
77262		A	Radiation therapy planning	2.11	0.75	0.75	0.11	2.97	2.97	XXX
77263		A	Radiation therapy planning	3.14	1.11	1.11	0.16	4.41	4.41	XXX
77280		A	Set radiation therapy field	0.70	3.69	NA	0.22	4.61	NA	XXX
77280	26	A	Set radiation therapy field	0.70	0.22	0.22	0.04	0.96	0.96	XXX
77280	TC	A	Set radiation therapy field	0.00	3.47	NA	0.18	3.65	NA	XXX
77285		A	Set radiation therapy field	1.05	5.91	NA	0.35	7.31	NA	XXX
77285	26	A	Set radiation therapy field	1.05	0.34	0.34	0.05	1.44	1.44	XXX
77285	TC	A	Set radiation therapy field	0.00	5.57	NA	0.30	5.87	NA	XXX
77290		A	Set radiation therapy field	1.56	7.01	NA	0.43	9.00	NA	XXX
77290	26	A	Set radiation therapy field	1.56	0.50	0.50	0.08	2.14	2.14	XXX
77290	TC	A	Set radiation therapy field	0.00	6.51	NA	0.35	6.86	NA	XXX
77295		A	Set radiation therapy field	4.56	29.39	NA	1.72	35.67	NA	XXX
77295	26	A	Set radiation therapy field	4.56	1.46	1.46	0.24	6.26	6.26	XXX
77295	TC	A	Set radiation therapy field	0.00	27.93	NA	1.48	29.41	NA	XXX
77299		C	Radiation therapy planning	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77299	26	C	Radiation therapy planning	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77299	TC	C	Radiation therapy planning	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77300		A	Radiation therapy dose plan	0.62	1.54	NA	0.10	2.26	NA	XXX
77300	26	A	Radiation therapy dose plan	0.62	0.20	0.20	0.03	0.85	0.85	XXX
77300	TC	A	Radiation therapy dose plan	0.00	1.34	NA	0.07	1.41	NA	XXX
77301		A	Radiotherapy dose plan, imrt	7.99	30.49	NA	1.88	40.36	NA	XXX
77301	26	A	Radiotherapy dose plan, imrt	7.99	2.56	2.56	0.40	10.95	10.95	XXX
77301	TC	A	Radiotherapy dose plan, imrt	0.00	27.93	NA	1.48	29.41	NA	XXX
77305		A	Teletx isodose plan simple	0.70	2.09	NA	0.15	2.94	NA	XXX
77305	26	A	Teletx isodose plan simple	0.70	0.23	0.23	0.04	0.97	0.97	XXX
77305	TC	A	Teletx isodose plan simple	0.00	1.86	NA	0.11	1.97	NA	XXX
77310		A	Teletx isodose plan intermed	1.05	2.67	NA	0.18	3.90	NA	XXX
77310	26	A	Teletx isodose plan intermed	1.05	0.34	0.34	0.05	1.44	1.44	XXX
77310	TC	A	Teletx isodose plan intermed	0.00	2.33	NA	0.13	2.46	NA	XXX
77315		A	Teletx isodose plan complex	1.56	3.16	NA	0.22	4.94	NA	XXX
77315	26	A	Teletx isodose plan complex	1.56	0.50	0.50	0.08	2.14	2.14	XXX
77315	TC	A	Teletx isodose plan complex	0.00	2.66	NA	0.14	2.80	NA	XXX
77321		A	Special teletx port plan	0.95	4.34	NA	0.26	5.55	NA	XXX
77321	26	A	Special teletx port plan	0.95	0.30	0.30	0.05	1.30	1.30	XXX
77321	TC	A	Special teletx port plan	0.00	4.04	NA	0.21	4.25	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
77326		A	Brachytx isodose calc simp	0.93	2.66	NA	0.18	3.77	NA	XXX
77326	26	A	Brachytx isodose calc simp	0.93	0.30	0.30	0.05	1.28	1.28	XXX
77326	TC	A	Brachytx isodose calc simp	0.00	2.36	NA	0.13	2.49	NA	XXX
77327		A	Brachytx isodose calc interm	1.39	3.91	NA	0.25	5.55	NA	XXX
77327	26	A	Brachytx isodose calc interm	1.39	0.44	0.44	0.07	1.90	1.90	XXX
77327	TC	A	Brachytx isodose calc interm	0.00	3.47	NA	0.18	3.65	NA	XXX
77328		A	Brachytx isodose plan compl	2.09	5.63	NA	0.36	8.08	NA	XXX
77328	26	A	Brachytx isodose plan compl	2.09	0.67	0.67	0.11	2.87	2.87	XXX
77328	TC	A	Brachytx isodose plan compl	0.00	4.96	NA	0.25	5.21	NA	XXX
77331		A	Special radiation dosimetry	0.87	0.78	NA	0.06	1.71	NA	XXX
77331	26	A	Special radiation dosimetry	0.87	0.28	0.28	0.04	1.19	1.19	XXX
77331	TC	A	Special radiation dosimetry	0.00	0.50	NA	0.02	0.52	NA	XXX
77332		A	Radiation treatment aid(s)	0.54	1.51	NA	0.10	2.15	NA	XXX
77332	26	A	Radiation treatment aid(s)	0.54	0.17	0.17	0.03	0.74	0.74	XXX
77332	TC	A	Radiation treatment aid(s)	0.00	1.34	NA	0.07	1.41	NA	XXX
77333		A	Radiation treatment aid(s)	0.84	2.16	NA	0.15	3.15	NA	XXX
77333	26	A	Radiation treatment aid(s)	0.84	0.27	0.27	0.04	1.15	1.15	XXX
77333	TC	A	Radiation treatment aid(s)	0.00	1.89	NA	0.11	2.00	NA	XXX
77334		A	Radiation treatment aid(s)	1.24	3.65	NA	0.23	5.12	NA	XXX
77334	26	A	Radiation treatment aid(s)	1.24	0.40	0.40	0.06	1.70	1.70	XXX
77334	TC	A	Radiation treatment aid(s)	0.00	3.25	NA	0.17	3.42	NA	XXX
77336		A	Radiation physics consult	0.00	2.98	NA	0.16	3.14	NA	XXX
77370		A	Radiation physics consult	0.00	3.49	NA	0.18	3.67	NA	XXX
77399		C	External radiation dosimetry	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77399	26	C	External radiation dosimetry	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77399	TC	C	External radiation dosimetry	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77401		A	Radiation treatment delivery	0.00	1.77	NA	0.11	1.88	NA	XXX
77402		A	Radiation treatment delivery	0.00	1.77	NA	0.11	1.88	NA	XXX
77403		A	Radiation treatment delivery	0.00	1.77	NA	0.11	1.88	NA	XXX
77404		A	Radiation treatment delivery	0.00	1.77	NA	0.11	1.88	NA	XXX
77406		A	Radiation treatment delivery	0.00	1.77	NA	0.11	1.88	NA	XXX
77407		A	Radiation treatment delivery	0.00	2.09	NA	0.12	2.21	NA	XXX
77408		A	Radiation treatment delivery	0.00	2.09	NA	0.12	2.21	NA	XXX
77409		A	Radiation treatment delivery	0.00	2.09	NA	0.12	2.21	NA	XXX
77411		A	Radiation treatment delivery	0.00	2.09	NA	0.12	2.21	NA	XXX
77412		A	Radiation treatment delivery	0.00	2.33	NA	0.13	2.46	NA	XXX
77413		A	Radiation treatment delivery	0.00	2.33	NA	0.13	2.46	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
77414		A	Radiation treatment delivery	0.00	2.33	NA	0.13	2.46	NA	XXX
77416		A	Radiation treatment delivery	0.00	2.33	NA	0.13	2.46	NA	XXX
77417		A	Radiology port film(s)	0.00	0.59	NA	0.04	0.63	NA	XXX
77418		A	Radiation tx delivery, imrt	0.00	17.98	NA	0.13	18.11	NA	XXX
77427		A	Radiation tx management, x5	3.31	1.06	1.06	0.17	4.54	4.54	XXX
77431		A	Radiation therapy management	1.81	0.68	0.68	0.09	2.58	2.58	XXX
77432		A	Stereotactic radiation trmt	7.92	2.90	2.90	0.41	11.23	11.23	XXX
77470		A	Special radiation treatment	2.09	11.82	NA	0.70	14.61	NA	XXX
77470	26	A	Special radiation treatment	2.09	0.67	0.67	0.11	2.87	2.87	XXX
77470	TC	A	Special radiation treatment	0.00	11.15	NA	0.59	11.74	NA	XXX
77499		C	Radiation therapy management	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77499	26	C	Radiation therapy management	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77499	TC	C	Radiation therapy management	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77520		C	Proton trmt, simple w/o comp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77522		C	Proton trmt, simple w/comp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77523		C	Proton trmt, intermediate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77525		C	Proton treatment, complex	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77600		R	Hyperthermia treatment	1.56	3.55	NA	0.24	5.35	NA	XXX
77600	26	R	Hyperthermia treatment	1.56	0.50	0.50	0.08	2.14	2.14	XXX
77600	TC	R	Hyperthermia treatment	0.00	3.05	NA	0.16	3.21	NA	XXX
77605		R	Hyperthermia treatment	2.09	4.72	NA	0.38	7.19	NA	XXX
77605	26	R	Hyperthermia treatment	2.09	0.66	0.66	0.16	2.91	2.91	XXX
77605	TC	R	Hyperthermia treatment	0.00	4.06	NA	0.22	4.28	NA	XXX
77610		R	Hyperthermia treatment	1.56	3.56	NA	0.24	5.36	NA	XXX
77610	26	R	Hyperthermia treatment	1.56	0.51	0.51	0.08	2.15	2.15	XXX
77610	TC	R	Hyperthermia treatment	0.00	3.05	NA	0.16	3.21	NA	XXX
77615		R	Hyperthermia treatment	2.09	4.72	NA	0.33	7.14	NA	XXX
77615	26	R	Hyperthermia treatment	2.09	0.66	0.66	0.11	2.86	2.86	XXX
77615	TC	R	Hyperthermia treatment	0.00	4.06	NA	0.22	4.28	NA	XXX
77620		R	Hyperthermia treatment	1.56	3.57	NA	0.36	5.49	NA	XXX
77620	26	R	Hyperthermia treatment	1.56	0.52	0.52	0.20	2.28	2.28	XXX
77620	TC	R	Hyperthermia treatment	0.00	3.05	NA	0.16	3.21	NA	XXX
77750		A	Infuse radioactive materials	4.90	2.91	NA	0.32	8.13	NA	090
77750	26	A	Infuse radioactive materials	4.90	1.58	1.58	0.25	6.73	6.73	090
77750	TC	A	Infuse radioactive materials	0.00	1.33	NA	0.07	1.40	NA	090
77761		A	Apply intrcav radiat simple	3.80	3.59	NA	0.33	7.72	NA	090
77761	26	A	Apply intrcav radiat simple	3.80	1.09	1.09	0.19	5.08	5.08	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
77761	TC	A	Apply intrcav radiat simple	0.00	2.50	NA	0.14	2.64	NA	090
77762		A	Apply intrcav radiat interm	5.71	5.44	NA	0.49	11.64	NA	090
77762	26	A	Apply intrcav radiat interm	5.71	1.83	1.83	0.30	7.84	7.84	090
77762	TC	A	Apply intrcav radiat interm	0.00	3.61	NA	0.19	3.80	NA	090
77763		A	Apply intrcav radiat compl	8.56	7.23	NA	0.68	16.47	NA	090
77763	26	A	Apply intrcav radiat compl	8.56	2.74	2.74	0.45	11.75	11.75	090
77763	TC	A	Apply intrcav radiat compl	0.00	4.49	NA	0.23	4.72	NA	090
77776		A	Apply interstit radiat simpl	4.65	3.13	NA	0.56	8.34	NA	090
77776	26	A	Apply interstit radiat simpl	4.65	0.95	0.95	0.43	6.03	6.03	090
77776	TC	A	Apply interstit radiat simpl	0.00	2.18	NA	0.13	2.31	NA	090
77777		A	Apply interstit radiat inter	7.47	6.60	NA	0.63	14.70	NA	090
77777	26	A	Apply interstit radiat inter	7.47	2.37	2.37	0.41	10.25	10.25	090
77777	TC	A	Apply interstit radiat inter	0.00	4.23	NA	0.22	4.45	NA	090
77778		A	Apply interstit radiat compl	11.17	8.70	NA	0.84	20.71	NA	090
77778	26	A	Apply interstit radiat compl	11.17	3.57	3.57	0.57	15.31	15.31	090
77778	TC	A	Apply interstit radiat compl	0.00	5.13	NA	0.27	5.40	NA	090
77781		A	High intensity brachytherapy	1.66	20.83	NA	1.14	23.63	NA	090
77781	26	A	High intensity brachytherapy	1.66	0.53	0.53	0.08	2.27	2.27	090
77781	TC	A	High intensity brachytherapy	0.00	20.30	NA	1.06	21.36	NA	090
77782		A	High intensity brachytherapy	2.49	21.10	NA	1.19	24.78	NA	090
77782	26	A	High intensity brachytherapy	2.49	0.80	0.80	0.13	3.42	3.42	090
77782	TC	A	High intensity brachytherapy	0.00	20.30	NA	1.06	21.36	NA	090
77783		A	High intensity brachytherapy	3.72	21.49	NA	1.25	26.46	NA	090
77783	26	A	High intensity brachytherapy	3.72	1.19	1.19	0.19	5.10	5.10	090
77783	TC	A	High intensity brachytherapy	0.00	20.30	NA	1.06	21.36	NA	090
77784		A	High intensity brachytherapy	5.60	22.09	NA	1.35	29.04	NA	090
77784	26	A	High intensity brachytherapy	5.60	1.79	1.79	0.29	7.68	7.68	090
77784	TC	A	High intensity brachytherapy	0.00	20.30	NA	1.06	21.36	NA	090
77789		A	Apply surface radiation	1.12	0.82	NA	0.07	2.01	NA	000
77789	26	A	Apply surface radiation	1.12	0.37	0.37	0.05	1.54	1.54	000
77789	TC	A	Apply surface radiation	0.00	0.45	NA	0.02	0.47	NA	000
77790		A	Radiation handling	1.05	0.84	NA	0.07	1.96	NA	XXX
77790	26	A	Radiation handling	1.05	0.34	0.34	0.05	1.44	1.44	XXX
77790	TC	A	Radiation handling	0.00	0.50	NA	0.02	0.52	NA	XXX
77799		C	Radium/radioisotope therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77799	26	C	Radium/radioisotope therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77799	TC	C	Radium/radioisotope therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
78000		A	Thyroid, single uptake	0.19	1.03	NA	0.07	1.29	NA	XXX
78000	26	A	Thyroid, single uptake	0.19	0.06	0.06	0.01	0.26	0.26	XXX
78000	TC	A	Thyroid, single uptake	0.00	0.97	NA	0.06	1.03	NA	XXX
78001		A	Thyroid, multiple uptakes	0.26	1.40	NA	0.08	1.74	NA	XXX
78001	26	A	Thyroid, multiple uptakes	0.26	0.09	0.09	0.01	0.36	0.36	XXX
78001	TC	A	Thyroid, multiple uptakes	0.00	1.31	NA	0.07	1.38	NA	XXX
78003		A	Thyroid suppress/stimul	0.33	1.08	NA	0.07	1.48	NA	XXX
78003	26	A	Thyroid suppress/stimul	0.33	0.11	0.11	0.01	0.45	0.45	XXX
78003	TC	A	Thyroid suppress/stimul	0.00	0.97	NA	0.06	1.03	NA	XXX
78006		A	Thyroid imaging with uptake	0.49	2.54	NA	0.15	3.18	NA	XXX
78006	26	A	Thyroid imaging with uptake	0.49	0.16	0.16	0.02	0.67	0.67	XXX
78006	TC	A	Thyroid imaging with uptake	0.00	2.38	NA	0.13	2.51	NA	XXX
78007		A	Thyroid image, mult uptakes	0.50	2.74	NA	0.16	3.40	NA	XXX
78007	26	A	Thyroid image, mult uptakes	0.50	0.17	0.17	0.02	0.69	0.69	XXX
78007	TC	A	Thyroid image, mult uptakes	0.00	2.57	NA	0.14	2.71	NA	XXX
78010		A	Thyroid imaging	0.39	1.95	NA	0.13	2.47	NA	XXX
78010	26	A	Thyroid imaging	0.39	0.13	0.13	0.02	0.54	0.54	XXX
78010	TC	A	Thyroid imaging	0.00	1.82	NA	0.11	1.93	NA	XXX
78011		A	Thyroid imaging with flow	0.45	2.56	NA	0.15	3.16	NA	XXX
78011	26	A	Thyroid imaging with flow	0.45	0.15	0.15	0.02	0.62	0.62	XXX
78011	TC	A	Thyroid imaging with flow	0.00	2.41	NA	0.13	2.54	NA	XXX
78015		A	Thyroid met imaging	0.67	2.80	NA	0.17	3.64	NA	XXX
78015	26	A	Thyroid met imaging	0.67	0.23	0.23	0.03	0.93	0.93	XXX
78015	TC	A	Thyroid met imaging	0.00	2.57	NA	0.14	2.71	NA	XXX
78016		A	Thyroid met imaging/studies	0.82	3.76	NA	0.22	4.80	NA	XXX
78016	26	A	Thyroid met imaging/studies	0.82	0.28	0.28	0.04	1.14	1.14	XXX
78016	TC	A	Thyroid met imaging/studies	0.00	3.48	NA	0.18	3.66	NA	XXX
78018		A	Thyroid met imaging, body	0.86	5.72	NA	0.33	6.91	NA	XXX
78018	26	A	Thyroid met imaging, body	0.86	0.30	0.30	0.04	1.20	1.20	XXX
78018	TC	A	Thyroid met imaging, body	0.00	5.42	NA	0.29	5.71	NA	XXX
78020		A	Thyroid met uptake	0.60	1.52	NA	0.16	2.28	NA	ZZZ
78020	26	A	Thyroid met uptake	0.60	0.21	0.21	0.02	0.83	0.83	ZZZ
78020	TC	A	Thyroid met uptake	0.00	1.31	NA	0.14	1.45	NA	ZZZ
78070		A	Parathyroid nuclear imaging	0.82	4.55	NA	0.15	5.52	NA	XXX
78070	26	A	Parathyroid nuclear imaging	0.82	0.28	0.28	0.04	1.14	1.14	XXX
78070	TC	A	Parathyroid nuclear imaging	0.00	4.27	NA	0.11	4.38	NA	XXX
78075		A	Adrenal nuclear imaging	0.74	5.68	NA	0.32	6.74	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
78075	26	A	Adrenal nuclear imaging	0.74	0.26	0.26	0.03	1.03	1.03	XXX
78075	TC	A	Adrenal nuclear imaging	0.00	5.42	NA	0.29	5.71	NA	XXX
78099		C	Endocrine nuclear procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78099	26	C	Endocrine nuclear procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78099	TC	C	Endocrine nuclear procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78102		A	Bone marrow imaging, ltd	0.55	2.23	NA	0.14	2.92	NA	XXX
78102	26	A	Bone marrow imaging, ltd	0.55	0.19	0.19	0.02	0.76	0.76	XXX
78102	TC	A	Bone marrow imaging, ltd	0.00	2.04	NA	0.12	2.16	NA	XXX
78103		A	Bone marrow imaging, mult	0.75	3.43	NA	0.20	4.38	NA	XXX
78103	26	A	Bone marrow imaging, mult	0.75	0.26	0.26	0.03	1.04	1.04	XXX
78103	TC	A	Bone marrow imaging, mult	0.00	3.17	NA	0.17	3.34	NA	XXX
78104		A	Bone marrow imaging, body	0.80	4.34	NA	0.25	5.39	NA	XXX
78104	26	A	Bone marrow imaging, body	0.80	0.27	0.27	0.03	1.10	1.10	XXX
78104	TC	A	Bone marrow imaging, body	0.00	4.07	NA	0.22	4.29	NA	XXX
78110		A	Plasma volume, single	0.19	1.02	NA	0.07	1.28	NA	XXX
78110	26	A	Plasma volume, single	0.19	0.07	0.07	0.01	0.27	0.27	XXX
78110	TC	A	Plasma volume, single	0.00	0.95	NA	0.06	1.01	NA	XXX
78111		A	Plasma volume, multiple	0.22	2.65	NA	0.15	3.02	NA	XXX
78111	26	A	Plasma volume, multiple	0.22	0.08	0.08	0.01	0.31	0.31	XXX
78111	TC	A	Plasma volume, multiple	0.00	2.57	NA	0.14	2.71	NA	XXX
78120		A	Red cell mass, single	0.23	1.81	NA	0.12	2.16	NA	XXX
78120	26	A	Red cell mass, single	0.23	0.08	0.08	0.01	0.32	0.32	XXX
78120	TC	A	Red cell mass, single	0.00	1.73	NA	0.11	1.84	NA	XXX
78121		A	Red cell mass, multiple	0.32	3.02	NA	0.15	3.49	NA	XXX
78121	26	A	Red cell mass, multiple	0.32	0.11	0.11	0.01	0.44	0.44	XXX
78121	TC	A	Red cell mass, multiple	0.00	2.91	NA	0.14	3.05	NA	XXX
78122		A	Blood volume	0.45	4.76	NA	0.26	5.47	NA	XXX
78122	26	A	Blood volume	0.45	0.16	0.16	0.02	0.63	0.63	XXX
78122	TC	A	Blood volume	0.00	4.60	NA	0.24	4.84	NA	XXX
78130		A	Red cell survival study	0.61	3.06	NA	0.17	3.84	NA	XXX
78130	26	A	Red cell survival study	0.61	0.21	0.21	0.03	0.85	0.85	XXX
78130	TC	A	Red cell survival study	0.00	2.85	NA	0.14	2.99	NA	XXX
78135		A	Red cell survival kinetics	0.64	5.09	NA	0.28	6.01	NA	XXX
78135	26	A	Red cell survival kinetics	0.64	0.22	0.22	0.03	0.89	0.89	XXX
78135	TC	A	Red cell survival kinetics	0.00	4.87	NA	0.25	5.12	NA	XXX
78140		A	Red cell sequestration	0.61	4.13	NA	0.24	4.98	NA	XXX
78140	26	A	Red cell sequestration	0.61	0.20	0.20	0.03	0.84	0.84	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
78140	TC	A	Red cell sequestration	0.00	3.93	NA	0.21	4.14	NA	XXX
78160		A	Plasma iron turnover	0.33	3.78	NA	0.23	4.34	NA	XXX
78160	26	A	Plasma iron turnover	0.33	0.12	0.12	0.04	0.49	0.49	XXX
78160	TC	A	Plasma iron turnover	0.00	3.66	NA	0.19	3.85	NA	XXX
78162		A	Radioiron absorption exam	0.45	3.39	NA	0.19	4.03	NA	XXX
78162	26	A	Radioiron absorption exam	0.45	0.19	0.19	0.02	0.66	0.66	XXX
78162	TC	A	Radioiron absorption exam	0.00	3.20	NA	0.17	3.37	NA	XXX
78170		A	Red cell iron utilization	0.41	5.45	NA	0.30	6.16	NA	XXX
78170	26	A	Red cell iron utilization	0.41	0.14	0.14	0.02	0.57	0.57	XXX
78170	TC	A	Red cell iron utilization	0.00	5.31	NA	0.28	5.59	NA	XXX
78172		C	Total body iron estimation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78172	26	A	Total body iron estimation	0.53	0.17	0.17	0.02	0.72	0.72	XXX
78172	TC	C	Total body iron estimation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78185		A	Spleen imaging	0.40	2.50	NA	0.15	3.05	NA	XXX
78185	26	A	Spleen imaging	0.40	0.14	0.14	0.02	0.56	0.56	XXX
78185	TC	A	Spleen imaging	0.00	2.36	NA	0.13	2.49	NA	XXX
78190		A	Platelet survival, kinetics	1.09	6.10	NA	0.38	7.57	NA	XXX
78190	26	A	Platelet survival, kinetics	1.09	0.39	0.39	0.08	1.56	1.56	XXX
78190	TC	A	Platelet survival, kinetics	0.00	5.71	NA	0.30	6.01	NA	XXX
78191		A	Platelet survival	0.61	7.54	NA	0.40	8.55	NA	XXX
78191	26	A	Platelet survival	0.61	0.20	0.20	0.03	0.84	0.84	XXX
78191	TC	A	Platelet survival	0.00	7.34	NA	0.37	7.71	NA	XXX
78195		A	Lymph system imaging	1.20	4.48	NA	0.28	5.96	NA	XXX
78195	26	A	Lymph system imaging	1.20	0.41	0.41	0.06	1.67	1.67	XXX
78195	TC	A	Lymph system imaging	0.00	4.07	NA	0.22	4.29	NA	XXX
78199		C	Blood/lymph nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78199	26	C	Blood/lymph nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78199	TC	C	Blood/lymph nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78201		A	Liver imaging	0.44	2.51	NA	0.15	3.10	NA	XXX
78201	26	A	Liver imaging	0.44	0.15	0.15	0.02	0.61	0.61	XXX
78201	TC	A	Liver imaging	0.00	2.36	NA	0.13	2.49	NA	XXX
78202		A	Liver imaging with flow	0.51	3.05	NA	0.16	3.72	NA	XXX
78202	26	A	Liver imaging with flow	0.51	0.17	0.17	0.02	0.70	0.70	XXX
78202	TC	A	Liver imaging with flow	0.00	2.88	NA	0.14	3.02	NA	XXX
78205		A	Liver imaging (3D)	0.71	6.15	NA	0.34	7.20	NA	XXX
78205	26	A	Liver imaging (3D)	0.71	0.24	0.24	0.03	0.98	0.98	XXX
78205	TC	A	Liver imaging (3D)	0.00	5.91	NA	0.31	6.22	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
78206		A	Liver image (3d) with flow	0.96	6.24	NA	0.15	7.35	NA	XXX
78206	26	A	Liver image (3d) with flow	0.96	0.33	0.33	0.04	1.33	1.33	XXX
78206	TC	A	Liver image (3d) with flow	0.00	5.91	NA	0.11	6.02	NA	XXX
78215		A	Liver and spleen imaging	0.49	3.10	NA	0.16	3.75	NA	XXX
78215	26	A	Liver and spleen imaging	0.49	0.16	0.16	0.02	0.67	0.67	XXX
78215	TC	A	Liver and spleen imaging	0.00	2.94	NA	0.14	3.08	NA	XXX
78216		A	Liver & spleen image/flow	0.57	3.67	NA	0.20	4.44	NA	XXX
78216	26	A	Liver & spleen image/flow	0.57	0.19	0.19	0.02	0.78	0.78	XXX
78216	TC	A	Liver & spleen image/flow	0.00	3.48	NA	0.18	3.66	NA	XXX
78220		A	Liver function study	0.49	3.88	NA	0.21	4.58	NA	XXX
78220	26	A	Liver function study	0.49	0.16	0.16	0.02	0.67	0.67	XXX
78220	TC	A	Liver function study	0.00	3.72	NA	0.19	3.91	NA	XXX
78223		A	Hepatobiliary imaging	0.84	3.94	NA	0.23	5.01	NA	XXX
78223	26	A	Hepatobiliary imaging	0.84	0.28	0.28	0.04	1.16	1.16	XXX
78223	TC	A	Hepatobiliary imaging	0.00	3.66	NA	0.19	3.85	NA	XXX
78230		A	Salivary gland imaging	0.45	2.33	NA	0.15	2.93	NA	XXX
78230	26	A	Salivary gland imaging	0.45	0.15	0.15	0.02	0.62	0.62	XXX
78230	TC	A	Salivary gland imaging	0.00	2.18	NA	0.13	2.31	NA	XXX
78231		A	Serial salivary imaging	0.52	3.35	NA	0.19	4.06	NA	XXX
78231	26	A	Serial salivary imaging	0.52	0.18	0.18	0.02	0.72	0.72	XXX
78231	TC	A	Serial salivary imaging	0.00	3.17	NA	0.17	3.34	NA	XXX
78232		A	Salivary gland function exam	0.47	3.70	NA	0.20	4.37	NA	XXX
78232	26	A	Salivary gland function exam	0.47	0.16	0.16	0.02	0.65	0.65	XXX
78232	TC	A	Salivary gland function exam	0.00	3.54	NA	0.18	3.72	NA	XXX
78258		A	Esophageal motility study	0.74	3.13	NA	0.17	4.04	NA	XXX
78258	26	A	Esophageal motility study	0.74	0.25	0.25	0.03	1.02	1.02	XXX
78258	TC	A	Esophageal motility study	0.00	2.88	NA	0.14	3.02	NA	XXX
78261		A	Gastric mucosa imaging	0.69	4.34	NA	0.25	5.28	NA	XXX
78261	26	A	Gastric mucosa imaging	0.69	0.24	0.24	0.03	0.96	0.96	XXX
78261	TC	A	Gastric mucosa imaging	0.00	4.10	NA	0.22	4.32	NA	XXX
78262		A	Gastroesophageal reflux exam	0.68	4.48	NA	0.25	5.41	NA	XXX
78262	26	A	Gastroesophageal reflux exam	0.68	0.23	0.23	0.03	0.94	0.94	XXX
78262	TC	A	Gastroesophageal reflux exam	0.00	4.25	NA	0.22	4.47	NA	XXX
78264		A	Gastric emptying study	0.78	4.39	NA	0.25	5.42	NA	XXX
78264	26	A	Gastric emptying study	0.78	0.26	0.26	0.03	1.07	1.07	XXX
78264	TC	A	Gastric emptying study	0.00	4.13	NA	0.22	4.35	NA	XXX
78267		X	Breath tst attain/anal c-14	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
78268		X	Breath test analysis, c-14	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78270		A	Vit B-12 absorption exam	0.20	1.62	NA	0.11	1.93	NA	XXX
78270	26	A	Vit B-12 absorption exam	0.20	0.07	0.07	0.01	0.28	0.28	XXX
78270	TC	A	Vit B-12 absorption exam	0.00	1.55	NA	0.10	1.65	NA	XXX
78271		A	Vit b-12 absrp exam, int fac	0.20	1.71	NA	0.11	2.02	NA	XXX
78271	26	A	Vit b-12 absrp exam, int fac	0.20	0.07	0.07	0.01	0.28	0.28	XXX
78271	TC	A	Vit b-12 absrp exam, int fac	0.00	1.64	NA	0.10	1.74	NA	XXX
78272		A	Vit B-12 absorp, combined	0.27	2.41	NA	0.14	2.82	NA	XXX
78272	26	A	Vit B-12 absorp, combined	0.27	0.09	0.09	0.01	0.37	0.37	XXX
78272	TC	A	Vit B-12 absorp, combined	0.00	2.32	NA	0.13	2.45	NA	XXX
78278		A	Acute GI blood loss imaging	0.99	5.20	NA	0.29	6.48	NA	XXX
78278	26	A	Acute GI blood loss imaging	0.99	0.33	0.33	0.04	1.36	1.36	XXX
78278	TC	A	Acute GI blood loss imaging	0.00	4.87	NA	0.25	5.12	NA	XXX
78282		C	GI protein loss exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78282	26	A	GI protein loss exam	0.38	0.13	0.13	0.02	0.53	0.53	XXX
78282	TC	C	GI protein loss exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78290		A	Meckel's divert exam	0.68	3.28	NA	0.19	4.15	NA	XXX
78290	26	A	Meckel's divert exam	0.68	0.23	0.23	0.03	0.94	0.94	XXX
78290	TC	A	Meckel's divert exam	0.00	3.05	NA	0.16	3.21	NA	XXX
78291		A	Leveen/shunt patency exam	0.88	3.36	NA	0.20	4.44	NA	XXX
78291	26	A	Leveen/shunt patency exam	0.88	0.30	0.30	0.04	1.22	1.22	XXX
78291	TC	A	Leveen/shunt patency exam	0.00	3.06	NA	0.16	3.22	NA	XXX
78299		C	GI nuclear procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78299	26	C	GI nuclear procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78299	TC	C	GI nuclear procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78300		A	Bone imaging, limited area	0.62	2.69	NA	0.17	3.48	NA	XXX
78300	26	A	Bone imaging, limited area	0.62	0.21	0.21	0.03	0.86	0.86	XXX
78300	TC	A	Bone imaging, limited area	0.00	2.48	NA	0.14	2.62	NA	XXX
78305		A	Bone imaging, multiple areas	0.83	3.94	NA	0.23	5.00	NA	XXX
78305	26	A	Bone imaging, multiple areas	0.83	0.28	0.28	0.04	1.15	1.15	XXX
78305	TC	A	Bone imaging, multiple areas	0.00	3.66	NA	0.19	3.85	NA	XXX
78306		A	Bone imaging, whole body	0.86	4.56	NA	0.26	5.68	NA	XXX
78306	26	A	Bone imaging, whole body	0.86	0.29	0.29	0.04	1.19	1.19	XXX
78306	TC	A	Bone imaging, whole body	0.00	4.27	NA	0.22	4.49	NA	XXX
78315		A	Bone imaging, 3 phase	1.02	5.12	NA	0.29	6.43	NA	XXX
78315	26	A	Bone imaging, 3 phase	1.02	0.34	0.34	0.04	1.40	1.40	XXX
78315	TC	A	Bone imaging, 3 phase	0.00	4.78	NA	0.25	5.03	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
78320		A	Bone imaging (3D)	1.04	6.27	NA	0.35	7.66	NA	XXX
78320	26	A	Bone imaging (3D)	1.04	0.36	0.36	0.04	1.44	1.44	XXX
78320	TC	A	Bone imaging (3D)	0.00	5.91	NA	0.31	6.22	NA	XXX
78350		A	Bone mineral, single photon	0.22	0.82	NA	0.06	1.10	NA	XXX
78350	26	A	Bone mineral, single photon	0.22	0.07	0.07	0.01	0.30	0.30	XXX
78350	TC	A	Bone mineral, single photon	0.00	0.75	NA	0.05	0.80	NA	XXX
78351		N	Bone mineral, dual photon	+0.30	1.72	0.12	0.01	2.03	0.43	XXX
78399		C	Musculoskeletal nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78399	26	C	Musculoskeletal nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78399	TC	C	Musculoskeletal nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78414		C	Non-imaging heart function	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78414	26	A	Non-imaging heart function	0.45	0.16	0.16	0.02	0.63	0.63	XXX
78414	TC	C	Non-imaging heart function	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78428		A	Cardiac shunt imaging	0.78	2.54	NA	0.16	3.48	NA	XXX
78428	26	A	Cardiac shunt imaging	0.78	0.29	0.29	0.03	1.10	1.10	XXX
78428	TC	A	Cardiac shunt imaging	0.00	2.25	NA	0.13	2.38	NA	XXX
78445		A	Vascular flow imaging	0.49	2.03	NA	0.13	2.65	NA	XXX
78445	26	A	Vascular flow imaging	0.49	0.17	0.17	0.02	0.68	0.68	XXX
78445	TC	A	Vascular flow imaging	0.00	1.86	NA	0.11	1.97	NA	XXX
78455		A	Venous thrombosis study	0.73	4.23	NA	0.24	5.20	NA	XXX
78455	26	A	Venous thrombosis study	0.73	0.25	0.25	0.03	1.01	1.01	XXX
78455	TC	A	Venous thrombosis study	0.00	3.98	NA	0.21	4.19	NA	XXX
78456		A	Acute venous thrombus image	1.00	4.32	NA	0.33	5.65	NA	XXX
78456	26	A	Acute venous thrombus image	1.00	0.34	0.34	0.04	1.38	1.38	XXX
78456	TC	A	Acute venous thrombus image	0.00	3.98	NA	0.29	4.27	NA	XXX
78457		A	Venous thrombosis imaging	0.77	2.92	NA	0.18	3.87	NA	XXX
78457	26	A	Venous thrombosis imaging	0.77	0.26	0.26	0.04	1.07	1.07	XXX
78457	TC	A	Venous thrombosis imaging	0.00	2.66	NA	0.14	2.80	NA	XXX
78458		A	Ven thrombosis images, bilat	0.90	4.34	NA	0.25	5.49	NA	XXX
78458	26	A	Ven thrombosis images, bilat	0.90	0.32	0.32	0.04	1.26	1.26	XXX
78458	TC	A	Ven thrombosis images, bilat	0.00	4.02	NA	0.21	4.23	NA	XXX
78459		C	Heart muscle imaging (PET)	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78459	26	R	Heart muscle imaging (PET)	1.50	0.57	0.57	0.05	2.12	2.12	XXX
78459	TC	C	Heart muscle imaging (PET)	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78460		A	Heart muscle blood, single	0.86	2.65	NA	0.17	3.68	NA	XXX
78460	26	A	Heart muscle blood, single	0.86	0.29	0.29	0.04	1.19	1.19	XXX
78460	TC	A	Heart muscle blood, single	0.00	2.36	NA	0.13	2.49	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
78461		A	Heart muscle blood, multiple	1.23	5.15	NA	0.30	6.68	NA	XXX
78461	26	A	Heart muscle blood, multiple	1.23	0.43	0.43	0.05	1.71	1.71	XXX
78461	TC	A	Heart muscle blood, multiple	0.00	4.72	NA	0.25	4.97	NA	XXX
78464		A	Heart image (3d), single	1.09	7.45	NA	0.41	8.95	NA	XXX
78464	26	A	Heart image (3d), single	1.09	0.38	0.38	0.04	1.51	1.51	XXX
78464	TC	A	Heart image (3d), single	0.00	7.07	NA	0.37	7.44	NA	XXX
78465		A	Heart image (3d), multiple	1.46	12.31	NA	0.68	14.45	NA	XXX
78465	26	A	Heart image (3d), multiple	1.46	0.52	0.52	0.06	2.04	2.04	XXX
78465	TC	A	Heart image (3d), multiple	0.00	11.79	NA	0.62	12.41	NA	XXX
78466		A	Heart infarct image	0.69	2.86	NA	0.17	3.72	NA	XXX
78466	26	A	Heart infarct image	0.69	0.24	0.24	0.03	0.96	0.96	XXX
78466	TC	A	Heart infarct image	0.00	2.62	NA	0.14	2.76	NA	XXX
78468		A	Heart infarct image (ef)	0.80	3.93	NA	0.22	4.95	NA	XXX
78468	26	A	Heart infarct image (ef)	0.80	0.27	0.27	0.03	1.10	1.10	XXX
78468	TC	A	Heart infarct image (ef)	0.00	3.66	NA	0.19	3.85	NA	XXX
78469		A	Heart infarct image (3D)	0.92	5.53	NA	0.31	6.76	NA	XXX
78469	26	A	Heart infarct image (3D)	0.92	0.31	0.31	0.03	1.26	1.26	XXX
78469	TC	A	Heart infarct image (3D)	0.00	5.22	NA	0.28	5.50	NA	XXX
78472		A	Gated heart, planar, single	0.98	5.85	NA	0.34	7.17	NA	XXX
78472	26	A	Gated heart, planar, single	0.98	0.34	0.34	0.04	1.36	1.36	XXX
78472	TC	A	Gated heart, planar, single	0.00	5.51	NA	0.30	5.81	NA	XXX
78473		A	Gated heart, multiple	1.47	8.77	NA	0.48	10.72	NA	XXX
78473	26	A	Gated heart, multiple	1.47	0.51	0.51	0.06	2.04	2.04	XXX
78473	TC	A	Gated heart, multiple	0.00	8.26	NA	0.42	8.68	NA	XXX
78478		A	Heart wall motion add-on	0.62	1.79	NA	0.12	2.53	NA	XXX
78478	26	A	Heart wall motion add-on	0.62	0.23	0.23	0.02	0.87	0.87	XXX
78478	TC	A	Heart wall motion add-on	0.00	1.56	NA	0.10	1.66	NA	XXX
78480		A	Heart function add-on	0.62	1.78	NA	0.12	2.52	NA	XXX
78480	26	A	Heart function add-on	0.62	0.22	0.22	0.02	0.86	0.86	XXX
78480	TC	A	Heart function add-on	0.00	1.56	NA	0.10	1.66	NA	XXX
78481		A	Heart first pass, single	0.98	5.58	NA	0.32	6.88	NA	XXX
78481	26	A	Heart first pass, single	0.98	0.36	0.36	0.04	1.38	1.38	XXX
78481	TC	A	Heart first pass, single	0.00	5.22	NA	0.28	5.50	NA	XXX
78483		A	Heart first pass, multiple	1.47	8.41	NA	0.46	10.34	NA	XXX
78483	26	A	Heart first pass, multiple	1.47	0.54	0.54	0.05	2.06	2.06	XXX
78483	TC	A	Heart first pass, multiple	0.00	7.87	NA	0.41	8.28	NA	XXX
78491		I	Heart image (pet), single	0.00	0.00	0.00	0.00	0.00	0.00	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
78491	26	I	Heart image (pet), single	+1.50	0.59	0.59	0.06	2.15	2.15	XXX
78491	TC	I	Heart image (pet), single	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78492		I	Heart image (pet), multiple	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78492	26	I	Heart image (pet), multiple	+1.87	0.74	0.74	0.07	2.68	2.68	XXX
78492	TC	I	Heart image (pet), multiple	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78494		A	Heart image, spect	1.19	7.49	NA	0.35	9.03	NA	XXX
78494	26	A	Heart image, spect	1.19	0.42	0.42	0.05	1.66	1.66	XXX
78494	TC	A	Heart image, spect	0.00	7.07	NA	0.30	7.37	NA	XXX
78496		A	Heart first pass add-on	0.50	7.25	NA	0.32	8.07	NA	ZZZ
78496	26	A	Heart first pass add-on	0.50	0.18	0.18	0.02	0.70	0.70	ZZZ
78496	TC	A	Heart first pass add-on	0.00	7.07	NA	0.30	7.37	NA	ZZZ
78499		C	Cardiovascular nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78499	26	C	Cardiovascular nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78499	TC	C	Cardiovascular nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78580		A	Lung perfusion imaging	0.74	3.68	NA	0.21	4.63	NA	XXX
78580	26	A	Lung perfusion imaging	0.74	0.25	0.25	0.03	1.02	1.02	XXX
78580	TC	A	Lung perfusion imaging	0.00	3.43	NA	0.18	3.61	NA	XXX
78584		A	Lung V/Q image single breath	0.99	3.53	NA	0.21	4.73	NA	XXX
78584	26	A	Lung V/Q image single breath	0.99	0.33	0.33	0.04	1.36	1.36	XXX
78584	TC	A	Lung V/Q image single breath	0.00	3.20	NA	0.17	3.37	NA	XXX
78585		A	Lung V/Q imaging	1.09	6.00	NA	0.35	7.44	NA	XXX
78585	26	A	Lung V/Q imaging	1.09	0.36	0.36	0.05	1.50	1.50	XXX
78585	TC	A	Lung V/Q imaging	0.00	5.64	NA	0.30	5.94	NA	XXX
78586		A	Aerosol lung image, single	0.40	2.72	NA	0.16	3.28	NA	XXX
78586	26	A	Aerosol lung image, single	0.40	0.13	0.13	0.02	0.55	0.55	XXX
78586	TC	A	Aerosol lung image, single	0.00	2.59	NA	0.14	2.73	NA	XXX
78587		A	Aerosol lung image, multiple	0.49	2.97	NA	0.16	3.62	NA	XXX
78587	26	A	Aerosol lung image, multiple	0.49	0.17	0.17	0.02	0.68	0.68	XXX
78587	TC	A	Aerosol lung image, multiple	0.00	2.80	NA	0.14	2.94	NA	XXX
78588		A	Perfusion lung image	1.09	3.56	NA	0.23	4.88	NA	XXX
78588	26	A	Perfusion lung image	1.09	0.36	0.36	0.05	1.50	1.50	XXX
78588	TC	A	Perfusion lung image	0.00	3.20	NA	0.18	3.38	NA	XXX
78591		A	Vent image, 1 breath, 1 proj	0.40	2.98	NA	0.16	3.54	NA	XXX
78591	26	A	Vent image, 1 breath, 1 proj	0.40	0.13	0.13	0.02	0.55	0.55	XXX
78591	TC	A	Vent image, 1 breath, 1 proj	0.00	2.85	NA	0.14	2.99	NA	XXX
78593		A	Vent image, 1 proj, gas	0.49	3.61	NA	0.20	4.30	NA	XXX
78593	26	A	Vent image, 1 proj, gas	0.49	0.16	0.16	0.02	0.67	0.67	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
78593	TC	A	Vent image, 1 proj, gas	0.00	3.45	NA	0.18	3.63	NA	XXX
78594		A	Vent image, mult proj, gas	0.53	5.16	NA	0.27	5.96	NA	XXX
78594	26	A	Vent image, mult proj, gas	0.53	0.18	0.18	0.02	0.73	0.73	XXX
78594	TC	A	Vent image, mult proj, gas	0.00	4.98	NA	0.25	5.23	NA	XXX
78596		A	Lung differential function	1.27	7.49	NA	0.42	9.18	NA	XXX
78596	26	A	Lung differential function	1.27	0.42	0.42	0.05	1.74	1.74	XXX
78596	TC	A	Lung differential function	0.00	7.07	NA	0.37	7.44	NA	XXX
78599		C	Respiratory nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78599	26	C	Respiratory nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78599	TC	C	Respiratory nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78600		A	Brain imaging, ltd static	0.44	3.03	NA	0.16	3.63	NA	XXX
78600	26	A	Brain imaging, ltd static	0.44	0.15	0.15	0.02	0.61	0.61	XXX
78600	TC	A	Brain imaging, ltd static	0.00	2.88	NA	0.14	3.02	NA	XXX
78601		A	Brain imaging, ltd w/flow	0.51	3.57	NA	0.20	4.28	NA	XXX
78601	26	A	Brain imaging, ltd w/flow	0.51	0.17	0.17	0.02	0.70	0.70	XXX
78601	TC	A	Brain imaging, ltd w/flow	0.00	3.40	NA	0.18	3.58	NA	XXX
78605		A	Brain imaging, complete	0.53	3.58	NA	0.20	4.31	NA	XXX
78605	26	A	Brain imaging, complete	0.53	0.18	0.18	0.02	0.73	0.73	XXX
78605	TC	A	Brain imaging, complete	0.00	3.40	NA	0.18	3.58	NA	XXX
78606		A	Brain imaging, compl w/flow	0.64	4.08	NA	0.24	4.96	NA	XXX
78606	26	A	Brain imaging, compl w/flow	0.64	0.21	0.21	0.03	0.88	0.88	XXX
78606	TC	A	Brain imaging, compl w/flow	0.00	3.87	NA	0.21	4.08	NA	XXX
78607		A	Brain imaging (3D)	1.23	6.98	NA	0.40	8.61	NA	XXX
78607	26	A	Brain imaging (3D)	1.23	0.43	0.43	0.05	1.71	1.71	XXX
78607	TC	A	Brain imaging (3D)	0.00	6.55	NA	0.35	6.90	NA	XXX
78608		N	Brain imaging (PET)	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78609		N	Brain imaging (PET)	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78610		A	Brain flow imaging only	0.30	1.69	NA	0.11	2.10	NA	XXX
78610	26	A	Brain flow imaging only	0.30	0.11	0.11	0.01	0.42	0.42	XXX
78610	TC	A	Brain flow imaging only	0.00	1.58	NA	0.10	1.68	NA	XXX
78615		A	Cerebral vascular flow image	0.42	4.00	NA	0.23	4.65	NA	XXX
78615	26	A	Cerebral vascular flow image	0.42	0.15	0.15	0.02	0.59	0.59	XXX
78615	TC	A	Cerebral vascular flow image	0.00	3.85	NA	0.21	4.06	NA	XXX
78630		A	Cerebrospinal fluid scan	0.68	5.27	NA	0.30	6.25	NA	XXX
78630	26	A	Cerebrospinal fluid scan	0.68	0.23	0.23	0.03	0.94	0.94	XXX
78630	TC	A	Cerebrospinal fluid scan	0.00	5.04	NA	0.27	5.31	NA	XXX
78635		A	CSF ventriculography	0.61	2.77	NA	0.16	3.54	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
78635	26	A	CSF ventriculography	0.61	0.23	0.23	0.02	0.86	0.86	XXX
78635	TC	A	CSF ventriculography	0.00	2.54	NA	0.14	2.68	NA	XXX
78645		A	CSF shunt evaluation	0.57	3.62	NA	0.20	4.39	NA	XXX
78645	26	A	CSF shunt evaluation	0.57	0.19	0.19	0.02	0.78	0.78	XXX
78645	TC	A	CSF shunt evaluation	0.00	3.43	NA	0.18	3.61	NA	XXX
78647		A	Cerebrospinal fluid scan	0.90	6.22	NA	0.35	7.47	NA	XXX
78647	26	A	Cerebrospinal fluid scan	0.90	0.31	0.31	0.04	1.25	1.25	XXX
78647	TC	A	Cerebrospinal fluid scan	0.00	5.91	NA	0.31	6.22	NA	XXX
78650		A	CSF leakage imaging	0.61	4.85	NA	0.27	5.73	NA	XXX
78650	26	A	CSF leakage imaging	0.61	0.21	0.21	0.03	0.85	0.85	XXX
78650	TC	A	CSF leakage imaging	0.00	4.64	NA	0.24	4.88	NA	XXX
78660		A	Nuclear exam of tear flow	0.53	2.30	NA	0.14	2.97	NA	XXX
78660	26	A	Nuclear exam of tear flow	0.53	0.18	0.18	0.02	0.73	0.73	XXX
78660	TC	A	Nuclear exam of tear flow	0.00	2.12	NA	0.12	2.24	NA	XXX
78699		C	Nervous system nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78699	26	C	Nervous system nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78699	TC	C	Nervous system nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78700		A	Kidney imaging, static	0.45	3.20	NA	0.18	3.83	NA	XXX
78700	26	A	Kidney imaging, static	0.45	0.15	0.15	0.02	0.62	0.62	XXX
78700	TC	A	Kidney imaging, static	0.00	3.05	NA	0.16	3.21	NA	XXX
78701		A	Kidney imaging with flow	0.49	3.72	NA	0.20	4.41	NA	XXX
78701	26	A	Kidney imaging with flow	0.49	0.16	0.16	0.02	0.67	0.67	XXX
78701	TC	A	Kidney imaging with flow	0.00	3.56	NA	0.18	3.74	NA	XXX
78704		A	Imaging renogram	0.74	4.20	NA	0.24	5.18	NA	XXX
78704	26	A	Imaging renogram	0.74	0.25	0.25	0.03	1.02	1.02	XXX
78704	TC	A	Imaging renogram	0.00	3.95	NA	0.21	4.16	NA	XXX
78707		A	Kidney flow/function image	0.96	4.79	NA	0.27	6.02	NA	XXX
78707	26	A	Kidney flow/function image	0.96	0.32	0.32	0.04	1.32	1.32	XXX
78707	TC	A	Kidney flow/function image	0.00	4.47	NA	0.23	4.70	NA	XXX
78708		A	Kidney flow/function image	1.21	4.88	NA	0.28	6.37	NA	XXX
78708	26	A	Kidney flow/function image	1.21	0.41	0.41	0.05	1.67	1.67	XXX
78708	TC	A	Kidney flow/function image	0.00	4.47	NA	0.23	4.70	NA	XXX
78709		A	Kidney flow/function image	1.41	4.94	NA	0.29	6.64	NA	XXX
78709	26	A	Kidney flow/function image	1.41	0.47	0.47	0.06	1.94	1.94	XXX
78709	TC	A	Kidney flow/function image	0.00	4.47	NA	0.23	4.70	NA	XXX
78710		A	Kidney imaging (3D)	0.66	6.13	NA	0.34	7.13	NA	XXX
78710	26	A	Kidney imaging (3D)	0.66	0.22	0.22	0.03	0.91	0.91	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
78710	TC	A	Kidney imaging (3D)	0.00	5.91	NA	0.31	6.22	NA	XXX
78715		A	Renal vascular flow exam	0.30	1.69	NA	0.11	2.10	NA	XXX
78715	26	A	Renal vascular flow exam	0.30	0.11	0.11	0.01	0.42	0.42	XXX
78715	TC	A	Renal vascular flow exam	0.00	1.58	NA	0.10	1.68	NA	XXX
78725		A	Kidney function study	0.38	1.91	NA	0.13	2.42	NA	XXX
78725	26	A	Kidney function study	0.38	0.13	0.13	0.02	0.53	0.53	XXX
78725	TC	A	Kidney function study	0.00	1.78	NA	0.11	1.89	NA	XXX
78730		A	Urinary bladder retention	0.36	1.58	NA	0.10	2.04	NA	XXX
78730	26	A	Urinary bladder retention	0.36	0.12	0.12	0.02	0.50	0.50	XXX
78730	TC	A	Urinary bladder retention	0.00	1.46	NA	0.08	1.54	NA	XXX
78740		A	Ureteral reflux study	0.57	2.31	NA	0.15	3.03	NA	XXX
78740	26	A	Ureteral reflux study	0.57	0.19	0.19	0.03	0.79	0.79	XXX
78740	TC	A	Ureteral reflux study	0.00	2.12	NA	0.12	2.24	NA	XXX
78760		A	Testicular imaging	0.66	2.90	NA	0.17	3.73	NA	XXX
78760	26	A	Testicular imaging	0.66	0.22	0.22	0.03	0.91	0.91	XXX
78760	TC	A	Testicular imaging	0.00	2.68	NA	0.14	2.82	NA	XXX
78761		A	Testicular imaging/flow	0.71	3.44	NA	0.20	4.35	NA	XXX
78761	26	A	Testicular imaging/flow	0.71	0.24	0.24	0.03	0.98	0.98	XXX
78761	TC	A	Testicular imaging/flow	0.00	3.20	NA	0.17	3.37	NA	XXX
78799		C	Genitourinary nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78799	26	C	Genitourinary nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78799	TC	C	Genitourinary nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78800		A	Tumor imaging, limited area	0.66	3.62	NA	0.22	4.50	NA	XXX
78800	26	A	Tumor imaging, limited area	0.66	0.22	0.22	0.04	0.92	0.92	XXX
78800	TC	A	Tumor imaging, limited area	0.00	3.40	NA	0.18	3.58	NA	XXX
78801		A	Tumor imaging, mult areas	0.79	4.49	NA	0.27	5.55	NA	XXX
78801	26	A	Tumor imaging, mult areas	0.79	0.27	0.27	0.05	1.11	1.11	XXX
78801	TC	A	Tumor imaging, mult areas	0.00	4.22	NA	0.22	4.44	NA	XXX
78802		A	Tumor imaging, whole body	0.86	5.82	NA	0.34	7.02	NA	XXX
78802	26	A	Tumor imaging, whole body	0.86	0.29	0.29	0.04	1.19	1.19	XXX
78802	TC	A	Tumor imaging, whole body	0.00	5.53	NA	0.30	5.83	NA	XXX
78803		A	Tumor imaging (3D)	1.09	6.93	NA	0.40	8.42	NA	XXX
78803	26	A	Tumor imaging (3D)	1.09	0.38	0.38	0.05	1.52	1.52	XXX
78803	TC	A	Tumor imaging (3D)	0.00	6.55	NA	0.35	6.90	NA	XXX
78804		A	Tumor imaging, whole body	1.07	11.43	NA	0.34	12.84	NA	XXX
78804	26	A	Tumor imaging, whole body	1.07	0.37	0.37	0.04	1.48	1.48	XXX
78804	TC	A	Tumor imaging, whole body	0.00	11.06	NA	0.30	11.36	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
78805		A	Abscess imaging, ltd area	0.73	3.65	NA	0.21	4.59	NA	XXX
78805	26	A	Abscess imaging, ltd area	0.73	0.25	0.25	0.03	1.01	1.01	XXX
78805	TC	A	Abscess imaging, ltd area	0.00	3.40	NA	0.18	3.58	NA	XXX
78806		A	Abscess imaging, whole body	0.86	6.72	NA	0.39	7.97	NA	XXX
78806	26	A	Abscess imaging, whole body	0.86	0.29	0.29	0.04	1.19	1.19	XXX
78806	TC	A	Abscess imaging, whole body	0.00	6.43	NA	0.35	6.78	NA	XXX
78807		A	Nuclear localization/abscess	1.09	6.94	NA	0.39	8.42	NA	XXX
78807	26	A	Nuclear localization/abscess	1.09	0.39	0.39	0.04	1.52	1.52	XXX
78807	TC	A	Nuclear localization/abscess	0.00	6.55	NA	0.35	6.90	NA	XXX
78811		I	Tumor imaging (pet), limited	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78811	26	I	Tumor imaging (pet), limited	+1.54	0.00	0.00	0.11	1.65	1.65	XXX
78811	TC	I	Tumor imaging (pet), limited	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78812		I	Tumor image (pet)/skul-thigh	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78812	26	I	Tumor image (pet)/skul-thigh	+1.93	0.00	0.00	0.11	2.04	2.04	XXX
78812	TC	I	Tumor image (pet)/skul-thigh	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78813		I	Tumor image (pet) full body	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78813	26	I	Tumor image (pet) full body	+2.00	0.00	0.00	0.11	2.11	2.11	XXX
78813	TC	I	Tumor image (pet) full body	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78814		I	Tumor image pet/ct, limited	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78814	26	I	Tumor image pet/ct, limited	+2.20	0.00	0.00	0.11	2.31	2.31	XXX
78814	TC	I	Tumor image pet/ct, limited	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78815		I	Tumorimage pet/ct skul-thigh	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78815	26	I	Tumorimage pet/ct skul-thigh	+2.44	0.00	0.00	0.11	2.55	2.55	XXX
78815	TC	I	Tumorimage pet/ct skul-thigh	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78816		I	Tumor image pet/ct full body	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78816	26	I	Tumor image pet/ct full body	+2.50	0.00	0.00	0.11	2.61	2.61	XXX
78816	TC	I	Tumor image pet/ct full body	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78890		B	Nuclear medicine data proc	+0.05	1.33	NA	0.07	1.45	NA	XXX
78890	26	B	Nuclear medicine data proc	+0.05	0.02	0.02	0.01	0.08	0.08	XXX
78890	TC	B	Nuclear medicine data proc	+0.00	1.31	NA	0.06	1.37	NA	XXX
78891		B	Nuclear med data proc	+0.10	2.66	NA	0.14	2.90	NA	XXX
78891	26	B	Nuclear med data proc	+0.10	0.04	0.04	0.01	0.15	0.15	XXX
78891	TC	B	Nuclear med data proc	+0.00	2.62	NA	0.13	2.75	NA	XXX
78999		C	Nuclear diagnostic exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78999	26	C	Nuclear diagnostic exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78999	TC	C	Nuclear diagnostic exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
79005		A	Nuclear rx, oral admin	1.80	3.22	NA	0.22	5.24	NA	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
79005	26	A	Nuclear rx, oral admin	1.80	0.60	0.60	0.08	2.48	2.48	XXX
79005	TC	A	Nuclear rx, oral admin	0.00	2.62	NA	0.14	2.76	NA	XXX
79101		A	Nuclear rx, iv admin	1.96	3.29	NA	0.22	5.47	NA	XXX
79101	26	A	Nuclear rx, iv admin	1.96	0.67	0.67	0.08	2.71	2.71	XXX
79101	TC	A	Nuclear rx, iv admin	0.00	2.62	NA	0.14	2.76	NA	XXX
79200		A	Nuclear rx, intracav admin	1.99	3.31	NA	0.23	5.53	NA	XXX
79200	26	A	Nuclear rx, intracav admin	1.99	0.69	0.69	0.09	2.77	2.77	XXX
79200	TC	A	Nuclear rx, intracav admin	0.00	2.62	NA	0.14	2.76	NA	XXX
79300		C	Nuclr rx, interstit colloid	0.00	0.00	0.00	0.00	0.00	0.00	XXX
79300	26	A	Nuclr rx, interstit colloid	1.60	0.56	0.56	0.13	2.29	2.29	XXX
79300	TC	C	Nuclr rx, interstit colloid	0.00	0.00	0.00	0.00	0.00	0.00	XXX
79403		A	Hematopoietic nuclear tx	2.25	5.16	NA	0.24	7.65	NA	XXX
79403	26	A	Hematopoietic nuclear tx	2.25	0.89	0.89	0.10	3.24	3.24	XXX
79403	TC	A	Hematopoietic nuclear tx	0.00	4.27	NA	0.14	4.41	NA	XXX
79440		A	Nuclear rx, intra-articular	1.99	3.34	NA	0.22	5.55	NA	XXX
79440	26	A	Nuclear rx, intra-articular	1.99	0.72	0.72	0.08	2.79	2.79	XXX
79440	TC	A	Nuclear rx, intra-articular	0.00	2.62	NA	0.14	2.76	NA	XXX
79445		A	Nuclear rx, intra-arterial	2.40	3.44	NA	0.28	6.12	NA	XXX
79445	26	A	Nuclear rx, intra-arterial	2.40	0.82	0.82	0.12	3.34	3.34	XXX
79445	TC	A	Nuclear rx, intra-arterial	0.00	2.62	NA	0.16	2.78	NA	XXX
79999		C	Nuclear medicine therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
79999	26	C	Nuclear medicine therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
79999	TC	C	Nuclear medicine therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
80500		A	Lab pathology consultation	0.37	0.21	0.16	0.01	0.59	0.54	XXX
80502		A	Lab pathology consultation	1.33	0.54	0.54	0.06	1.93	1.93	XXX
83020	26	A	Hemoglobin electrophoresis	0.37	0.15	0.15	0.01	0.53	0.53	XXX
83912	26	A	Genetic examination	0.37	0.12	0.12	0.01	0.50	0.50	XXX
84165	26	A	Protein e-phoresis, serum	0.37	0.14	0.14	0.01	0.52	0.52	XXX
84166	26	A	Protein e-phoresis/urine/csf	0.37	0.14	0.14	0.01	0.52	0.52	XXX
84181	26	A	Western blot test	0.37	0.14	0.14	0.01	0.52	0.52	XXX
84182	26	A	Protein, western blot test	0.37	0.16	0.16	0.02	0.55	0.55	XXX
85060		A	Blood smear interpretation	0.45	0.18	0.18	0.02	0.65	0.65	XXX
85097		A	Bone marrow interpretation	0.94	1.91	0.41	0.04	2.89	1.39	XXX
85390	26	A	Fibrinolysins screen	0.37	0.13	0.13	0.01	0.51	0.51	XXX
85396		A	Clotting assay, whole blood	0.37	NA	0.16	0.04	NA	0.57	XXX
85576	26	A	Blood platelet aggregation	0.37	0.16	0.16	0.01	0.54	0.54	XXX
86077		A	Physician blood bank service	0.94	0.39	0.39	0.04	1.37	1.37	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
86078		A	Physician blood bank service	0.94	0.46	0.40	0.04	1.44	1.38	XXX
86079		A	Physician blood bank service	0.94	0.45	0.41	0.03	1.42	1.38	XXX
86255	26	A	Fluorescent antibody, screen	0.37	0.15	0.15	0.01	0.53	0.53	XXX
86256	26	A	Fluorescent antibody, titer	0.37	0.15	0.15	0.01	0.53	0.53	XXX
86320	26	A	Serum immunoelectrophoresis	0.37	0.15	0.15	0.01	0.53	0.53	XXX
86325	26	A	Other immunoelectrophoresis	0.37	0.13	0.13	0.01	0.51	0.51	XXX
86327	26	A	Immunoelectrophoresis assay	0.42	0.18	0.18	0.02	0.62	0.62	XXX
86334	26	A	Immunofix e-phoresis, serum	0.37	0.15	0.15	0.01	0.53	0.53	XXX
86335	26	A	Immunfix e-phorsis/urine/csf	0.37	0.14	0.14	0.01	0.52	0.52	XXX
86485		C	Skin test, candida	0.00	0.00	0.00	0.00	0.00	0.00	XXX
86490		A	Coccidioidomycosis skin test	0.00	0.29	NA	0.02	0.31	NA	XXX
86510		A	Histoplasmosis skin test	0.00	0.32	NA	0.02	0.34	NA	XXX
86580		A	TB intradermal test	0.00	0.25	NA	0.02	0.27	NA	XXX
86585		A	TB tine test	0.00	0.20	NA	0.01	0.21	NA	XXX
86586		C	Skin test, unlisted	0.00	0.00	0.00	0.00	0.00	0.00	XXX
87164	26	A	Dark field examination	0.37	0.12	0.12	0.01	0.50	0.50	XXX
87207	26	A	Smear, special stain	0.37	0.16	0.16	0.01	0.54	0.54	XXX
88104		A	Cytopathology, fluids	0.56	0.85	NA	0.04	1.45	NA	XXX
88104	26	A	Cytopathology, fluids	0.56	0.24	0.24	0.02	0.82	0.82	XXX
88104	TC	A	Cytopathology, fluids	0.00	0.61	NA	0.02	0.63	NA	XXX
88106		A	Cytopathology, fluids	0.56	1.35	NA	0.04	1.95	NA	XXX
88106	26	A	Cytopathology, fluids	0.56	0.24	0.24	0.02	0.82	0.82	XXX
88106	TC	A	Cytopathology, fluids	0.00	1.11	NA	0.02	1.13	NA	XXX
88107		A	Cytopathology, fluids	0.76	1.54	NA	0.05	2.35	NA	XXX
88107	26	A	Cytopathology, fluids	0.76	0.33	0.33	0.03	1.12	1.12	XXX
88107	TC	A	Cytopathology, fluids	0.00	1.21	NA	0.02	1.23	NA	XXX
88108		A	Cytopath, concentrate tech	0.56	1.21	NA	0.04	1.81	NA	XXX
88108	26	A	Cytopath, concentrate tech	0.56	0.24	0.24	0.02	0.82	0.82	XXX
88108	TC	A	Cytopath, concentrate tech	0.00	0.97	NA	0.02	0.99	NA	XXX
88112		A	Cytopath, cell enhance tech	1.18	1.97	NA	0.04	3.19	NA	XXX
88112	26	A	Cytopath, cell enhance tech	1.18	0.51	0.51	0.02	1.71	1.71	XXX
88112	TC	A	Cytopath, cell enhance tech	0.00	1.46	NA	0.02	1.48	NA	XXX
88125		A	Forensic cytopathology	0.26	0.25	NA	0.02	0.53	NA	XXX
88125	26	A	Forensic cytopathology	0.26	0.11	0.11	0.01	0.38	0.38	XXX
88125	TC	A	Forensic cytopathology	0.00	0.14	NA	0.01	0.15	NA	XXX
88141		A	Cytopath, c/v, interpret	0.42	0.15	0.15	0.02	0.59	0.59	XXX
88160		A	Cytopath smear, other source	0.50	0.83	NA	0.04	1.37	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
88160	26	A	Cytopath smear, other source	0.50	0.21	0.21	0.02	0.73	0.73	XXX
88160	TC	A	Cytopath smear, other source	0.00	0.62	NA	0.02	0.64	NA	XXX
88161		A	Cytopath smear, other source	0.50	0.94	NA	0.04	1.48	NA	XXX
88161	26	A	Cytopath smear, other source	0.50	0.21	0.21	0.02	0.73	0.73	XXX
88161	TC	A	Cytopath smear, other source	0.00	0.73	NA	0.02	0.75	NA	XXX
88162		A	Cytopath smear, other source	0.76	1.02	NA	0.05	1.83	NA	XXX
88162	26	A	Cytopath smear, other source	0.76	0.33	0.33	0.03	1.12	1.12	XXX
88162	TC	A	Cytopath smear, other source	0.00	0.69	NA	0.02	0.71	NA	XXX
88172		A	Cytopathology eval of fna	0.60	0.73	NA	0.04	1.37	NA	XXX
88172	26	A	Cytopathology eval of fna	0.60	0.26	0.26	0.02	0.88	0.88	XXX
88172	TC	A	Cytopathology eval of fna	0.00	0.47	NA	0.02	0.49	NA	XXX
88173		A	Cytopath eval, fna, report	1.39	2.14	NA	0.07	3.60	NA	XXX
88173	26	A	Cytopath eval, fna, report	1.39	0.59	0.59	0.05	2.03	2.03	XXX
88173	TC	A	Cytopath eval, fna, report	0.00	1.55	NA	0.02	1.57	NA	XXX
88182		A	Cell marker study	0.77	1.98	NA	0.07	2.82	NA	XXX
88182	26	A	Cell marker study	0.77	0.33	0.33	0.03	1.13	1.13	XXX
88182	TC	A	Cell marker study	0.00	1.65	NA	0.04	1.69	NA	XXX
88184		A	Flowcytometry/ tc, 1 marker	0.00	1.32	NA	0.02	1.34	NA	XXX
88185		A	Flowcytometry/tc, add-on	0.00	0.64	NA	0.02	0.66	NA	ZZZ
88187		A	Flowcytometry/read, 2-8	1.36	0.45	0.45	0.01	1.82	1.82	XXX
88188		A	Flowcytometry/read, 9-15	1.69	0.57	0.57	0.01	2.27	2.27	XXX
88189		A	Flowcytometry/read, 16 & >	2.23	0.75	0.75	0.01	2.99	2.99	XXX
88199		C	Cytopathology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88199	26	C	Cytopathology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88199	TC	C	Cytopathology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88291		A	Cyto/molecular report	0.52	0.17	0.17	0.02	0.71	0.71	XXX
88299		C	Cytogenetic study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88300		A	Surgical path, gross	0.08	0.45	NA	0.02	0.55	NA	XXX
88300	26	A	Surgical path, gross	0.08	0.03	0.03	0.01	0.12	0.12	XXX
88300	TC	A	Surgical path, gross	0.00	0.42	NA	0.01	0.43	NA	XXX
88302		A	Tissue exam by pathologist	0.13	1.03	NA	0.03	1.19	NA	XXX
88302	26	A	Tissue exam by pathologist	0.13	0.06	0.06	0.01	0.20	0.20	XXX
88302	TC	A	Tissue exam by pathologist	0.00	0.97	NA	0.02	0.99	NA	XXX
88304		A	Tissue exam by pathologist	0.22	1.32	NA	0.03	1.57	NA	XXX
88304	26	A	Tissue exam by pathologist	0.22	0.09	0.09	0.01	0.32	0.32	XXX
88304	TC	A	Tissue exam by pathologist	0.00	1.23	NA	0.02	1.25	NA	XXX
88305		A	Tissue exam by pathologist	0.75	1.91	NA	0.07	2.73	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
88305	26	A	Tissue exam by pathologist	0.75	0.33	0.33	0.03	1.11	1.11	XXX
88305	TC	A	Tissue exam by pathologist	0.00	1.58	NA	0.04	1.62	NA	XXX
88307		A	Tissue exam by pathologist	1.59	3.15	NA	0.12	4.86	NA	XXX
88307	26	A	Tissue exam by pathologist	1.59	0.68	0.68	0.06	2.33	2.33	XXX
88307	TC	A	Tissue exam by pathologist	0.00	2.47	NA	0.06	2.53	NA	XXX
88309		A	Tissue exam by pathologist	2.28	4.39	NA	0.14	6.81	NA	XXX
88309	26	A	Tissue exam by pathologist	2.28	0.97	0.97	0.08	3.33	3.33	XXX
88309	TC	A	Tissue exam by pathologist	0.00	3.42	NA	0.06	3.48	NA	XXX
88311		A	Decalcify tissue	0.24	0.23	NA	0.02	0.49	NA	XXX
88311	26	A	Decalcify tissue	0.24	0.10	0.10	0.01	0.35	0.35	XXX
88311	TC	A	Decalcify tissue	0.00	0.13	NA	0.01	0.14	NA	XXX
88312		A	Special stains	0.54	1.52	NA	0.03	2.09	NA	XXX
88312	26	A	Special stains	0.54	0.23	0.23	0.02	0.79	0.79	XXX
88312	TC	A	Special stains	0.00	1.29	NA	0.01	1.30	NA	XXX
88313		A	Special stains	0.24	1.25	NA	0.02	1.51	NA	XXX
88313	26	A	Special stains	0.24	0.10	0.10	0.01	0.35	0.35	XXX
88313	TC	A	Special stains	0.00	1.15	NA	0.01	1.16	NA	XXX
88314		A	Histochemical stain	0.45	2.06	NA	0.04	2.55	NA	XXX
88314	26	A	Histochemical stain	0.45	0.19	0.19	0.02	0.66	0.66	XXX
88314	TC	A	Histochemical stain	0.00	1.87	NA	0.02	1.89	NA	XXX
88318		A	Chemical histochemistry	0.42	1.65	NA	0.03	2.10	NA	XXX
88318	26	A	Chemical histochemistry	0.42	0.18	0.18	0.02	0.62	0.62	XXX
88318	TC	A	Chemical histochemistry	0.00	1.47	NA	0.01	1.48	NA	XXX
88319		A	Enzyme histochemistry	0.53	3.41	NA	0.04	3.98	NA	XXX
88319	26	A	Enzyme histochemistry	0.53	0.22	0.22	0.02	0.77	0.77	XXX
88319	TC	A	Enzyme histochemistry	0.00	3.19	NA	0.02	3.21	NA	XXX
88321		A	Microslide consultation	1.30	0.79	0.56	0.05	2.14	1.91	XXX
88323		A	Microslide consultation	1.35	1.78	NA	0.07	3.20	NA	XXX
88323	26	A	Microslide consultation	1.35	0.57	0.57	0.05	1.97	1.97	XXX
88323	TC	A	Microslide consultation	0.00	1.21	NA	0.02	1.23	NA	XXX
88325		A	Comprehensive review of data	2.22	2.93	0.95	0.09	5.24	3.26	XXX
88329		A	Path consult introp	0.67	0.65	0.29	0.03	1.35	0.99	XXX
88331		A	Path consult intraop, 1 bloc	1.19	1.10	NA	0.08	2.37	NA	XXX
88331	26	A	Path consult intraop, 1 bloc	1.19	0.51	0.51	0.04	1.74	1.74	XXX
88331	TC	A	Path consult intraop, 1 bloc	0.00	0.59	NA	0.04	0.63	NA	XXX
88332		A	Path consult intraop, add'l	0.59	0.46	NA	0.04	1.09	NA	XXX
88332	26	A	Path consult intraop, add'l	0.59	0.25	0.25	0.02	0.86	0.86	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
88332	TC	A	Path consult intraop, add'l	0.00	0.21	NA	0.02	0.23	NA	XXX
88342		A	Immunohistochemistry	0.85	1.46	NA	0.05	2.36	NA	XXX
88342	26	A	Immunohistochemistry	0.85	0.36	0.36	0.03	1.24	1.24	XXX
88342	TC	A	Immunohistochemistry	0.00	1.10	NA	0.02	1.12	NA	XXX
88346		A	Immunofluorescent study	0.86	1.57	NA	0.05	2.48	NA	XXX
88346	26	A	Immunofluorescent study	0.86	0.36	0.36	0.03	1.25	1.25	XXX
88346	TC	A	Immunofluorescent study	0.00	1.21	NA	0.02	1.23	NA	XXX
88347		A	Immunofluorescent study	0.86	1.26	NA	0.05	2.17	NA	XXX
88347	26	A	Immunofluorescent study	0.86	0.35	0.35	0.03	1.24	1.24	XXX
88347	TC	A	Immunofluorescent study	0.00	0.91	NA	0.02	0.93	NA	XXX
88348		A	Electron microscopy	1.51	9.35	NA	0.13	10.99	NA	XXX
88348	26	A	Electron microscopy	1.51	0.64	0.64	0.06	2.21	2.21	XXX
88348	TC	A	Electron microscopy	0.00	8.71	NA	0.07	8.78	NA	XXX
88349		A	Scanning electron microscopy	0.76	3.56	NA	0.09	4.41	NA	XXX
88349	26	A	Scanning electron microscopy	0.76	0.33	0.33	0.03	1.12	1.12	XXX
88349	TC	A	Scanning electron microscopy	0.00	3.23	NA	0.06	3.29	NA	XXX
88355		A	Analysis, skeletal muscle	1.85	8.77	NA	0.13	10.75	NA	XXX
88355	26	A	Analysis, skeletal muscle	1.85	0.79	0.79	0.07	2.71	2.71	XXX
88355	TC	A	Analysis, skeletal muscle	0.00	7.98	NA	0.06	8.04	NA	XXX
88356		A	Analysis, nerve	3.02	4.18	NA	0.19	7.39	NA	XXX
88356	26	A	Analysis, nerve	3.02	1.26	1.26	0.12	4.40	4.40	XXX
88356	TC	A	Analysis, nerve	0.00	2.92	NA	0.07	2.99	NA	XXX
88358		A	Analysis, tumor	0.95	0.84	NA	0.18	1.97	NA	XXX
88358	26	A	Analysis, tumor	0.95	0.40	0.40	0.11	1.46	1.46	XXX
88358	TC	A	Analysis, tumor	0.00	0.44	NA	0.07	0.51	NA	XXX
88360		A	Tumor immunohistochem/manual	1.10	1.73	NA	0.08	2.91	NA	XXX
88360	26	A	Tumor immunohistochem/manual	1.10	0.47	0.47	0.06	1.63	1.63	XXX
88360	TC	A	Tumor immunohistochem/manual	0.00	1.26	NA	0.02	1.28	NA	XXX
88361		A	Tumor immunohistochem/comput	1.18	3.02	NA	0.18	4.38	NA	XXX
88361	26	A	Tumor immunohistochem/comput	1.18	0.49	0.49	0.11	1.78	1.78	XXX
88361	TC	A	Tumor immunohistochem/comput	0.00	2.53	NA	0.07	2.60	NA	XXX
88362		A	Nerve teasing preparations	2.17	4.69	NA	0.16	7.02	NA	XXX
88362	26	A	Nerve teasing preparations	2.17	0.92	0.92	0.10	3.19	3.19	XXX
88362	TC	A	Nerve teasing preparations	0.00	3.77	NA	0.06	3.83	NA	XXX
88365		A	Insitu hybridization (fish)	1.20	2.13	NA	0.05	3.38	NA	XXX
88365	26	A	Insitu hybridization (fish)	1.20	0.51	0.51	0.03	1.74	1.74	XXX
88365	TC	A	Insitu hybridization (fish)	0.00	1.62	NA	0.02	1.64	NA	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
88367		A	Insitu hybridization, auto	1.30	4.11	NA	0.12	5.53	NA	XXX
88367	26	A	Insitu hybridization, auto	1.30	0.54	0.54	0.06	1.90	1.90	XXX
88367	TC	A	Insitu hybridization, auto	0.00	3.57	NA	0.06	3.63	NA	XXX
88368		A	Insitu hybridization, manual	1.40	3.50	NA	0.12	5.02	NA	XXX
88368	26	A	Insitu hybridization, manual	1.40	0.60	0.60	0.06	2.06	2.06	XXX
88368	TC	A	Insitu hybridization, manual	0.00	2.90	NA	0.06	2.96	NA	XXX
88371	26	A	Protein, western blot tissue	0.37	0.13	0.13	0.01	0.51	0.51	XXX
88372	26	A	Protein analysis w/probe	0.37	0.16	0.16	0.01	0.54	0.54	XXX
88380		C	Microdissection	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88380	26	C	Microdissection	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88380	TC	C	Microdissection	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88399		C	Surgical pathology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88399	26	C	Surgical pathology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88399	TC	C	Surgical pathology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
89060	26	A	Exam,synovial fluid crystals	0.37	0.16	0.16	0.01	0.54	0.54	XXX
89100		A	Sample intestinal contents	0.60	1.83	0.21	0.03	2.46	0.84	XXX
89105		A	Sample intestinal contents	0.50	2.22	0.17	0.02	2.74	0.69	XXX
89130		A	Sample stomach contents	0.45	1.74	0.13	0.02	2.21	0.60	XXX
89132		A	Sample stomach contents	0.19	1.55	0.06	0.01	1.75	0.26	XXX
89135		A	Sample stomach contents	0.79	1.89	0.25	0.04	2.72	1.08	XXX
89136		A	Sample stomach contents	0.21	1.73	0.09	0.01	1.95	0.31	XXX
89140		A	Sample stomach contents	0.94	2.08	0.27	0.04	3.06	1.25	XXX
89141		A	Sample stomach contents	0.85	2.79	0.33	0.03	3.67	1.21	XXX
89220		A	Sputum specimen collection	0.00	0.39	NA	0.02	0.41	NA	XXX
89230		A	Collect sweat for test	0.00	0.11	NA	0.02	0.13	NA	XXX
89240		C	Pathology lab procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90281		I	Human ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90283		I	Human ig, iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90287		I	Botulinum antitoxin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90288		I	Botulism ig, iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90291		I	Cmv ig, iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90296		E	Diphtheria antitoxin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90371		E	Hep b ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90375		E	Rabies ig, im/sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90376		E	Rabies ig, heat treated	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90378		X	Rsv ig, im, 50mg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90379		I	Rsv ig, iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
90384		I	Rh ig, full-dose, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90385		E	Rh ig, minidose, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90386		I	Rh ig, iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90389		I	Tetanus ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90393		E	Vaccina ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90396		E	Varicella-zoster ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90399		I	Immune globulin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90465		A	Immune admin 1 inj, < 8 yrs	0.17	0.31	NA	0.01	0.49	NA	XXX
90466		A	Immune admin addl inj, < 8 y	0.15	0.13	NA	0.01	0.29	NA	ZZZ
90467		R	Immune admin o or n, < 8 yrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90468		R	Immune admin o/n, addl < 8 y	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
90471		A	Immunization admin	0.17	0.31	NA	0.01	0.49	NA	XXX
90472		A	Immunization admin, each add	0.15	0.13	NA	0.01	0.29	NA	ZZZ
90473		R	Immune admin oral/nasal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90474		R	Immune admin oral/nasal addl	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
90476		E	Adenovirus vaccine, type 4	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90477		E	Adenovirus vaccine, type 7	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90581		E	Anthrax vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90585		E	Bcg vaccine, percut	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90586		E	Bcg vaccine, intravesical	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90632		E	Hep a vaccine, adult im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90633		E	Hep a vacc, ped/adol, 2 dose	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90634		E	Hep a vacc, ped/adol, 3 dose	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90636		E	Hep a/hep b vacc, adult im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90645		E	Hib vaccine, hboc, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90646		E	Hib vaccine, prp-d, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90647		E	Hib vaccine, prp-omp, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90648		E	Hib vaccine, prp-t, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90655		X	Flu vaccine no preserv 6-35m	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90656		E	Flu vaccine no preserv 3 & >	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90657		X	Flu vaccine, 3 yrs, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90658		X	Flu vaccine, 3 yrs & >, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90660		X	Flu vaccine, nasal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90665		E	Lyme disease vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90669		N	Pneumococcal vacc, ped <5	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90675		E	Rabies vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90676		E	Rabies vaccine, id	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
90680		E	Rotovirus vaccine, oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90690		E	Typhoid vaccine, oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90691		E	Typhoid vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90692		E	Typhoid vaccine, h-p, sc/id	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90693		E	Typhoid vaccine, akd, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90698		E	Dtap-hib-ip vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90700		E	Dtap vaccine, < 7 yrs, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90701		E	Dtp vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90702		E	Dt vaccine < 7, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90703		E	Tetanus vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90704		E	Mumps vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90705		E	Measles vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90706		E	Rubella vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90707		E	Mmr vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90708		E	Measles-rubella vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90710		E	Mmrv vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90712		E	Oral poliovirus vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90713		E	Poliovirus, ipv, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90715		E	Tdap vaccine >7 im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90716		E	Chicken pox vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90717		E	Yellow fever vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90718		E	Td vaccine > 7, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90719		E	Diphtheria vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90720		E	Dtp/hib vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90721		E	Dtap/hib vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90723		I	Dtap-hep b-ipv vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90725		E	Cholera vaccine, injectable	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90727		E	Plague vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90732		X	Pneumococcal vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90733		E	Meningococcal vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90734		E	Meningococcal vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90735		E	Encephalitis vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90740		X	Hepb vacc, ill pat 3 dose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90743		X	Hep b vacc, adol, 2 dose, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90744		X	Hepb vacc ped/adol 3 dose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90746		X	Hep b vaccine, adult, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90747		X	Hepb vacc, ill pat 4 dose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
90748		I	Hep b/hib vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90749		E	Vaccine toxoid	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90780		I	IV infusion therapy, 1 hour	+0.17	2.15	2.15	0.07	2.39	2.39	XXX
90781		I	IV infusion, additional hour	+0.17	0.46	0.46	0.04	0.67	0.67	ZZZ
90782		I	Injection, sc/im	+0.17	0.32	0.32	0.01	0.50	0.50	XXX
90783		A	Injection, ia	0.17	0.31	NA	0.02	0.50	NA	XXX
90784		I	Injection, iv	+0.17	0.80	0.80	0.04	1.01	1.01	XXX
90788		A	Injection of antibiotic	0.17	0.26	NA	0.01	0.44	NA	XXX
90799		C	Ther/prophylactic/dx inject	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90801		A	Psy dx interview	2.80	1.17	0.93	0.07	4.04	3.80	XXX
90802		A	Intac psy dx interview	3.01	1.20	0.98	0.08	4.29	4.07	XXX
90804		A	Psytx, office, 20-30 min	1.21	0.49	0.38	0.03	1.73	1.62	XXX
90805		A	Psytx, off, 20-30 min w/e&m	1.37	0.50	0.42	0.03	1.90	1.82	XXX
90806		A	Psytx, off, 45-50 min	1.86	0.70	0.60	0.05	2.61	2.51	XXX
90807		A	Psytx, off, 45-50 min w/e&m	2.02	0.70	0.63	0.05	2.77	2.70	XXX
90808		A	Psytx, office, 75-80 min	2.79	1.03	0.90	0.07	3.89	3.76	XXX
90809		A	Psytx, off, 75-80, w/e&m	2.95	1.00	0.92	0.08	4.03	3.95	XXX
90810		A	Intac psytx, off, 20-30 min	1.32	0.51	0.42	0.04	1.87	1.78	XXX
90811		A	Intac psytx, 20-30, w/e&m	1.48	0.57	0.46	0.04	2.09	1.98	XXX
90812		A	Intac psytx, off, 45-50 min	1.97	0.79	0.64	0.05	2.81	2.66	XXX
90813		A	Intac psytx, 45-50 min w/e&m	2.13	0.77	0.67	0.05	2.95	2.85	XXX
90814		A	Intac psytx, off, 75-80 min	2.90	1.10	0.98	0.07	4.07	3.95	XXX
90815		A	Intac psytx, 75-80 w/e&m	3.06	1.05	0.95	0.08	4.19	4.09	XXX
90816		A	Psytx, hosp, 20-30 min	1.25	NA	0.46	0.03	NA	1.74	XXX
90817		A	Psytx, hosp, 20-30 min w/e&m	1.41	NA	0.46	0.04	NA	1.91	XXX
90818		A	Psytx, hosp, 45-50 min	1.89	NA	0.69	0.05	NA	2.63	XXX
90819		A	Psytx, hosp, 45-50 min w/e&m	2.05	NA	0.65	0.05	NA	2.75	XXX
90821		A	Psytx, hosp, 75-80 min	2.83	NA	1.01	0.07	NA	3.91	XXX
90822		A	Psytx, hosp, 75-80 min w/e&m	2.99	NA	0.95	0.08	NA	4.02	XXX
90823		A	Intac psytx, hosp, 20-30 min	1.36	NA	0.48	0.03	NA	1.87	XXX
90824		A	Intac psytx, hsp 20-30 w/e&m	1.52	NA	0.49	0.04	NA	2.05	XXX
90826		A	Intac psytx, hosp, 45-50 min	2.01	NA	0.72	0.05	NA	2.78	XXX
90827		A	Intac psytx, hsp 45-50 w/e&m	2.16	NA	0.68	0.05	NA	2.89	XXX
90828		A	Intac psytx, hosp, 75-80 min	2.94	NA	1.06	0.07	NA	4.07	XXX
90829		A	Intac psytx, hsp 75-80 w/e&m	3.10	NA	0.98	0.08	NA	4.16	XXX
90845		A	Psychoanalysis	1.79	0.58	0.55	0.04	2.41	2.38	XXX
90846		R	Family psytx w/o patient	1.83	0.65	0.65	0.05	2.53	2.53	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
90847		R	Family psytx w/patient	2.21	0.82	0.76	0.05	3.08	3.02	XXX
90849		R	Multiple family group psytx	0.59	0.27	0.24	0.02	0.88	0.85	XXX
90853		A	Group psychotherapy	0.59	0.25	0.23	0.02	0.86	0.84	XXX
90857		A	Intac group psytx	0.63	0.29	0.25	0.02	0.94	0.90	XXX
90862		A	Medication management	0.95	0.40	0.32	0.02	1.37	1.29	XXX
90865		A	Narcosynthesis	2.84	1.36	0.91	0.11	4.31	3.86	XXX
90870		A	Electroconvulsive therapy	1.88	1.93	0.59	0.05	3.86	2.52	000
90871		N	Electroconvulsive therapy	+2.72	1.07	1.07	0.07	3.86	3.86	000
90875		N	Psychophysiological therapy	+1.20	0.90	0.46	0.04	2.14	1.70	XXX
90876		N	Psychophysiological therapy	+1.90	1.16	0.73	0.05	3.11	2.68	XXX
90880		A	Hypnotherapy	2.19	1.04	0.69	0.06	3.29	2.94	XXX
90882		N	Environmental manipulation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90885		B	Psy evaluation of records	+0.97	0.37	0.37	0.02	1.36	1.36	XXX
90887		B	Consultation with family	+1.48	0.82	0.56	0.04	2.34	2.08	XXX
90889		B	Preparation of report	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90899		C	Psychiatric service/therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90901		A	Biofeedback train, any meth	0.41	0.65	0.14	0.02	1.08	0.57	000
90911		A	Biofeedback peri/uro/rectal	0.89	1.56	0.31	0.05	2.50	1.25	000
90918		I	ESRD related services, month	+11.16	6.11	6.11	0.36	17.63	17.63	XXX
90919		I	ESRD related services, month	+8.53	4.00	4.00	0.29	12.82	12.82	XXX
90920		I	ESRD related services, month	+7.26	3.75	3.75	0.23	11.24	11.24	XXX
90921		I	ESRD related services, month	+4.46	2.44	2.44	0.14	7.04	7.04	XXX
90922		I	ESRD related services, day	+0.37	0.21	0.21	0.01	0.59	0.59	XXX
90923		I	Esrd related services, day	+0.28	0.13	0.13	0.01	0.42	0.42	XXX
90924		I	Esrd related services, day	+0.24	0.12	0.12	0.01	0.37	0.37	XXX
90925		I	Esrd related services, day	+0.15	0.08	0.08	0.01	0.24	0.24	XXX
90935		A	Hemodialysis, one evaluation	1.22	NA	0.67	0.04	NA	1.93	000
90937		A	Hemodialysis, repeated eval	2.11	NA	0.97	0.07	NA	3.15	000
90939		X	Hemodialysis study, transcut	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90940		X	Hemodialysis access study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90945		A	Dialysis, one evaluation	1.28	NA	0.69	0.04	NA	2.01	000
90947		A	Dialysis, repeated eval	2.16	NA	0.99	0.07	NA	3.22	000
90989		X	Dialysis training, complete	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90993		X	Dialysis training, incompl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90997		A	Hemoperfusion	1.84	NA	0.66	0.06	NA	2.56	000
90999		C	Dialysis procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91000		A	Esophageal intubation	0.73	0.33	NA	0.04	1.10	NA	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
91000	26	A	Esophageal intubation	0.73	0.25	0.25	0.03	1.01	1.01	000
91000	TC	A	Esophageal intubation	0.00	0.08	NA	0.01	0.09	NA	000
91010		A	Esophagus motility study	1.25	4.41	NA	0.12	5.78	NA	000
91010	26	A	Esophagus motility study	1.25	0.44	0.44	0.06	1.75	1.75	000
91010	TC	A	Esophagus motility study	0.00	3.97	NA	0.06	4.03	NA	000
91011		A	Esophagus motility study	1.50	5.23	NA	0.13	6.86	NA	000
91011	26	A	Esophagus motility study	1.50	0.53	0.53	0.07	2.10	2.10	000
91011	TC	A	Esophagus motility study	0.00	4.70	NA	0.06	4.76	NA	000
91012		A	Esophagus motility study	1.46	5.75	NA	0.14	7.35	NA	000
91012	26	A	Esophagus motility study	1.46	0.51	0.51	0.07	2.04	2.04	000
91012	TC	A	Esophagus motility study	0.00	5.24	NA	0.07	5.31	NA	000
91020		A	Gastric motility	1.44	4.52	NA	0.13	6.09	NA	000
91020	26	A	Gastric motility	1.44	0.49	0.49	0.07	2.00	2.00	000
91020	TC	A	Gastric motility	0.00	4.03	NA	0.06	4.09	NA	000
91030		A	Acid perfusion of esophagus	0.91	2.43	NA	0.06	3.40	NA	000
91030	26	A	Acid perfusion of esophagus	0.91	0.32	0.32	0.04	1.27	1.27	000
91030	TC	A	Acid perfusion of esophagus	0.00	2.11	NA	0.02	2.13	NA	000
91034		A	Gastroesophageal reflux test	0.97	5.24	NA	0.12	6.33	NA	XXX
91034	26	A	Gastroesophageal reflux test	0.97	0.34	0.34	0.06	1.37	1.37	XXX
91034	TC	A	Gastroesophageal reflux test	0.00	4.90	NA	0.06	4.96	NA	XXX
91035		A	G-esoph reflx tst w/electrod	1.59	10.80	NA	0.12	12.51	NA	XXX
91035	26	A	G-esoph reflx tst w/electrod	1.59	0.56	0.56	0.06	2.21	2.21	XXX
91035	TC	A	G-esoph reflx tst w/electrod	0.00	10.24	NA	0.06	10.30	NA	XXX
91037		A	Esoph imped function test	0.97	2.93	NA	0.12	4.02	NA	XXX
91037	26	A	Esoph imped function test	0.97	0.34	0.34	0.06	1.37	1.37	XXX
91037	TC	A	Esoph imped function test	0.00	2.59	NA	0.06	2.65	NA	XXX
91038		A	Esoph imped funct test > 1h	1.10	2.22	NA	0.12	3.44	NA	XXX
91038	26	A	Esoph imped funct test > 1h	1.10	0.39	0.39	0.06	1.55	1.55	XXX
91038	TC	A	Esoph imped funct test > 1h	0.00	1.83	NA	0.06	1.89	NA	XXX
91040		A	Esoph balloon distension tst	0.97	11.13	NA	0.12	12.22	NA	XXX
91040	26	A	Esoph balloon distension tst	0.97	0.34	0.34	0.06	1.37	1.37	XXX
91040	TC	A	Esoph balloon distension tst	0.00	10.79	NA	0.06	10.85	NA	XXX
91052		A	Gastric analysis test	0.79	2.45	NA	0.06	3.30	NA	000
91052	26	A	Gastric analysis test	0.79	0.28	0.28	0.04	1.11	1.11	000
91052	TC	A	Gastric analysis test	0.00	2.17	NA	0.02	2.19	NA	000
91055		A	Gastric intubation for smear	0.94	2.94	NA	0.07	3.95	NA	000
91055	26	A	Gastric intubation for smear	0.94	0.27	0.27	0.05	1.26	1.26	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
91055	TC	A	Gastric intubation for smear	0.00	2.67	NA	0.02	2.69	NA	000
91060		A	Gastric saline load test	0.45	1.96	NA	0.05	2.46	NA	000
91060	26	A	Gastric saline load test	0.45	0.14	0.14	0.03	0.62	0.62	000
91060	TC	A	Gastric saline load test	0.00	1.82	NA	0.02	1.84	NA	000
91065		A	Breath hydrogen test	0.20	1.46	NA	0.03	1.69	NA	000
91065	26	A	Breath hydrogen test	0.20	0.07	0.07	0.01	0.28	0.28	000
91065	TC	A	Breath hydrogen test	0.00	1.39	NA	0.02	1.41	NA	000
91100		A	Pass intestine bleeding tube	1.08	2.79	0.28	0.07	3.94	1.43	000
91105		A	Gastric intubation treatment	0.37	2.10	0.09	0.03	2.50	0.49	000
91110		A	Gi tract capsule endoscopy	3.64	22.18	NA	0.16	25.98	NA	XXX
91110	26	A	Gi tract capsule endoscopy	3.64	1.28	1.28	0.09	5.01	5.01	XXX
91110	TC	A	Gi tract capsule endoscopy	0.00	20.90	NA	0.07	20.97	NA	XXX
91120		A	Rectal sensation test	0.97	10.98	NA	0.11	12.06	NA	XXX
91120	26	A	Rectal sensation test	0.97	0.34	0.34	0.07	1.38	1.38	XXX
91120	TC	A	Rectal sensation test	0.00	10.64	NA	0.04	10.68	NA	XXX
91122		A	Anal pressure record	1.77	5.10	NA	0.20	7.07	NA	000
91122	26	A	Anal pressure record	1.77	0.60	0.60	0.12	2.49	2.49	000
91122	TC	A	Anal pressure record	0.00	4.50	NA	0.08	4.58	NA	000
91123		B	Irrigate fecal impaction	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91132		C	Electrogastrography	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91132	26	A	Electrogastrography	0.52	0.18	0.18	0.03	0.73	0.73	XXX
91132	TC	C	Electrogastrography	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91133		C	Electrogastrography w/test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91133	26	A	Electrogastrography w/test	0.66	0.23	0.23	0.03	0.92	0.92	XXX
91133	TC	C	Electrogastrography w/test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91299		C	Gastroenterology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91299	26	C	Gastroenterology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91299	TC	C	Gastroenterology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92002		A	Eye exam, new patient	0.88	0.97	0.34	0.02	1.87	1.24	XXX
92004		A	Eye exam, new patient	1.67	1.70	0.68	0.04	3.41	2.39	XXX
92012		A	Eye exam established pat	0.67	1.03	0.29	0.02	1.72	0.98	XXX
92014		A	Eye exam & treatment	1.10	1.41	0.47	0.03	2.54	1.60	XXX
92015		N	Refraction	+0.38	1.49	0.15	0.01	1.88	0.54	XXX
92018		A	New eye exam & treatment	2.50	NA	1.07	0.07	NA	3.64	XXX
92019		A	Eye exam & treatment	1.31	NA	0.56	0.03	NA	1.90	XXX
92020		A	Special eye evaluation	0.37	0.34	0.16	0.01	0.72	0.54	XXX
92060		A	Special eye evaluation	0.69	0.73	NA	0.03	1.45	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
92060	26	A	Special eye evaluation	0.69	0.29	0.29	0.02	1.00	1.00	XXX
92060	TC	A	Special eye evaluation	0.00	0.44	NA	0.01	0.45	NA	XXX
92065		A	Orthoptic/pleoptic training	0.37	0.53	NA	0.02	0.92	NA	XXX
92065	26	A	Orthoptic/pleoptic training	0.37	0.15	0.15	0.01	0.53	0.53	XXX
92065	TC	A	Orthoptic/pleoptic training	0.00	0.38	NA	0.01	0.39	NA	XXX
92070		A	Fitting of contact lens	0.70	1.07	0.32	0.02	1.79	1.04	XXX
92081		A	Visual field examination(s)	0.36	0.94	NA	0.02	1.32	NA	XXX
92081	26	A	Visual field examination(s)	0.36	0.15	0.15	0.01	0.52	0.52	XXX
92081	TC	A	Visual field examination(s)	0.00	0.79	NA	0.01	0.80	NA	XXX
92082		A	Visual field examination(s)	0.44	1.23	NA	0.02	1.69	NA	XXX
92082	26	A	Visual field examination(s)	0.44	0.19	0.19	0.01	0.64	0.64	XXX
92082	TC	A	Visual field examination(s)	0.00	1.04	NA	0.01	1.05	NA	XXX
92083		A	Visual field examination(s)	0.50	1.43	NA	0.02	1.95	NA	XXX
92083	26	A	Visual field examination(s)	0.50	0.22	0.22	0.01	0.73	0.73	XXX
92083	TC	A	Visual field examination(s)	0.00	1.21	NA	0.01	1.22	NA	XXX
92100		A	Serial tonometry exam(s)	0.92	1.35	0.36	0.02	2.29	1.30	XXX
92120		A	Tonography & eye evaluation	0.81	1.07	0.32	0.02	1.90	1.15	XXX
92130		A	Water provocation tonography	0.81	1.28	0.37	0.02	2.11	1.20	XXX
92135		A	Opthalmic dx imaging	0.35	0.79	NA	0.02	1.16	NA	XXX
92135	26	A	Opthalmic dx imaging	0.35	0.15	0.15	0.01	0.51	0.51	XXX
92135	TC	A	Opthalmic dx imaging	0.00	0.64	NA	0.01	0.65	NA	XXX
92136		A	Ophthalmic biometry	0.54	1.65	NA	0.08	2.27	NA	XXX
92136	26	A	Ophthalmic biometry	0.54	0.24	0.24	0.01	0.79	0.79	XXX
92136	TC	A	Ophthalmic biometry	0.00	1.41	NA	0.07	1.48	NA	XXX
92140		A	Glaucoma provocative tests	0.50	0.99	0.21	0.01	1.50	0.72	XXX
92225		A	Special eye exam, initial	0.38	0.22	0.16	0.01	0.61	0.55	XXX
92226		A	Special eye exam, subsequent	0.33	0.21	0.14	0.01	0.55	0.48	XXX
92230		A	Eye exam with photos	0.60	1.53	0.20	0.02	2.15	0.82	XXX
92235		A	Eye exam with photos	0.81	2.61	NA	0.08	3.50	NA	XXX
92235	26	A	Eye exam with photos	0.81	0.37	0.37	0.02	1.20	1.20	XXX
92235	TC	A	Eye exam with photos	0.00	2.24	NA	0.06	2.30	NA	XXX
92240		A	Icg angiography	1.10	6.10	NA	0.09	7.29	NA	XXX
92240	26	A	Icg angiography	1.10	0.50	0.50	0.03	1.63	1.63	XXX
92240	TC	A	Icg angiography	0.00	5.60	NA	0.06	5.66	NA	XXX
92250		A	Eye exam with photos	0.44	1.53	NA	0.02	1.99	NA	XXX
92250	26	A	Eye exam with photos	0.44	0.19	0.19	0.01	0.64	0.64	XXX
92250	TC	A	Eye exam with photos	0.00	1.34	NA	0.01	1.35	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
92260		A	Ophthalmoscopy/dynamometry	0.20	0.26	0.09	0.01	0.47	0.30	XXX
92265		A	Eye muscle evaluation	0.81	1.49	NA	0.06	2.36	NA	XXX
92265	26	A	Eye muscle evaluation	0.81	0.28	0.28	0.04	1.13	1.13	XXX
92265	TC	A	Eye muscle evaluation	0.00	1.21	NA	0.02	1.23	NA	XXX
92270		A	Electro-oculography	0.81	1.53	NA	0.05	2.39	NA	XXX
92270	26	A	Electro-oculography	0.81	0.33	0.33	0.03	1.17	1.17	XXX
92270	TC	A	Electro-oculography	0.00	1.20	NA	0.02	1.22	NA	XXX
92275		A	Electroretinography	1.01	1.94	NA	0.05	3.00	NA	XXX
92275	26	A	Electroretinography	1.01	0.43	0.43	0.03	1.47	1.47	XXX
92275	TC	A	Electroretinography	0.00	1.51	NA	0.02	1.53	NA	XXX
92283		A	Color vision examination	0.17	0.84	NA	0.02	1.03	NA	XXX
92283	26	A	Color vision examination	0.17	0.07	0.07	0.01	0.25	0.25	XXX
92283	TC	A	Color vision examination	0.00	0.77	NA	0.01	0.78	NA	XXX
92284		A	Dark adaptation eye exam	0.24	1.88	NA	0.02	2.14	NA	XXX
92284	26	A	Dark adaptation eye exam	0.24	0.08	0.08	0.01	0.33	0.33	XXX
92284	TC	A	Dark adaptation eye exam	0.00	1.80	NA	0.01	1.81	NA	XXX
92285		A	Eye photography	0.20	0.99	NA	0.02	1.21	NA	XXX
92285	26	A	Eye photography	0.20	0.09	0.09	0.01	0.30	0.30	XXX
92285	TC	A	Eye photography	0.00	0.90	NA	0.01	0.91	NA	XXX
92286		A	Internal eye photography	0.66	3.05	NA	0.04	3.75	NA	XXX
92286	26	A	Internal eye photography	0.66	0.29	0.29	0.02	0.97	0.97	XXX
92286	TC	A	Internal eye photography	0.00	2.76	NA	0.02	2.78	NA	XXX
92287		A	Internal eye photography	0.81	2.38	0.31	0.02	3.21	1.14	XXX
92310		N	Contact lens fitting	+1.17	1.12	0.45	0.04	2.33	1.66	XXX
92311		A	Contact lens fitting	1.08	1.09	0.35	0.03	2.20	1.46	XXX
92312		A	Contact lens fitting	1.26	1.08	0.50	0.03	2.37	1.79	XXX
92313		A	Contact lens fitting	0.92	1.06	0.29	0.02	2.00	1.23	XXX
92314		N	Prescription of contact lens	+0.69	0.94	0.27	0.01	1.64	0.97	XXX
92315		A	Prescription of contact lens	0.45	0.85	0.16	0.01	1.31	0.62	XXX
92316		A	Prescription of contact lens	0.68	0.91	0.29	0.02	1.61	0.99	XXX
92317		A	Prescription of contact lens	0.45	0.94	0.15	0.01	1.40	0.61	XXX
92325		A	Modification of contact lens	0.00	0.40	NA	0.01	0.41	NA	XXX
92326		A	Replacement of contact lens	0.00	1.63	NA	0.06	1.69	NA	XXX
92330		A	Fitting of artificial eye	1.08	0.99	0.32	0.03	2.10	1.43	XXX
92335		A	Fitting of artificial eye	0.45	0.90	0.16	0.01	1.36	0.62	XXX
92340		N	Fitting of spectacles	+0.37	0.70	0.14	0.01	1.08	0.52	XXX
92341		N	Fitting of spectacles	+0.47	0.74	0.18	0.01	1.22	0.66	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
92342		N	Fitting of spectacles	+0.53	0.76	0.21	0.01	1.30	0.75	XXX
92352		B	Special spectacles fitting	+0.37	0.68	0.14	0.01	1.06	0.52	XXX
92353		B	Special spectacles fitting	+0.50	0.73	0.19	0.02	1.25	0.71	XXX
92354		B	Special spectacles fitting	+0.00	8.86	NA	0.10	8.96	NA	XXX
92355		B	Special spectacles fitting	+0.00	4.33	NA	0.01	4.34	NA	XXX
92358		B	Eye prosthesis service	+0.00	0.97	NA	0.05	1.02	NA	XXX
92370		N	Repair & adjust spectacles	+0.32	0.55	0.13	0.02	0.89	0.47	XXX
92371		B	Repair & adjust spectacles	+0.00	0.62	NA	0.02	0.64	NA	XXX
92390		N	Supply of spectacles	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92391		N	Supply of contact lenses	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92392		I	Supply of low vision aids	+0.00	3.79	3.79	0.02	3.81	3.81	XXX
92393		I	Supply of artificial eye	+0.00	11.76	11.76	0.57	12.33	12.33	XXX
92395		I	Supply of spectacles	+0.00	1.28	1.28	0.10	1.38	1.38	XXX
92396		I	Supply of contact lenses	+0.00	2.16	2.16	0.07	2.23	2.23	XXX
92499		C	Eye service or procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92499	26	C	Eye service or procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92499	TC	C	Eye service or procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92502		A	Ear and throat examination	1.51	NA	1.11	0.05	NA	2.67	000
92504		A	Ear microscopy examination	0.18	0.50	0.09	0.01	0.69	0.28	XXX
92506		A	Speech/hearing evaluation	0.86	2.59	0.40	0.03	3.48	1.29	XXX
92507		A	Speech/hearing therapy	0.52	1.11	0.23	0.02	1.65	0.77	XXX
92508		A	Speech/hearing therapy	0.26	0.51	0.12	0.01	0.78	0.39	XXX
92510		I	Rehab for ear implant	+1.50	2.08	0.82	0.07	3.65	2.39	XXX
92511		A	Nasopharyngoscopy	0.84	3.31	0.78	0.03	4.18	1.65	000
92512		A	Nasal function studies	0.55	1.14	0.18	0.02	1.71	0.75	XXX
92516		A	Facial nerve function test	0.43	1.20	0.22	0.01	1.64	0.66	XXX
92520		A	Laryngeal function studies	0.76	0.51	0.39	0.03	1.30	1.18	XXX
92526		A	Oral function therapy	0.55	1.64	0.20	0.02	2.21	0.77	XXX
92531		B	Spontaneous nystagmus study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92532		B	Positional nystagmus test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92533		B	Caloric vestibular test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92534		B	Optokinetic nystagmus test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92541		A	Spontaneous nystagmus test	0.40	1.03	NA	0.04	1.47	NA	XXX
92541	26	A	Spontaneous nystagmus test	0.40	0.19	0.19	0.02	0.61	0.61	XXX
92541	TC	A	Spontaneous nystagmus test	0.00	0.84	NA	0.02	0.86	NA	XXX
92542		A	Positional nystagmus test	0.33	1.14	NA	0.03	1.50	NA	XXX
92542	26	A	Positional nystagmus test	0.33	0.16	0.16	0.01	0.50	0.50	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
92542	TC	A	Positional nystagmus test	0.00	0.98	NA	0.02	1.00	NA	XXX
92543		A	Caloric vestibular test	0.10	0.57	NA	0.02	0.69	NA	XXX
92543	26	A	Caloric vestibular test	0.10	0.05	0.05	0.01	0.16	0.16	XXX
92543	TC	A	Caloric vestibular test	0.00	0.52	NA	0.01	0.53	NA	XXX
92544		A	Optokinetic nystagmus test	0.26	0.90	NA	0.03	1.19	NA	XXX
92544	26	A	Optokinetic nystagmus test	0.26	0.12	0.12	0.01	0.39	0.39	XXX
92544	TC	A	Optokinetic nystagmus test	0.00	0.78	NA	0.02	0.80	NA	XXX
92545		A	Oscillating tracking test	0.23	0.80	NA	0.03	1.06	NA	XXX
92545	26	A	Oscillating tracking test	0.23	0.11	0.11	0.01	0.35	0.35	XXX
92545	TC	A	Oscillating tracking test	0.00	0.69	NA	0.02	0.71	NA	XXX
92546		A	Sinusoidal rotational test	0.29	1.98	NA	0.03	2.30	NA	XXX
92546	26	A	Sinusoidal rotational test	0.29	0.13	0.13	0.01	0.43	0.43	XXX
92546	TC	A	Sinusoidal rotational test	0.00	1.85	NA	0.02	1.87	NA	XXX
92547		A	Supplemental electrical test	0.00	0.08	NA	0.06	0.14	NA	ZZZ
92548		A	Posturography	0.50	2.25	NA	0.15	2.90	NA	XXX
92548	26	A	Posturography	0.50	0.26	0.26	0.02	0.78	0.78	XXX
92548	TC	A	Posturography	0.00	1.99	NA	0.13	2.12	NA	XXX
92551		N	Pure tone hearing test, air	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92552		A	Pure tone audiometry, air	0.00	0.44	NA	0.04	0.48	NA	XXX
92553		A	Audiometry, air & bone	0.00	0.66	NA	0.06	0.72	NA	XXX
92555		A	Speech threshold audiometry	0.00	0.38	NA	0.04	0.42	NA	XXX
92556		A	Speech audiometry, complete	0.00	0.57	NA	0.06	0.63	NA	XXX
92557		A	Comprehensive hearing test	0.00	1.19	NA	0.12	1.31	NA	XXX
92559		N	Group audiometric testing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92560		N	Bekesy audiometry, screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92561		A	Bekesy audiometry, diagnosis	0.00	0.72	NA	0.06	0.78	NA	XXX
92562		A	Loudness balance test	0.00	0.41	NA	0.04	0.45	NA	XXX
92563		A	Tone decay hearing test	0.00	0.38	NA	0.04	0.42	NA	XXX
92564		A	Sisi hearing test	0.00	0.47	NA	0.05	0.52	NA	XXX
92565		A	Stenger test, pure tone	0.00	0.40	NA	0.04	0.44	NA	XXX
92567		A	Tympanometry	0.00	0.52	NA	0.06	0.58	NA	XXX
92568		A	Acoustic reflex testing	0.00	0.38	NA	0.04	0.42	NA	XXX
92569		A	Acoustic reflex decay test	0.00	0.41	NA	0.04	0.45	NA	XXX
92571		A	Filtered speech hearing test	0.00	0.39	NA	0.04	0.43	NA	XXX
92572		A	Staggered spondaic word test	0.00	0.09	NA	0.01	0.10	NA	XXX
92573		A	Lombard test	0.00	0.35	NA	0.04	0.39	NA	XXX
92575		A	Sensorineural acuity test	0.00	0.30	NA	0.02	0.32	NA	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
92576		A	Synthetic sentence test	0.00	0.44	NA	0.05	0.49	NA	XXX
92577		A	Stenger test, speech	0.00	0.72	NA	0.07	0.79	NA	XXX
92579		A	Visual audiometry (vra)	0.00	0.73	NA	0.06	0.79	NA	XXX
92582		A	Conditioning play audiometry	0.00	0.73	NA	0.06	0.79	NA	XXX
92583		A	Select picture audiometry	0.00	0.89	NA	0.08	0.97	NA	XXX
92584		A	Electrocochleography	0.00	2.47	NA	0.21	2.68	NA	XXX
92585		A	Auditor evoke potent, compre	0.50	2.06	NA	0.17	2.73	NA	XXX
92585	26	A	Auditor evoke potent, compre	0.50	0.21	0.21	0.03	0.74	0.74	XXX
92585	TC	A	Auditor evoke potent, compre	0.00	1.85	NA	0.14	1.99	NA	XXX
92586		A	Auditor evoke potent, limit	0.00	1.85	NA	0.14	1.99	NA	XXX
92587		A	Evoked auditory test	0.13	1.37	NA	0.12	1.62	NA	XXX
92587	26	A	Evoked auditory test	0.13	0.06	0.06	0.01	0.20	0.20	XXX
92587	TC	A	Evoked auditory test	0.00	1.31	NA	0.11	1.42	NA	XXX
92588		A	Evoked auditory test	0.36	1.63	NA	0.14	2.13	NA	XXX
92588	26	A	Evoked auditory test	0.36	0.16	0.16	0.01	0.53	0.53	XXX
92588	TC	A	Evoked auditory test	0.00	1.47	NA	0.13	1.60	NA	XXX
92590		N	Hearing aid exam, one ear	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92591		N	Hearing aid exam, both ears	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92592		N	Hearing aid check, one ear	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92593		N	Hearing aid check, both ears	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92594		N	Electro hearng aid test, one	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92595		N	Electro hearng aid tst, both	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92596		A	Ear protector evaluation	0.00	0.59	NA	0.06	0.65	NA	XXX
92597		A	Oral speech device eval	0.86	1.69	0.45	0.03	2.58	1.34	XXX
92601		A	Cochlear implt f/up exam < 7	0.00	3.50	NA	0.07	3.57	NA	XXX
92602		A	Reprogram cochlear implt < 7	0.00	2.38	NA	0.07	2.45	NA	XXX
92603		A	Cochlear implt f/up exam 7 >	0.00	2.14	NA	0.07	2.21	NA	XXX
92604		A	Reprogram cochlear implt 7 >	0.00	1.35	NA	0.07	1.42	NA	XXX
92605		B	Eval for nonspeech device rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92606		B	Non-speech device service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92607		A	Ex for speech device rx, 1hr	0.00	3.08	NA	0.05	3.13	NA	XXX
92608		A	Ex for speech device rx addl	0.00	0.55	NA	0.05	0.60	NA	XXX
92609		A	Use of speech device service	0.00	1.59	NA	0.04	1.63	NA	XXX
92610		A	Evaluate swallowing function	0.00	3.43	NA	0.08	3.51	NA	XXX
92611		A	Motion fluoroscopy/swallow	0.00	3.43	NA	0.08	3.51	NA	XXX
92612		A	Endoscopy swallow tst (fees)	1.27	2.74	0.66	0.04	4.05	1.97	XXX
92613		A	Endoscopy swallow tst (fees)	0.71	0.40	0.39	0.05	1.16	1.15	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
92614		A	Laryngoscopic sensory test	1.27	2.50	0.66	0.04	3.81	1.97	XXX
92615		A	Eval laryngoscopy sense tst	0.63	0.35	0.35	0.05	1.03	1.03	XXX
92616		A	Fees w/laryngeal sense test	1.88	3.39	0.99	0.06	5.33	2.93	XXX
92617		A	Interprt fees/laryngeal test	0.79	0.44	0.44	0.05	1.28	1.28	XXX
92620		A	Auditory function, 60 min	0.00	1.14	NA	0.06	1.20	NA	XXX
92621		A	Auditory function, + 15 min	0.00	0.25	NA	0.06	0.31	NA	ZZZ
92625		A	Tinnitus assessment	0.00	1.12	NA	0.06	1.18	NA	XXX
92700		C	Ent procedure/service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92950		A	Heart/lung resuscitation cpr	3.79	4.20	0.97	0.26	8.25	5.02	000
92953		A	Temporary external pacing	0.23	NA	0.07	0.02	NA	0.32	000
92960		A	Cardioversion electric, ext	2.25	6.31	1.17	0.08	8.64	3.50	000
92961		A	Cardioversion, electric, int	4.59	NA	2.08	0.29	NA	6.96	000
92970		A	Cardioassist, internal	3.51	NA	1.06	0.19	NA	4.76	000
92971		A	Cardioassist, external	1.77	NA	0.85	0.06	NA	2.68	000
92973		A	Percut coronary thrombectomy	3.28	NA	1.29	0.23	NA	4.80	ZZZ
92974		A	Cath place, cardio brachytx	3.00	NA	1.18	0.21	NA	4.39	ZZZ
92975		A	Dissolve clot, heart vessel	7.24	NA	2.81	0.23	NA	10.28	000
92977		A	Dissolve clot, heart vessel	0.00	8.05	NA	0.46	8.51	NA	XXX
92978		A	Intravasc us, heart add-on	1.80	5.27	NA	0.30	7.37	NA	ZZZ
92978	26	A	Intravasc us, heart add-on	1.80	0.71	0.71	0.06	2.57	2.57	ZZZ
92978	TC	A	Intravasc us, heart add-on	0.00	4.56	NA	0.24	4.80	NA	ZZZ
92979		A	Intravasc us, heart add-on	1.44	2.85	NA	0.19	4.48	NA	ZZZ
92979	26	A	Intravasc us, heart add-on	1.44	0.56	0.56	0.06	2.06	2.06	ZZZ
92979	TC	A	Intravasc us, heart add-on	0.00	2.29	NA	0.13	2.42	NA	ZZZ
92980		A	Insert intracoronary stent	14.82	NA	6.05	0.48	NA	21.35	000
92981		A	Insert intracoronary stent	4.16	NA	1.63	0.13	NA	5.92	ZZZ
92982		A	Coronary artery dilation	10.96	NA	4.53	0.35	NA	15.84	000
92984		A	Coronary artery dilation	2.97	NA	1.16	0.09	NA	4.22	ZZZ
92986		A	Revision of aortic valve	21.77	NA	11.83	0.70	NA	34.30	090
92987		A	Revision of mitral valve	22.67	NA	12.21	0.72	NA	35.60	090
92990		A	Revision of pulmonary valve	17.31	NA	9.79	0.79	NA	27.89	090
92992		C	Revision of heart chamber	0.00	0.00	0.00	0.00	0.00	0.00	090
92993		C	Revision of heart chamber	0.00	0.00	0.00	0.00	0.00	0.00	090
92995		A	Coronary atherectomy	12.07	NA	4.96	0.39	NA	17.42	000
92996		A	Coronary atherectomy add-on	3.26	NA	1.27	0.10	NA	4.63	ZZZ
92997		A	Pul art balloon repr, percut	11.98	NA	4.82	0.46	NA	17.26	000
92998		A	Pul art balloon repr, percut	5.99	NA	2.20	0.28	NA	8.47	ZZZ

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
93000		A	Electrocardiogram, complete	0.17	0.51	NA	0.03	0.71	NA	XXX
93005		A	Electrocardiogram, tracing	0.00	0.45	NA	0.02	0.47	NA	XXX
93010		A	Electrocardiogram report	0.17	0.06	0.06	0.01	0.24	0.24	XXX
93012		A	Transmission of ecg	0.00	6.01	NA	0.18	6.19	NA	XXX
93014		A	Report on transmitted ecg	0.52	0.19	0.19	0.02	0.73	0.73	XXX
93015		A	Cardiovascular stress test	0.75	1.96	NA	0.14	2.85	NA	XXX
93016		A	Cardiovascular stress test	0.45	0.17	0.17	0.02	0.64	0.64	XXX
93017		A	Cardiovascular stress test	0.00	1.68	NA	0.11	1.79	NA	XXX
93018		A	Cardiovascular stress test	0.30	0.11	0.11	0.01	0.42	0.42	XXX
93024		A	Cardiac drug stress test	1.17	1.57	NA	0.13	2.87	NA	XXX
93024	26	A	Cardiac drug stress test	1.17	0.45	0.45	0.05	1.67	1.67	XXX
93024	TC	A	Cardiac drug stress test	0.00	1.12	NA	0.08	1.20	NA	XXX
93025		A	Microvolt t-wave assess	0.75	7.59	NA	0.14	8.48	NA	XXX
93025	26	A	Microvolt t-wave assess	0.75	0.29	0.29	0.03	1.07	1.07	XXX
93025	TC	A	Microvolt t-wave assess	0.00	7.30	NA	0.11	7.41	NA	XXX
93040		A	Rhythm ECG with report	0.16	0.20	NA	0.02	0.38	NA	XXX
93041		A	Rhythm ECG, tracing	0.00	0.15	NA	0.01	0.16	NA	XXX
93042		A	Rhythm ECG, report	0.16	0.05	0.05	0.01	0.22	0.22	XXX
93224		A	ECG monitor/report, 24 hrs	0.52	3.61	NA	0.24	4.37	NA	XXX
93225		A	ECG monitor/record, 24 hrs	0.00	1.24	NA	0.08	1.32	NA	XXX
93226		A	ECG monitor/report, 24 hrs	0.00	2.18	NA	0.14	2.32	NA	XXX
93227		A	ECG monitor/review, 24 hrs	0.52	0.19	0.19	0.02	0.73	0.73	XXX
93230		A	ECG monitor/report, 24 hrs	0.52	3.89	NA	0.26	4.67	NA	XXX
93231		A	Ecg monitor/record, 24 hrs	0.00	1.52	NA	0.11	1.63	NA	XXX
93232		A	ECG monitor/report, 24 hrs	0.00	2.18	NA	0.13	2.31	NA	XXX
93233		A	ECG monitor/review, 24 hrs	0.52	0.19	0.19	0.02	0.73	0.73	XXX
93235		A	ECG monitor/report, 24 hrs	0.45	2.78	NA	0.16	3.39	NA	XXX
93236		A	ECG monitor/report, 24 hrs	0.00	2.62	NA	0.14	2.76	NA	XXX
93237		A	ECG monitor/review, 24 hrs	0.45	0.16	0.16	0.02	0.63	0.63	XXX
93268		A	ECG record/review	0.52	7.44	NA	0.28	8.24	NA	XXX
93270		A	ECG recording	0.00	1.24	NA	0.08	1.32	NA	XXX
93271		A	Ecg/monitoring and analysis	0.00	6.01	NA	0.18	6.19	NA	XXX
93272		A	Ecg/review, interpret only	0.52	0.19	0.19	0.02	0.73	0.73	XXX
93278		A	ECG/signal-averaged	0.25	1.25	NA	0.12	1.62	NA	XXX
93278	26	A	ECG/signal-averaged	0.25	0.10	0.10	0.01	0.36	0.36	XXX
93278	TC	A	ECG/signal-averaged	0.00	1.15	NA	0.11	1.26	NA	XXX
93303		A	Echo transthoracic	1.30	4.34	NA	0.27	5.91	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
93303	26	A	Echo transthoracic	1.30	0.48	0.48	0.04	1.82	1.82	XXX
93303	TC	A	Echo transthoracic	0.00	3.86	NA	0.23	4.09	NA	XXX
93304		A	Echo transthoracic	0.75	2.22	NA	0.16	3.13	NA	XXX
93304	26	A	Echo transthoracic	0.75	0.28	0.28	0.03	1.06	1.06	XXX
93304	TC	A	Echo transthoracic	0.00	1.94	NA	0.13	2.07	NA	XXX
93307		A	Echo exam of heart	0.92	4.21	NA	0.26	5.39	NA	XXX
93307	26	A	Echo exam of heart	0.92	0.35	0.35	0.03	1.30	1.30	XXX
93307	TC	A	Echo exam of heart	0.00	3.86	NA	0.23	4.09	NA	XXX
93308		A	Echo exam of heart	0.53	2.14	NA	0.15	2.82	NA	XXX
93308	26	A	Echo exam of heart	0.53	0.20	0.20	0.02	0.75	0.75	XXX
93308	TC	A	Echo exam of heart	0.00	1.94	NA	0.13	2.07	NA	XXX
93312		A	Echo transesophageal	2.20	4.57	NA	0.37	7.14	NA	XXX
93312	26	A	Echo transesophageal	2.20	0.79	0.79	0.08	3.07	3.07	XXX
93312	TC	A	Echo transesophageal	0.00	3.78	NA	0.29	4.07	NA	XXX
93313		A	Echo transesophageal	0.95	NA	0.21	0.06	NA	1.22	XXX
93314		A	Echo transesophageal	1.25	4.25	NA	0.34	5.84	NA	XXX
93314	26	A	Echo transesophageal	1.25	0.47	0.47	0.05	1.77	1.77	XXX
93314	TC	A	Echo transesophageal	0.00	3.78	NA	0.29	4.07	NA	XXX
93315		C	Echo transesophageal	0.00	0.00	NA	0.00	0.00	NA	XXX
93315	26	A	Echo transesophageal	2.78	1.01	1.01	0.11	3.90	3.90	XXX
93315	TC	C	Echo transesophageal	0.00	0.00	NA	0.00	0.00	NA	XXX
93316		A	Echo transesophageal	0.95	NA	0.24	0.05	NA	1.24	XXX
93317		C	Echo transesophageal	0.00	0.00	NA	0.00	0.00	NA	XXX
93317	26	A	Echo transesophageal	1.83	0.67	0.67	0.08	2.58	2.58	XXX
93317	TC	C	Echo transesophageal	0.00	0.00	NA	0.00	0.00	NA	XXX
93318		C	Echo transesophageal intraop	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93318	26	A	Echo transesophageal intraop	2.20	0.48	0.48	0.14	2.82	2.82	XXX
93318	TC	C	Echo transesophageal intraop	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93320		A	Doppler echo exam, heart	0.38	1.86	NA	0.13	2.37	NA	ZZZ
93320	26	A	Doppler echo exam, heart	0.38	0.15	0.15	0.01	0.54	0.54	ZZZ
93320	TC	A	Doppler echo exam, heart	0.00	1.71	NA	0.12	1.83	NA	ZZZ
93321		A	Doppler echo exam, heart	0.15	1.17	NA	0.09	1.41	NA	ZZZ
93321	26	A	Doppler echo exam, heart	0.15	0.06	0.06	0.01	0.22	0.22	ZZZ
93321	TC	A	Doppler echo exam, heart	0.00	1.11	NA	0.08	1.19	NA	ZZZ
93325		A	Doppler color flow add-on	0.07	2.93	NA	0.22	3.22	NA	ZZZ
93325	26	A	Doppler color flow add-on	0.07	0.03	0.03	0.01	0.11	0.11	ZZZ
93325	TC	A	Doppler color flow add-on	0.00	2.90	NA	0.21	3.11	NA	ZZZ

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
93350		A	Echo transthoracic	1.48	2.33	NA	0.18	3.99	NA	XXX
93350	26	A	Echo transthoracic	1.48	0.57	0.57	0.05	2.10	2.10	XXX
93350	TC	A	Echo transthoracic	0.00	1.76	NA	0.13	1.89	NA	XXX
93501		A	Right heart catheterization	3.02	18.05	NA	1.26	22.33	NA	000
93501	26	A	Right heart catheterization	3.02	1.15	1.15	0.21	4.38	4.38	000
93501	TC	A	Right heart catheterization	0.00	16.90	NA	1.05	17.95	NA	000
93503		A	Insert/place heart catheter	2.91	NA	0.68	0.20	NA	3.79	000
93505		A	Biopsy of heart lining	4.37	3.66	NA	0.48	8.51	NA	000
93505	26	A	Biopsy of heart lining	4.37	1.68	1.68	0.32	6.37	6.37	000
93505	TC	A	Biopsy of heart lining	0.00	1.98	NA	0.16	2.14	NA	000
93508		A	Cath placement, angiography	4.09	14.68	NA	0.93	19.70	NA	000
93508	26	A	Cath placement, angiography	4.09	2.08	2.08	0.28	6.45	6.45	000
93508	TC	A	Cath placement, angiography	0.00	12.60	NA	0.65	13.25	NA	000
93510		A	Left heart catheterization	4.32	39.12	NA	2.60	46.04	NA	000
93510	26	A	Left heart catheterization	4.32	2.17	2.17	0.30	6.79	6.79	000
93510	TC	A	Left heart catheterization	0.00	36.95	NA	2.30	39.25	NA	000
93511		A	Left heart catheterization	5.02	38.41	NA	2.58	46.01	NA	000
93511	26	A	Left heart catheterization	5.02	2.44	2.44	0.35	7.81	7.81	000
93511	TC	A	Left heart catheterization	0.00	35.97	NA	2.23	38.20	NA	000
93514		A	Left heart catheterization	7.04	39.09	NA	2.72	48.85	NA	000
93514	26	A	Left heart catheterization	7.04	3.12	3.12	0.49	10.65	10.65	000
93514	TC	A	Left heart catheterization	0.00	35.97	NA	2.23	38.20	NA	000
93524		A	Left heart catheterization	6.94	50.17	NA	3.41	60.52	NA	000
93524	26	A	Left heart catheterization	6.94	3.17	3.17	0.48	10.59	10.59	000
93524	TC	A	Left heart catheterization	0.00	47.00	NA	2.93	49.93	NA	000
93526		A	Rt & Lt heart catheters	5.98	51.10	NA	3.43	60.51	NA	000
93526	26	A	Rt & Lt heart catheters	5.98	2.81	2.81	0.41	9.20	9.20	000
93526	TC	A	Rt & Lt heart catheters	0.00	48.29	NA	3.02	51.31	NA	000
93527		A	Rt & Lt heart catheters	7.27	50.31	NA	3.43	61.01	NA	000
93527	26	A	Rt & Lt heart catheters	7.27	3.31	3.31	0.50	11.08	11.08	000
93527	TC	A	Rt & Lt heart catheters	0.00	47.00	NA	2.93	49.93	NA	000
93528		A	Rt & Lt heart catheters	8.99	51.03	NA	3.55	63.57	NA	000
93528	26	A	Rt & Lt heart catheters	8.99	4.03	4.03	0.62	13.64	13.64	000
93528	TC	A	Rt & Lt heart catheters	0.00	47.00	NA	2.93	49.93	NA	000
93529		A	Rt, lt heart catheterization	4.79	49.27	NA	3.26	57.32	NA	000
93529	26	A	Rt, lt heart catheterization	4.79	2.27	2.27	0.33	7.39	7.39	000
93529	TC	A	Rt, lt heart catheterization	0.00	47.00	NA	2.93	49.93	NA	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
93530		A	Rt heart cath, congenital	4.22	18.83	NA	1.34	24.39	NA	000
93530	26	A	Rt heart cath, congenital	4.22	1.93	1.93	0.29	6.44	6.44	000
93530	TC	A	Rt heart cath, congenital	0.00	16.90	NA	1.05	17.95	NA	000
93531		A	R & I heart cath, congenital	8.34	51.87	NA	3.60	63.81	NA	000
93531	26	A	R & I heart cath, congenital	8.34	3.58	3.58	0.58	12.50	12.50	000
93531	TC	A	R & I heart cath, congenital	0.00	48.29	NA	3.02	51.31	NA	000
93532		A	R & I heart cath, congenital	9.99	51.25	NA	3.62	64.86	NA	000
93532	26	A	R & I heart cath, congenital	9.99	4.25	4.25	0.69	14.93	14.93	000
93532	TC	A	R & I heart cath, congenital	0.00	47.00	NA	2.93	49.93	NA	000
93533		A	R & I heart cath, congenital	6.69	49.79	NA	3.39	59.87	NA	000
93533	26	A	R & I heart cath, congenital	6.69	2.79	2.79	0.46	9.94	9.94	000
93533	TC	A	R & I heart cath, congenital	0.00	47.00	NA	2.93	49.93	NA	000
93539		A	Injection, cardiac cath	0.40	NA	0.16	0.01	NA	0.57	000
93540		A	Injection, cardiac cath	0.43	NA	0.17	0.01	NA	0.61	000
93541		A	Injection for lung angiogram	0.29	NA	0.11	0.01	NA	0.41	000
93542		A	Injection for heart x-rays	0.29	NA	0.11	0.01	NA	0.41	000
93543		A	Injection for heart x-rays	0.29	NA	0.11	0.01	NA	0.41	000
93544		A	Injection for aortography	0.25	NA	0.10	0.01	NA	0.36	000
93545		A	Inject for coronary x-rays	0.40	NA	0.16	0.01	NA	0.57	000
93555		A	Imaging, cardiac cath	0.81	6.59	NA	0.37	7.77	NA	XXX
93555	26	A	Imaging, cardiac cath	0.81	0.32	0.32	0.03	1.16	1.16	XXX
93555	TC	A	Imaging, cardiac cath	0.00	6.27	NA	0.34	6.61	NA	XXX
93556		A	Imaging, cardiac cath	0.83	10.21	NA	0.54	11.58	NA	XXX
93556	26	A	Imaging, cardiac cath	0.83	0.32	0.32	0.03	1.18	1.18	XXX
93556	TC	A	Imaging, cardiac cath	0.00	9.89	NA	0.51	10.40	NA	XXX
93561		A	Cardiac output measurement	0.50	0.68	NA	0.09	1.27	NA	000
93561	26	A	Cardiac output measurement	0.50	0.16	0.16	0.03	0.69	0.69	000
93561	TC	A	Cardiac output measurement	0.00	0.52	NA	0.06	0.58	NA	000
93562		A	Cardiac output measurement	0.16	0.37	NA	0.05	0.58	NA	000
93562	26	A	Cardiac output measurement	0.16	0.05	0.05	0.01	0.22	0.22	000
93562	TC	A	Cardiac output measurement	0.00	0.32	NA	0.04	0.36	NA	000
93571		A	Heart flow reserve measure	1.80	5.24	NA	0.30	7.34	NA	ZZZ
93571	26	A	Heart flow reserve measure	1.80	0.68	0.68	0.06	2.54	2.54	ZZZ
93571	TC	A	Heart flow reserve measure	0.00	4.56	NA	0.24	4.80	NA	ZZZ
93572		A	Heart flow reserve measure	1.44	2.79	NA	0.18	4.41	NA	ZZZ
93572	26	A	Heart flow reserve measure	1.44	0.50	0.50	0.05	1.99	1.99	ZZZ
93572	TC	A	Heart flow reserve measure	0.00	2.29	NA	0.13	2.42	NA	ZZZ

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
93580		A	Transcath closure of asd	17.97	NA	7.38	1.25	NA	26.60	000
93581		A	Transcath closure of vsd	24.39	NA	9.39	1.69	NA	35.47	000
93600		A	Bundle of His recording	2.12	2.78	NA	0.29	5.19	NA	000
93600	26	A	Bundle of His recording	2.12	0.83	0.83	0.16	3.11	3.11	000
93600	TC	A	Bundle of His recording	0.00	1.95	NA	0.13	2.08	NA	000
93602		A	Intra-atrial recording	2.12	1.93	NA	0.24	4.29	NA	000
93602	26	A	Intra-atrial recording	2.12	0.82	0.82	0.17	3.11	3.11	000
93602	TC	A	Intra-atrial recording	0.00	1.11	NA	0.07	1.18	NA	000
93603		A	Right ventricular recording	2.12	2.49	NA	0.29	4.90	NA	000
93603	26	A	Right ventricular recording	2.12	0.81	0.81	0.18	3.11	3.11	000
93603	TC	A	Right ventricular recording	0.00	1.68	NA	0.11	1.79	NA	000
93609		A	Map tachycardia, add-on	4.99	4.67	NA	0.52	10.18	NA	ZZZ
93609	26	A	Map tachycardia, add-on	4.99	1.95	1.95	0.35	7.29	7.29	ZZZ
93609	TC	A	Map tachycardia, add-on	0.00	2.72	NA	0.17	2.89	NA	ZZZ
93610		A	Intra-atrial pacing	3.02	2.51	NA	0.35	5.88	NA	000
93610	26	A	Intra-atrial pacing	3.02	1.16	1.16	0.25	4.43	4.43	000
93610	TC	A	Intra-atrial pacing	0.00	1.35	NA	0.10	1.45	NA	000
93612		A	Intraventricular pacing	3.02	2.77	NA	0.36	6.15	NA	000
93612	26	A	Intraventricular pacing	3.02	1.16	1.16	0.25	4.43	4.43	000
93612	TC	A	Intraventricular pacing	0.00	1.61	NA	0.11	1.72	NA	000
93613		A	Electrophys map 3d, add-on	6.99	NA	2.76	0.48	NA	10.23	ZZZ
93615		A	Esophageal recording	0.99	0.59	NA	0.05	1.63	NA	000
93615	26	A	Esophageal recording	0.99	0.27	0.27	0.03	1.29	1.29	000
93615	TC	A	Esophageal recording	0.00	0.32	NA	0.02	0.34	NA	000
93616		A	Esophageal recording	1.49	0.75	NA	0.11	2.35	NA	000
93616	26	A	Esophageal recording	1.49	0.43	0.43	0.09	2.01	2.01	000
93616	TC	A	Esophageal recording	0.00	0.32	NA	0.02	0.34	NA	000
93618		A	Heart rhythm pacing	4.25	5.63	NA	0.38	10.26	NA	000
93618	26	A	Heart rhythm pacing	4.25	1.67	1.67	0.14	6.06	6.06	000
93618	TC	A	Heart rhythm pacing	0.00	3.96	NA	0.24	4.20	NA	000
93619		A	Electrophysiology evaluation	7.31	10.88	NA	0.71	18.90	NA	000
93619	26	A	Electrophysiology evaluation	7.31	3.18	3.18	0.24	10.73	10.73	000
93619	TC	A	Electrophysiology evaluation	0.00	7.70	NA	0.47	8.17	NA	000
93620		C	Electrophysiology evaluation	0.00	0.00	NA	0.00	0.00	NA	000
93620	26	A	Electrophysiology evaluation	11.57	4.84	4.84	0.38	16.79	16.79	000
93620	TC	C	Electrophysiology evaluation	0.00	0.00	NA	0.00	0.00	NA	000
93621		C	Electrophysiology evaluation	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
93621	26	A	Electrophysiology evaluation	2.10	0.82	0.82	0.07	2.99	2.99	ZZZ
93621	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
93622		C	Electrophysiology evaluation	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
93622	26	A	Electrophysiology evaluation	3.10	1.21	1.21	0.10	4.41	4.41	ZZZ
93622	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
93623		C	Stimulation, pacing heart	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
93623	26	A	Stimulation, pacing heart	2.85	1.11	1.11	0.09	4.05	4.05	ZZZ
93623	TC	C	Stimulation, pacing heart	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
93624		A	Electrophysiologic study	4.80	4.17	NA	0.28	9.25	NA	000
93624	26	A	Electrophysiologic study	4.80	2.19	2.19	0.15	7.14	7.14	000
93624	TC	A	Electrophysiologic study	0.00	1.98	NA	0.13	2.11	NA	000
93631		A	Heart pacing, mapping	7.59	8.92	NA	1.49	18.00	NA	000
93631	26	A	Heart pacing, mapping	7.59	2.77	2.77	0.87	11.23	11.23	000
93631	TC	A	Heart pacing, mapping	0.00	6.15	NA	0.62	6.77	NA	000
93640		A	Evaluation heart device	3.51	8.53	NA	0.54	12.58	NA	000
93640	26	A	Evaluation heart device	3.51	1.36	1.36	0.12	4.99	4.99	000
93640	TC	A	Evaluation heart device	0.00	7.17	NA	0.42	7.59	NA	000
93641		A	Electrophysiology evaluation	5.92	9.48	NA	0.62	16.02	NA	000
93641	26	A	Electrophysiology evaluation	5.92	2.31	2.31	0.20	8.43	8.43	000
93641	TC	A	Electrophysiology evaluation	0.00	7.17	NA	0.42	7.59	NA	000
93642		A	Electrophysiology evaluation	4.88	9.38	NA	0.58	14.84	NA	000
93642	26	A	Electrophysiology evaluation	4.88	2.21	2.21	0.16	7.25	7.25	000
93642	TC	A	Electrophysiology evaluation	0.00	7.17	NA	0.42	7.59	NA	000
93650		A	Ablate heart dysrhythm focus	10.49	NA	4.43	0.73	NA	15.65	000
93651		A	Ablate heart dysrhythm focus	16.23	NA	6.32	1.12	NA	23.67	000
93652		A	Ablate heart dysrhythm focus	17.65	NA	6.88	1.22	NA	25.75	000
93660		A	Tilt table evaluation	1.89	2.42	NA	0.08	4.39	NA	000
93660	26	A	Tilt table evaluation	1.89	0.74	0.74	0.06	2.69	2.69	000
93660	TC	A	Tilt table evaluation	0.00	1.68	NA	0.02	1.70	NA	000
93662		C	Intracardiac ecg (ice)	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
93662	26	A	Intracardiac ecg (ice)	2.80	1.11	1.11	0.09	4.00	4.00	ZZZ
93662	TC	C	Intracardiac ecg (ice)	0.00	0.00	NA	0.00	0.00	NA	ZZZ
93668		N	Peripheral vascular rehab	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93701		A	Bioimpedance, thoracic	0.17	0.98	NA	0.02	1.17	NA	XXX
93701	26	A	Bioimpedance, thoracic	0.17	0.07	0.07	0.01	0.25	0.25	XXX
93701	TC	A	Bioimpedance, thoracic	0.00	0.91	NA	0.01	0.92	NA	XXX
93720		A	Total body plethysmography	0.17	0.76	NA	0.07	1.00	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
93721		A	Plethysmography tracing	0.00	0.71	NA	0.06	0.77	NA	XXX
93722		A	Plethysmography report	0.17	0.05	0.05	0.01	0.23	0.23	XXX
93724		A	Analyze pacemaker system	4.88	5.87	NA	0.40	11.15	NA	000
93724	26	A	Analyze pacemaker system	4.88	1.91	1.91	0.16	6.95	6.95	000
93724	TC	A	Analyze pacemaker system	0.00	3.96	NA	0.24	4.20	NA	000
93727		A	Analyze ilr system	0.52	0.20	0.20	0.02	0.74	0.74	XXX
93731		A	Analyze pacemaker system	0.45	0.66	NA	0.06	1.17	NA	XXX
93731	26	A	Analyze pacemaker system	0.45	0.17	0.17	0.02	0.64	0.64	XXX
93731	TC	A	Analyze pacemaker system	0.00	0.49	NA	0.04	0.53	NA	XXX
93732		A	Analyze pacemaker system	0.92	0.86	NA	0.07	1.85	NA	XXX
93732	26	A	Analyze pacemaker system	0.92	0.35	0.35	0.03	1.30	1.30	XXX
93732	TC	A	Analyze pacemaker system	0.00	0.51	NA	0.04	0.55	NA	XXX
93733		A	Telephone analy, pacemaker	0.17	0.80	NA	0.07	1.04	NA	XXX
93733	26	A	Telephone analy, pacemaker	0.17	0.07	0.07	0.01	0.25	0.25	XXX
93733	TC	A	Telephone analy, pacemaker	0.00	0.73	NA	0.06	0.79	NA	XXX
93734		A	Analyze pacemaker system	0.38	0.50	NA	0.03	0.91	NA	XXX
93734	26	A	Analyze pacemaker system	0.38	0.15	0.15	0.01	0.54	0.54	XXX
93734	TC	A	Analyze pacemaker system	0.00	0.35	NA	0.02	0.37	NA	XXX
93735		A	Analyze pacemaker system	0.74	0.72	NA	0.07	1.53	NA	XXX
93735	26	A	Analyze pacemaker system	0.74	0.28	0.28	0.03	1.05	1.05	XXX
93735	TC	A	Analyze pacemaker system	0.00	0.44	NA	0.04	0.48	NA	XXX
93736		A	Telephonic analy, pacemaker	0.15	0.69	NA	0.07	0.91	NA	XXX
93736	26	A	Telephonic analy, pacemaker	0.15	0.06	0.06	0.01	0.22	0.22	XXX
93736	TC	A	Telephonic analy, pacemaker	0.00	0.63	NA	0.06	0.69	NA	XXX
93740		B	Temperature gradient studies	+0.16	0.19	NA	0.02	0.37	NA	XXX
93740	26	B	Temperature gradient studies	+0.16	0.04	0.04	0.01	0.21	0.21	XXX
93740	TC	B	Temperature gradient studies	+0.00	0.15	NA	0.01	0.16	NA	XXX
93741		A	Analyze ht pace device sngl	0.80	0.98	NA	0.07	1.85	NA	XXX
93741	26	A	Analyze ht pace device sngl	0.80	0.31	0.31	0.03	1.14	1.14	XXX
93741	TC	A	Analyze ht pace device sngl	0.00	0.67	NA	0.04	0.71	NA	XXX
93742		A	Analyze ht pace device sngl	0.91	1.03	NA	0.07	2.01	NA	XXX
93742	26	A	Analyze ht pace device sngl	0.91	0.36	0.36	0.03	1.30	1.30	XXX
93742	TC	A	Analyze ht pace device sngl	0.00	0.67	NA	0.04	0.71	NA	XXX
93743		A	Analyze ht pace device dual	1.03	1.13	NA	0.08	2.24	NA	XXX
93743	26	A	Analyze ht pace device dual	1.03	0.40	0.40	0.04	1.47	1.47	XXX
93743	TC	A	Analyze ht pace device dual	0.00	0.73	NA	0.04	0.77	NA	XXX
93744		A	Analyze ht pace device dual	1.18	1.13	NA	0.08	2.39	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
93744	26	A	Analyze ht pace device dual	1.18	0.46	0.46	0.04	1.68	1.68	XXX
93744	TC	A	Analyze ht pace device dual	0.00	0.67	NA	0.04	0.71	NA	XXX
93745		C	Set-up cardiovert-defibrill	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93745	26	C	Set-up cardiovert-defibrill	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93745	TC	C	Set-up cardiovert-defibrill	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93760		N	Cephalic thermogram	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93762		N	Peripheral thermogram	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93770		B	Measure venous pressure	+0.16	0.08	NA	0.02	0.26	NA	XXX
93770	26	B	Measure venous pressure	+0.16	0.05	0.05	0.01	0.22	0.22	XXX
93770	TC	B	Measure venous pressure	+0.00	0.03	NA	0.01	0.04	NA	XXX
93784		A	Ambulatory BP monitoring	0.38	1.55	NA	0.03	1.96	NA	XXX
93786		A	Ambulatory BP recording	0.00	0.91	NA	0.01	0.92	NA	XXX
93788		A	Ambulatory BP analysis	0.00	0.51	NA	0.01	0.52	NA	XXX
93790		A	Review/report BP recording	0.38	0.13	0.13	0.01	0.52	0.52	XXX
93797		A	Cardiac rehab	0.18	0.30	0.07	0.01	0.49	0.26	000
93798		A	Cardiac rehab/monitor	0.28	0.46	0.11	0.01	0.75	0.40	000
93799		C	Cardiovascular procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93799	26	C	Cardiovascular procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93799	TC	C	Cardiovascular procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93875		A	Extracranial study	0.22	2.33	NA	0.12	2.67	NA	XXX
93875	26	A	Extracranial study	0.22	0.08	0.08	0.01	0.31	0.31	XXX
93875	TC	A	Extracranial study	0.00	2.25	NA	0.11	2.36	NA	XXX
93880		A	Extracranial study	0.60	5.55	NA	0.39	6.54	NA	XXX
93880	26	A	Extracranial study	0.60	0.20	0.20	0.04	0.84	0.84	XXX
93880	TC	A	Extracranial study	0.00	5.35	NA	0.35	5.70	NA	XXX
93882		A	Extracranial study	0.40	3.50	NA	0.26	4.16	NA	XXX
93882	26	A	Extracranial study	0.40	0.14	0.14	0.04	0.58	0.58	XXX
93882	TC	A	Extracranial study	0.00	3.36	NA	0.22	3.58	NA	XXX
93886		A	Intracranial study	0.94	6.74	NA	0.45	8.13	NA	XXX
93886	26	A	Intracranial study	0.94	0.37	0.37	0.06	1.37	1.37	XXX
93886	TC	A	Intracranial study	0.00	6.37	NA	0.39	6.76	NA	XXX
93888		A	Intracranial study	0.62	4.24	NA	0.32	5.18	NA	XXX
93888	26	A	Intracranial study	0.62	0.23	0.23	0.05	0.90	0.90	XXX
93888	TC	A	Intracranial study	0.00	4.01	NA	0.27	4.28	NA	XXX
93890		A	Tcd, vasoreactivity study	1.00	4.90	NA	0.45	6.35	NA	XXX
93890	26	A	Tcd, vasoreactivity study	1.00	0.40	0.40	0.06	1.46	1.46	XXX
93890	TC	A	Tcd, vasoreactivity study	0.00	4.50	NA	0.39	4.89	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
93892		A	Tcd, emboli detect w/o inj	1.15	5.16	NA	0.45	6.76	NA	XXX
93892	26	A	Tcd, emboli detect w/o inj	1.15	0.46	0.46	0.06	1.67	1.67	XXX
93892	TC	A	Tcd, emboli detect w/o inj	0.00	4.70	NA	0.39	5.09	NA	XXX
93893		A	Tcd, emboli detect w/inj	1.15	5.03	NA	0.45	6.63	NA	XXX
93893	26	A	Tcd, emboli detect w/inj	1.15	0.46	0.46	0.06	1.67	1.67	XXX
93893	TC	A	Tcd, emboli detect w/inj	0.00	4.57	NA	0.39	4.96	NA	XXX
93922		A	Extremity study	0.25	2.68	NA	0.15	3.08	NA	XXX
93922	26	A	Extremity study	0.25	0.08	0.08	0.02	0.35	0.35	XXX
93922	TC	A	Extremity study	0.00	2.60	NA	0.13	2.73	NA	XXX
93923		A	Extremity study	0.45	4.03	NA	0.26	4.74	NA	XXX
93923	26	A	Extremity study	0.45	0.15	0.15	0.04	0.64	0.64	XXX
93923	TC	A	Extremity study	0.00	3.88	NA	0.22	4.10	NA	XXX
93924		A	Extremity study	0.50	4.79	NA	0.30	5.59	NA	XXX
93924	26	A	Extremity study	0.50	0.17	0.17	0.05	0.72	0.72	XXX
93924	TC	A	Extremity study	0.00	4.62	NA	0.25	4.87	NA	XXX
93925		A	Lower extremity study	0.58	6.78	NA	0.39	7.75	NA	XXX
93925	26	A	Lower extremity study	0.58	0.20	0.20	0.04	0.82	0.82	XXX
93925	TC	A	Lower extremity study	0.00	6.58	NA	0.35	6.93	NA	XXX
93926		A	Lower extremity study	0.39	4.05	NA	0.27	4.71	NA	XXX
93926	26	A	Lower extremity study	0.39	0.13	0.13	0.04	0.56	0.56	XXX
93926	TC	A	Lower extremity study	0.00	3.92	NA	0.23	4.15	NA	XXX
93930		A	Upper extremity study	0.46	5.35	NA	0.41	6.22	NA	XXX
93930	26	A	Upper extremity study	0.46	0.16	0.16	0.04	0.66	0.66	XXX
93930	TC	A	Upper extremity study	0.00	5.19	NA	0.37	5.56	NA	XXX
93931		A	Upper extremity study	0.31	3.48	NA	0.27	4.06	NA	XXX
93931	26	A	Upper extremity study	0.31	0.10	0.10	0.03	0.44	0.44	XXX
93931	TC	A	Upper extremity study	0.00	3.38	NA	0.24	3.62	NA	XXX
93965		A	Extremity study	0.35	2.79	NA	0.14	3.28	NA	XXX
93965	26	A	Extremity study	0.35	0.12	0.12	0.02	0.49	0.49	XXX
93965	TC	A	Extremity study	0.00	2.67	NA	0.12	2.79	NA	XXX
93970		A	Extremity study	0.68	5.25	NA	0.45	6.38	NA	XXX
93970	26	A	Extremity study	0.68	0.23	0.23	0.05	0.96	0.96	XXX
93970	TC	A	Extremity study	0.00	5.02	NA	0.40	5.42	NA	XXX
93971		A	Extremity study	0.45	3.59	NA	0.30	4.34	NA	XXX
93971	26	A	Extremity study	0.45	0.15	0.15	0.03	0.63	0.63	XXX
93971	TC	A	Extremity study	0.00	3.44	NA	0.27	3.71	NA	XXX
93975		A	Vascular study	1.80	7.63	NA	0.56	9.99	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
93975	26	A	Vascular study	1.80	0.60	0.60	0.13	2.53	2.53	XXX
93975	TC	A	Vascular study	0.00	7.03	NA	0.43	7.46	NA	XXX
93976		A	Vascular study	1.21	4.33	NA	0.36	5.90	NA	XXX
93976	26	A	Vascular study	1.21	0.40	0.40	0.06	1.67	1.67	XXX
93976	TC	A	Vascular study	0.00	3.93	NA	0.30	4.23	NA	XXX
93978		A	Vascular study	0.65	4.51	NA	0.43	5.59	NA	XXX
93978	26	A	Vascular study	0.65	0.22	0.22	0.06	0.93	0.93	XXX
93978	TC	A	Vascular study	0.00	4.29	NA	0.37	4.66	NA	XXX
93979		A	Vascular study	0.44	3.21	NA	0.27	3.92	NA	XXX
93979	26	A	Vascular study	0.44	0.15	0.15	0.03	0.62	0.62	XXX
93979	TC	A	Vascular study	0.00	3.06	NA	0.24	3.30	NA	XXX
93980		A	Penile vascular study	1.25	2.85	NA	0.42	4.52	NA	XXX
93980	26	A	Penile vascular study	1.25	0.41	0.41	0.08	1.74	1.74	XXX
93980	TC	A	Penile vascular study	0.00	2.44	NA	0.34	2.78	NA	XXX
93981		A	Penile vascular study	0.44	2.87	NA	0.33	3.64	NA	XXX
93981	26	A	Penile vascular study	0.44	0.14	0.14	0.02	0.60	0.60	XXX
93981	TC	A	Penile vascular study	0.00	2.73	NA	0.31	3.04	NA	XXX
93990		A	Doppler flow testing	0.25	3.99	NA	0.26	4.50	NA	XXX
93990	26	A	Doppler flow testing	0.25	0.09	0.09	0.03	0.37	0.37	XXX
93990	TC	A	Doppler flow testing	0.00	3.90	NA	0.23	4.13	NA	XXX
94010		A	Breathing capacity test	0.17	0.67	NA	0.03	0.87	NA	XXX
94010	26	A	Breathing capacity test	0.17	0.05	0.05	0.01	0.23	0.23	XXX
94010	TC	A	Breathing capacity test	0.00	0.62	NA	0.02	0.64	NA	XXX
94014		A	Patient recorded spirometry	0.52	0.76	NA	0.03	1.31	NA	XXX
94015		A	Patient recorded spirometry	0.00	0.59	NA	0.01	0.60	NA	XXX
94016		A	Review patient spirometry	0.52	0.17	0.17	0.02	0.71	0.71	XXX
94060		A	Evaluation of wheezing	0.31	1.07	NA	0.07	1.45	NA	XXX
94060	26	A	Evaluation of wheezing	0.31	0.09	0.09	0.01	0.41	0.41	XXX
94060	TC	A	Evaluation of wheezing	0.00	0.98	NA	0.06	1.04	NA	XXX
94070		A	Evaluation of wheezing	0.60	0.82	NA	0.13	1.55	NA	XXX
94070	26	A	Evaluation of wheezing	0.60	0.18	0.18	0.03	0.81	0.81	XXX
94070	TC	A	Evaluation of wheezing	0.00	0.64	NA	0.10	0.74	NA	XXX
94150		B	Vital capacity test	+0.07	0.47	NA	0.02	0.56	NA	XXX
94150	26	B	Vital capacity test	+0.07	0.03	0.03	0.01	0.11	0.11	XXX
94150	TC	B	Vital capacity test	+0.00	0.44	NA	0.01	0.45	NA	XXX
94200		A	Lung function test (MBC/MVV)	0.11	0.44	NA	0.03	0.58	NA	XXX
94200	26	A	Lung function test (MBC/MVV)	0.11	0.03	0.03	0.01	0.15	0.15	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
94200	TC	A	Lung function test (MBC/MVV)	0.00	0.41	NA	0.02	0.43	NA	XXX
94240		A	Residual lung capacity	0.26	0.66	NA	0.06	0.98	NA	XXX
94240	26	A	Residual lung capacity	0.26	0.08	0.08	0.01	0.35	0.35	XXX
94240	TC	A	Residual lung capacity	0.00	0.58	NA	0.05	0.63	NA	XXX
94250		A	Expired gas collection	0.11	0.64	NA	0.02	0.77	NA	XXX
94250	26	A	Expired gas collection	0.11	0.03	0.03	0.01	0.15	0.15	XXX
94250	TC	A	Expired gas collection	0.00	0.61	NA	0.01	0.62	NA	XXX
94260		A	Thoracic gas volume	0.13	0.58	NA	0.05	0.76	NA	XXX
94260	26	A	Thoracic gas volume	0.13	0.04	0.04	0.01	0.18	0.18	XXX
94260	TC	A	Thoracic gas volume	0.00	0.54	NA	0.04	0.58	NA	XXX
94350		A	Lung nitrogen washout curve	0.26	0.76	NA	0.05	1.07	NA	XXX
94350	26	A	Lung nitrogen washout curve	0.26	0.08	0.08	0.01	0.35	0.35	XXX
94350	TC	A	Lung nitrogen washout curve	0.00	0.68	NA	0.04	0.72	NA	XXX
94360		A	Measure airflow resistance	0.26	0.70	NA	0.07	1.03	NA	XXX
94360	26	A	Measure airflow resistance	0.26	0.08	0.08	0.01	0.35	0.35	XXX
94360	TC	A	Measure airflow resistance	0.00	0.62	NA	0.06	0.68	NA	XXX
94370		A	Breath airway closing volume	0.26	0.72	NA	0.03	1.01	NA	XXX
94370	26	A	Breath airway closing volume	0.26	0.08	0.08	0.01	0.35	0.35	XXX
94370	TC	A	Breath airway closing volume	0.00	0.64	NA	0.02	0.66	NA	XXX
94375		A	Respiratory flow volume loop	0.31	0.60	NA	0.03	0.94	NA	XXX
94375	26	A	Respiratory flow volume loop	0.31	0.09	0.09	0.01	0.41	0.41	XXX
94375	TC	A	Respiratory flow volume loop	0.00	0.51	NA	0.02	0.53	NA	XXX
94400		A	CO2 breathing response curve	0.40	0.84	NA	0.09	1.33	NA	XXX
94400	26	A	CO2 breathing response curve	0.40	0.12	0.12	0.03	0.55	0.55	XXX
94400	TC	A	CO2 breathing response curve	0.00	0.72	NA	0.06	0.78	NA	XXX
94450		A	Hypoxia response curve	0.40	0.85	NA	0.04	1.29	NA	XXX
94450	26	A	Hypoxia response curve	0.40	0.12	0.12	0.02	0.54	0.54	XXX
94450	TC	A	Hypoxia response curve	0.00	0.73	NA	0.02	0.75	NA	XXX
94452		A	Hast w/report	0.31	1.02	NA	0.04	1.37	NA	XXX
94452	26	A	Hast w/report	0.31	0.09	0.09	0.02	0.42	0.42	XXX
94452	TC	A	Hast w/report	0.00	0.93	NA	0.02	0.95	NA	XXX
94453		A	Hast w/oxygen titrate	0.40	1.51	NA	0.04	1.95	NA	XXX
94453	26	A	Hast w/oxygen titrate	0.40	0.12	0.12	0.02	0.54	0.54	XXX
94453	TC	A	Hast w/oxygen titrate	0.00	1.39	NA	0.02	1.41	NA	XXX
94620		A	Pulmonary stress test/simple	0.64	2.49	NA	0.13	3.26	NA	XXX
94620	26	A	Pulmonary stress test/simple	0.64	0.20	0.20	0.03	0.87	0.87	XXX
94620	TC	A	Pulmonary stress test/simple	0.00	2.29	NA	0.10	2.39	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
94621		A	Pulm stress test/complex	1.42	2.20	NA	0.16	3.78	NA	XXX
94621	26	A	Pulm stress test/complex	1.42	0.44	0.44	0.06	1.92	1.92	XXX
94621	TC	A	Pulm stress test/complex	0.00	1.76	NA	0.10	1.86	NA	XXX
94640		A	Airway inhalation treatment	0.00	0.30	NA	0.02	0.32	NA	XXX
94642		C	Aerosol inhalation treatment	0.00	0.00	0.00	0.00	0.00	0.00	XXX
94656		A	Initial ventilator mgmt	1.22	1.16	0.32	0.07	2.45	1.61	XXX
94657		A	Continued ventilator mgmt	0.83	0.98	0.25	0.04	1.85	1.12	XXX
94660		A	Pos airway pressure, CPAP	0.76	0.65	0.23	0.04	1.45	1.03	XXX
94662		A	Neg press ventilation, cnp	0.76	NA	0.23	0.03	NA	1.02	XXX
94664		A	Evaluate pt use of inhaler	0.00	0.31	NA	0.04	0.35	NA	XXX
94667		A	Chest wall manipulation	0.00	0.52	NA	0.05	0.57	NA	XXX
94668		A	Chest wall manipulation	0.00	0.45	NA	0.02	0.47	NA	XXX
94680		A	Exhaled air analysis, o2	0.26	1.86	NA	0.07	2.19	NA	XXX
94680	26	A	Exhaled air analysis, o2	0.26	0.08	0.08	0.01	0.35	0.35	XXX
94680	TC	A	Exhaled air analysis, o2	0.00	1.78	NA	0.06	1.84	NA	XXX
94681		A	Exhaled air analysis, o2/co2	0.20	2.52	NA	0.13	2.85	NA	XXX
94681	26	A	Exhaled air analysis, o2/co2	0.20	0.06	0.06	0.01	0.27	0.27	XXX
94681	TC	A	Exhaled air analysis, o2/co2	0.00	2.46	NA	0.12	2.58	NA	XXX
94690		A	Exhaled air analysis	0.07	1.99	NA	0.05	2.11	NA	XXX
94690	26	A	Exhaled air analysis	0.07	0.02	0.02	0.01	0.10	0.10	XXX
94690	TC	A	Exhaled air analysis	0.00	1.97	NA	0.04	2.01	NA	XXX
94720		A	Monoxide diffusing capacity	0.26	1.00	NA	0.07	1.33	NA	XXX
94720	26	A	Monoxide diffusing capacity	0.26	0.08	0.08	0.01	0.35	0.35	XXX
94720	TC	A	Monoxide diffusing capacity	0.00	0.92	NA	0.06	0.98	NA	XXX
94725		A	Membrane diffusion capacity	0.26	2.91	NA	0.13	3.30	NA	XXX
94725	26	A	Membrane diffusion capacity	0.26	0.08	0.08	0.01	0.35	0.35	XXX
94725	TC	A	Membrane diffusion capacity	0.00	2.83	NA	0.12	2.95	NA	XXX
94750		A	Pulmonary compliance study	0.23	1.34	NA	0.05	1.62	NA	XXX
94750	26	A	Pulmonary compliance study	0.23	0.07	0.07	0.01	0.31	0.31	XXX
94750	TC	A	Pulmonary compliance study	0.00	1.27	NA	0.04	1.31	NA	XXX
94760		T	Measure blood oxygen level	0.00	0.04	NA	0.02	0.06	NA	XXX
94761		T	Measure blood oxygen level	0.00	0.07	NA	0.06	0.13	NA	XXX
94762		A	Measure blood oxygen level	0.00	0.47	NA	0.10	0.57	NA	XXX
94770		A	Exhaled carbon dioxide test	0.15	0.75	NA	0.08	0.98	NA	XXX
94770	26	A	Exhaled carbon dioxide test	0.15	0.04	0.04	0.01	0.20	0.20	XXX
94770	TC	A	Exhaled carbon dioxide test	0.00	0.71	NA	0.07	0.78	NA	XXX
94772		C	Breath recording, infant	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
94772	26	C	Breath recording, infant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
94772	TC	C	Breath recording, infant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
94799		C	Pulmonary service/procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
94799	26	C	Pulmonary service/procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
94799	TC	C	Pulmonary service/procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95004		A	Percut allergy skin tests	0.00	0.10	NA	0.01	0.11	NA	XXX
95010		A	Percut allergy titrate test	0.15	0.32	0.06	0.01	0.48	0.22	XXX
95015		A	Id allergy titrate-drug/bug	0.15	0.14	0.06	0.01	0.30	0.22	XXX
95024		A	Id allergy test, drug/bug	0.00	0.15	NA	0.01	0.16	NA	XXX
95027		A	Id allergy titrate-airborne	0.00	0.15	NA	0.01	0.16	NA	XXX
95028		A	Id allergy test-delayed type	0.00	0.23	NA	0.01	0.24	NA	XXX
95044		A	Allergy patch tests	0.00	0.20	NA	0.01	0.21	NA	XXX
95052		A	Photo patch test	0.00	0.25	NA	0.01	0.26	NA	XXX
95056		A	Photosensitivity tests	0.00	0.17	NA	0.01	0.18	NA	XXX
95060		A	Eye allergy tests	0.00	0.35	NA	0.02	0.37	NA	XXX
95065		A	Nose allergy test	0.00	0.20	NA	0.01	0.21	NA	XXX
95070		A	Bronchial allergy tests	0.00	2.28	NA	0.02	2.30	NA	XXX
95071		A	Bronchial allergy tests	0.00	2.92	NA	0.02	2.94	NA	XXX
95075		A	Ingestion challenge test	0.95	0.82	0.38	0.03	1.80	1.36	XXX
95078		A	Provocative testing	0.00	0.25	NA	0.02	0.27	NA	XXX
95115		A	Immunotherapy, one injection	0.00	0.39	NA	0.02	0.41	NA	000
95117		A	Immunotherapy injections	0.00	0.50	NA	0.02	0.52	NA	000
95120		I	Immunotherapy, one injection	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95125		I	Immunotherapy, many antigens	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95130		I	Immunotherapy, insect venom	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95131		I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95132		I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95133		I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95134		I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95144		A	Antigen therapy services	0.06	0.19	0.02	0.01	0.26	0.09	000
95145		A	Antigen therapy services	0.06	0.32	0.02	0.01	0.39	0.09	000
95146		A	Antigen therapy services	0.06	0.44	0.03	0.01	0.51	0.10	000
95147		A	Antigen therapy services	0.06	0.42	0.02	0.01	0.49	0.09	000
95148		A	Antigen therapy services	0.06	0.56	0.03	0.01	0.65	0.10	000
95149		A	Antigen therapy services	0.06	0.80	0.03	0.01	0.87	0.10	000
95165		A	Antigen therapy services	0.06	0.19	0.02	0.01	0.26	0.09	000
95170		A	Antigen therapy services	0.06	0.13	0.03	0.01	0.20	0.10	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
95180		A	Rapid desensitization	2.01	2.03	0.93	0.05	4.09	2.99	000
95199		C	Allergy immunology services	0.00	0.00	0.00	0.00	0.00	0.00	000
95250		A	Glucose monitoring, cont	0.00	4.10	NA	0.01	4.11	NA	XXX
95805		A	Multiple sleep latency test	1.88	17.26	NA	0.43	19.57	NA	XXX
95805	26	A	Multiple sleep latency test	1.88	0.66	0.66	0.09	2.63	2.63	XXX
95805	TC	A	Multiple sleep latency test	0.00	16.60	NA	0.34	16.94	NA	XXX
95806		A	Sleep study, unattended	1.66	3.33	NA	0.38	5.37	NA	XXX
95806	26	A	Sleep study, unattended	1.66	0.54	0.54	0.07	2.27	2.27	XXX
95806	TC	A	Sleep study, unattended	0.00	2.79	NA	0.31	3.10	NA	XXX
95807		A	Sleep study, attended	1.66	11.85	NA	0.50	14.01	NA	XXX
95807	26	A	Sleep study, attended	1.66	0.53	0.53	0.08	2.27	2.27	XXX
95807	TC	A	Sleep study, attended	0.00	11.32	NA	0.42	11.74	NA	XXX
95808		A	Polysomnography, 1-3	2.65	13.19	NA	0.55	16.39	NA	XXX
95808	26	A	Polysomnography, 1-3	2.65	0.92	0.92	0.13	3.70	3.70	XXX
95808	TC	A	Polysomnography, 1-3	0.00	12.27	NA	0.42	12.69	NA	XXX
95810		A	Polysomnography, 4 or more	3.52	17.49	NA	0.59	21.60	NA	XXX
95810	26	A	Polysomnography, 4 or more	3.52	1.18	1.18	0.17	4.87	4.87	XXX
95810	TC	A	Polysomnography, 4 or more	0.00	16.31	NA	0.42	16.73	NA	XXX
95811		A	Polysomnography w/cpap	3.79	19.19	NA	0.61	23.59	NA	XXX
95811	26	A	Polysomnography w/cpap	3.79	1.27	1.27	0.18	5.24	5.24	XXX
95811	TC	A	Polysomnography w/cpap	0.00	17.92	NA	0.43	18.35	NA	XXX
95812		A	Eeg, 41-60 minutes	1.08	4.03	NA	0.17	5.28	NA	XXX
95812	26	A	Eeg, 41-60 minutes	1.08	0.45	0.45	0.06	1.59	1.59	XXX
95812	TC	A	Eeg, 41-60 minutes	0.00	3.58	NA	0.11	3.69	NA	XXX
95813		A	Eeg, over 1 hour	1.73	5.02	NA	0.21	6.96	NA	XXX
95813	26	A	Eeg, over 1 hour	1.73	0.70	0.70	0.10	2.53	2.53	XXX
95813	TC	A	Eeg, over 1 hour	0.00	4.32	NA	0.11	4.43	NA	XXX
95816		A	Eeg, awake and drowsy	1.08	3.71	NA	0.16	4.95	NA	XXX
95816	26	A	Eeg, awake and drowsy	1.08	0.46	0.46	0.06	1.60	1.60	XXX
95816	TC	A	Eeg, awake and drowsy	0.00	3.25	NA	0.10	3.35	NA	XXX
95819		A	Eeg, awake and asleep	1.08	2.98	NA	0.16	4.22	NA	XXX
95819	26	A	Eeg, awake and asleep	1.08	0.46	0.46	0.06	1.60	1.60	XXX
95819	TC	A	Eeg, awake and asleep	0.00	2.52	NA	0.10	2.62	NA	XXX
95822		A	Eeg, coma or sleep only	1.08	4.60	NA	0.19	5.87	NA	XXX
95822	26	A	Eeg, coma or sleep only	1.08	0.46	0.46	0.06	1.60	1.60	XXX
95822	TC	A	Eeg, coma or sleep only	0.00	4.14	NA	0.13	4.27	NA	XXX
95824		C	Eeg, cerebral death only	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
95824	26	A	Eeg, cerebral death only	0.74	0.31	0.31	0.04	1.09	1.09	XXX
95824	TC	C	Eeg, cerebral death only	0.00	0.00	NA	0.00	0.00	NA	XXX
95827		A	Eeg, all night recording	1.08	2.70	NA	0.19	3.97	NA	XXX
95827	26	A	Eeg, all night recording	1.08	0.41	0.41	0.05	1.54	1.54	XXX
95827	TC	A	Eeg, all night recording	0.00	2.29	NA	0.14	2.43	NA	XXX
95829		A	Surgery electrocorticogram	6.20	31.00	NA	0.50	37.70	NA	XXX
95829	26	A	Surgery electrocorticogram	6.20	2.31	2.31	0.48	8.99	8.99	XXX
95829	TC	A	Surgery electrocorticogram	0.00	28.69	NA	0.02	28.71	NA	XXX
95830		A	Insert electrodes for EEG	1.70	3.29	0.73	0.11	5.10	2.54	XXX
95831		A	Limb muscle testing, manual	0.28	0.46	0.13	0.01	0.75	0.42	XXX
95832		A	Hand muscle testing, manual	0.29	0.33	0.12	0.02	0.64	0.43	XXX
95833		A	Body muscle testing, manual	0.47	0.58	0.23	0.02	1.07	0.72	XXX
95834		A	Body muscle testing, manual	0.60	0.63	0.28	0.03	1.26	0.91	XXX
95851		A	Range of motion measurements	0.16	0.36	0.08	0.01	0.53	0.25	XXX
95852		A	Range of motion measurements	0.11	0.26	0.05	0.01	0.38	0.17	XXX
95857		A	Tensilon test	0.53	0.60	0.23	0.02	1.15	0.78	XXX
95858		A	Tensilon test & myogram	1.56	1.07	NA	0.12	2.75	NA	XXX
95858	26	A	Tensilon test & myogram	1.56	0.67	0.67	0.08	2.31	2.31	XXX
95858	TC	A	Tensilon test & myogram	0.00	0.40	NA	0.04	0.44	NA	XXX
95860		A	Muscle test, one limb	0.96	1.42	NA	0.07	2.45	NA	XXX
95860	26	A	Muscle test, one limb	0.96	0.42	0.42	0.05	1.43	1.43	XXX
95860	TC	A	Muscle test, one limb	0.00	1.00	NA	0.02	1.02	NA	XXX
95861		A	Muscle test, 2 limbs	1.54	1.41	NA	0.14	3.09	NA	XXX
95861	26	A	Muscle test, 2 limbs	1.54	0.68	0.68	0.08	2.30	2.30	XXX
95861	TC	A	Muscle test, 2 limbs	0.00	0.73	NA	0.06	0.79	NA	XXX
95863		A	Muscle test, 3 limbs	1.87	1.74	NA	0.15	3.76	NA	XXX
95863	26	A	Muscle test, 3 limbs	1.87	0.80	0.80	0.09	2.76	2.76	XXX
95863	TC	A	Muscle test, 3 limbs	0.00	0.94	NA	0.06	1.00	NA	XXX
95864		A	Muscle test, 4 limbs	1.99	2.65	NA	0.22	4.86	NA	XXX
95864	26	A	Muscle test, 4 limbs	1.99	0.87	0.87	0.10	2.96	2.96	XXX
95864	TC	A	Muscle test, 4 limbs	0.00	1.78	NA	0.12	1.90	NA	XXX
95867		A	Muscle test cran nerv unilat	0.79	0.93	NA	0.07	1.79	NA	XXX
95867	26	A	Muscle test cran nerv unilat	0.79	0.35	0.35	0.03	1.17	1.17	XXX
95867	TC	A	Muscle test cran nerv unilat	0.00	0.58	NA	0.04	0.62	NA	XXX
95868		A	Muscle test cran nerve bilat	1.18	1.21	NA	0.11	2.50	NA	XXX
95868	26	A	Muscle test cran nerve bilat	1.18	0.51	0.51	0.06	1.75	1.75	XXX
95868	TC	A	Muscle test cran nerve bilat	0.00	0.70	NA	0.05	0.75	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
95869		A	Muscle test, thor paraspinal	0.37	0.37	NA	0.04	0.78	NA	XXX
95869	26	A	Muscle test, thor paraspinal	0.37	0.16	0.16	0.02	0.55	0.55	XXX
95869	TC	A	Muscle test, thor paraspinal	0.00	0.21	NA	0.02	0.23	NA	XXX
95870		A	Muscle test, nonparaspinal	0.37	0.37	NA	0.04	0.78	NA	XXX
95870	26	A	Muscle test, nonparaspinal	0.37	0.16	0.16	0.02	0.55	0.55	XXX
95870	TC	A	Muscle test, nonparaspinal	0.00	0.21	NA	0.02	0.23	NA	XXX
95872		A	Muscle test, one fiber	1.50	1.23	NA	0.13	2.86	NA	XXX
95872	26	A	Muscle test, one fiber	1.50	0.63	0.63	0.08	2.21	2.21	XXX
95872	TC	A	Muscle test, one fiber	0.00	0.60	NA	0.05	0.65	NA	XXX
95875		A	Limb exercise test	1.10	1.45	NA	0.11	2.66	NA	XXX
95875	26	A	Limb exercise test	1.10	0.47	0.47	0.05	1.62	1.62	XXX
95875	TC	A	Limb exercise test	0.00	0.98	NA	0.06	1.04	NA	XXX
95900		A	Motor nerve conduction test	0.42	1.26	NA	0.04	1.72	NA	XXX
95900	26	A	Motor nerve conduction test	0.42	0.18	0.18	0.02	0.62	0.62	XXX
95900	TC	A	Motor nerve conduction test	0.00	1.08	NA	0.02	1.10	NA	XXX
95903		A	Motor nerve conduction test	0.60	1.19	NA	0.05	1.84	NA	XXX
95903	26	A	Motor nerve conduction test	0.60	0.26	0.26	0.03	0.89	0.89	XXX
95903	TC	A	Motor nerve conduction test	0.00	0.93	NA	0.02	0.95	NA	XXX
95904		A	Sense nerve conduction test	0.34	1.09	NA	0.04	1.47	NA	XXX
95904	26	A	Sense nerve conduction test	0.34	0.15	0.15	0.02	0.51	0.51	XXX
95904	TC	A	Sense nerve conduction test	0.00	0.94	NA	0.02	0.96	NA	XXX
95920		A	Intraop nerve test add-on	2.11	2.24	NA	0.23	4.58	NA	ZZZ
95920	26	A	Intraop nerve test add-on	2.11	0.93	0.93	0.16	3.20	3.20	ZZZ
95920	TC	A	Intraop nerve test add-on	0.00	1.31	NA	0.07	1.38	NA	ZZZ
95921		A	Autonomic nerv function test	0.90	0.71	NA	0.06	1.67	NA	XXX
95921	26	A	Autonomic nerv function test	0.90	0.33	0.33	0.04	1.27	1.27	XXX
95921	TC	A	Autonomic nerv function test	0.00	0.38	NA	0.02	0.40	NA	XXX
95922		A	Autonomic nerv function test	0.96	0.78	NA	0.07	1.81	NA	XXX
95922	26	A	Autonomic nerv function test	0.96	0.40	0.40	0.05	1.41	1.41	XXX
95922	TC	A	Autonomic nerv function test	0.00	0.38	NA	0.02	0.40	NA	XXX
95923		A	Autonomic nerv function test	0.90	1.94	NA	0.07	2.91	NA	XXX
95923	26	A	Autonomic nerv function test	0.90	0.38	0.38	0.05	1.33	1.33	XXX
95923	TC	A	Autonomic nerv function test	0.00	1.56	NA	0.02	1.58	NA	XXX
95925		A	Somatosensory testing	0.54	1.13	NA	0.10	1.77	NA	XXX
95925	26	A	Somatosensory testing	0.54	0.22	0.22	0.04	0.80	0.80	XXX
95925	TC	A	Somatosensory testing	0.00	0.91	NA	0.06	0.97	NA	XXX
95926		A	Somatosensory testing	0.54	1.14	NA	0.09	1.77	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
95926	26	A	Somatosensory testing	0.54	0.23	0.23	0.03	0.80	0.80	XXX
95926	TC	A	Somatosensory testing	0.00	0.91	NA	0.06	0.97	NA	XXX
95927		A	Somatosensory testing	0.54	1.16	NA	0.09	1.79	NA	XXX
95927	26	A	Somatosensory testing	0.54	0.25	0.25	0.03	0.82	0.82	XXX
95927	TC	A	Somatosensory testing	0.00	0.91	NA	0.06	0.97	NA	XXX
95928		A	C motor evoked, uppr limbs	1.50	3.02	NA	0.09	4.61	NA	XXX
95928	26	A	C motor evoked, uppr limbs	1.50	0.65	0.65	0.06	2.21	2.21	XXX
95928	TC	A	C motor evoked, uppr limbs	0.00	2.37	NA	0.03	2.40	NA	XXX
95929		A	C motor evoked, lwr limbs	1.50	3.21	NA	0.09	4.80	NA	XXX
95929	26	A	C motor evoked, lwr limbs	1.50	0.65	0.65	0.06	2.21	2.21	XXX
95929	TC	A	C motor evoked, lwr limbs	0.00	2.56	NA	0.03	2.59	NA	XXX
95930		A	Visual evoked potential test	0.35	2.24	NA	0.03	2.62	NA	XXX
95930	26	A	Visual evoked potential test	0.35	0.15	0.15	0.02	0.52	0.52	XXX
95930	TC	A	Visual evoked potential test	0.00	2.09	NA	0.01	2.10	NA	XXX
95933		A	Blink reflex test	0.59	1.02	NA	0.10	1.71	NA	XXX
95933	26	A	Blink reflex test	0.59	0.24	0.24	0.04	0.87	0.87	XXX
95933	TC	A	Blink reflex test	0.00	0.78	NA	0.06	0.84	NA	XXX
95934		A	H-reflex test	0.51	0.43	NA	0.04	0.98	NA	XXX
95934	26	A	H-reflex test	0.51	0.22	0.22	0.02	0.75	0.75	XXX
95934	TC	A	H-reflex test	0.00	0.21	NA	0.02	0.23	NA	XXX
95936		A	H-reflex test	0.55	0.45	NA	0.05	1.05	NA	XXX
95936	26	A	H-reflex test	0.55	0.24	0.24	0.03	0.82	0.82	XXX
95936	TC	A	H-reflex test	0.00	0.21	NA	0.02	0.23	NA	XXX
95937		A	Neuromuscular junction test	0.65	0.61	NA	0.09	1.35	NA	XXX
95937	26	A	Neuromuscular junction test	0.65	0.27	0.27	0.07	0.99	0.99	XXX
95937	TC	A	Neuromuscular junction test	0.00	0.34	NA	0.02	0.36	NA	XXX
95950		A	Ambulatory eeg monitoring	1.51	3.93	NA	0.51	5.95	NA	XXX
95950	26	A	Ambulatory eeg monitoring	1.51	0.64	0.64	0.08	2.23	2.23	XXX
95950	TC	A	Ambulatory eeg monitoring	0.00	3.29	NA	0.43	3.72	NA	XXX
95951		C	EEG monitoring/videorecord	0.00	0.00	NA	0.00	0.00	NA	XXX
95951	26	A	EEG monitoring/videorecord	5.99	2.55	2.55	0.33	8.87	8.87	XXX
95951	TC	C	EEG monitoring/videorecord	0.00	0.00	NA	0.00	0.00	NA	XXX
95953		A	EEG monitoring/computer	3.08	7.62	NA	0.60	11.30	NA	XXX
95953	26	A	EEG monitoring/computer	3.08	1.29	1.29	0.17	4.54	4.54	XXX
95953	TC	A	EEG monitoring/computer	0.00	6.33	NA	0.43	6.76	NA	XXX
95954		A	EEG monitoring/giving drugs	2.45	4.22	NA	0.19	6.86	NA	XXX
95954	26	A	EEG monitoring/giving drugs	2.45	1.04	1.04	0.13	3.62	3.62	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
95954	TC	A	EEG monitoring/giving drugs	0.00	3.18	NA	0.06	3.24	NA	XXX
95955		A	EEG during surgery	1.01	2.32	NA	0.23	3.56	NA	XXX
95955	26	A	EEG during surgery	1.01	0.36	0.36	0.06	1.43	1.43	XXX
95955	TC	A	EEG during surgery	0.00	1.96	NA	0.17	2.13	NA	XXX
95956		A	Eeg monitoring, cable/radio	3.08	15.41	NA	0.59	19.08	NA	XXX
95956	26	A	Eeg monitoring, cable/radio	3.08	1.30	1.30	0.16	4.54	4.54	XXX
95956	TC	A	Eeg monitoring, cable/radio	0.00	14.11	NA	0.43	14.54	NA	XXX
95957		A	EEG digital analysis	1.98	2.55	NA	0.23	4.76	NA	XXX
95957	26	A	EEG digital analysis	1.98	0.85	0.85	0.11	2.94	2.94	XXX
95957	TC	A	EEG digital analysis	0.00	1.70	NA	0.12	1.82	NA	XXX
95958		A	EEG monitoring/function test	4.24	3.48	NA	0.37	8.09	NA	XXX
95958	26	A	EEG monitoring/function test	4.24	1.74	1.74	0.24	6.22	6.22	XXX
95958	TC	A	EEG monitoring/function test	0.00	1.74	NA	0.13	1.87	NA	XXX
95961		A	Electrode stimulation, brain	2.97	2.63	NA	0.54	6.14	NA	XXX
95961	26	A	Electrode stimulation, brain	2.97	1.32	1.32	0.47	4.76	4.76	XXX
95961	TC	A	Electrode stimulation, brain	0.00	1.31	NA	0.07	1.38	NA	XXX
95962		A	Electrode stim, brain add-on	3.21	2.70	NA	0.39	6.30	NA	ZZZ
95962	26	A	Electrode stim, brain add-on	3.21	1.39	1.39	0.32	4.92	4.92	ZZZ
95962	TC	A	Electrode stim, brain add-on	0.00	1.31	NA	0.07	1.38	NA	ZZZ
95965		C	Meg, spontaneous	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95965	26	A	Meg, spontaneous	7.99	3.42	3.42	0.45	11.86	11.86	XXX
95965	TC	C	Meg, spontaneous	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95966		C	Meg, evoked, single	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95966	26	A	Meg, evoked, single	3.99	1.71	1.71	0.19	5.89	5.89	XXX
95966	TC	C	Meg, evoked, single	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95967		C	Meg, evoked, each add'l	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
95967	26	A	Meg, evoked, each add'l	3.49	1.18	1.18	0.15	4.82	4.82	ZZZ
95967	TC	C	Meg, evoked, each add'l	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
95970		A	Analyze neurostim, no prog	0.45	0.85	0.14	0.03	1.33	0.62	XXX
95971		A	Analyze neurostim, simple	0.78	0.68	0.22	0.07	1.53	1.07	XXX
95972		A	Analyze neurostim, complex	1.50	1.21	0.49	0.14	2.85	2.13	XXX
95973		A	Analyze neurostim, complex	0.92	0.62	0.34	0.07	1.61	1.33	ZZZ
95974		A	Cranial neurostim, complex	3.00	1.70	1.30	0.17	4.87	4.47	XXX
95975		A	Cranial neurostim, complex	1.70	0.89	0.73	0.12	2.71	2.55	ZZZ
95978		A	Analyze neurostim brain/1h	3.50	1.93	1.30	0.18	5.61	4.98	XXX
95979		A	Analyz neurostim brain addon	1.64	0.87	0.69	0.08	2.59	2.41	ZZZ
95990		A	Spin/brain pump refil & main	0.00	1.50	NA	0.06	1.56	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
95991		A	Spin/brain pump refil & main	0.77	1.46	0.17	0.06	2.29	1.00	XXX
95999		C	Neurological procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
96000		A	Motion analysis, video/3d	1.80	NA	0.53	0.11	NA	2.44	XXX
96001		A	Motion test w/ft press meas	2.15	NA	0.66	0.10	NA	2.91	XXX
96002		A	Dynamic surface emg	0.41	NA	0.15	0.02	NA	0.58	XXX
96003		A	Dynamic fine wire emg	0.37	NA	0.12	0.02	NA	0.51	XXX
96004		A	Phys review of motion tests	2.14	0.94	0.94	0.11	3.19	3.19	XXX
96100		A	Psychological testing	0.00	1.76	NA	0.18	1.94	NA	XXX
96105		A	Assessment of aphasia	0.00	1.76	NA	0.18	1.94	NA	XXX
96110		A	Developmental test, lim	0.00	0.18	NA	0.18	0.36	NA	XXX
96111		A	Developmental test, extend	2.60	1.05	NA	0.18	3.83	NA	XXX
96115		A	Neurobehavior status exam	0.00	1.76	NA	0.18	1.94	NA	XXX
96117		A	Neuropsych test battery	0.00	1.76	NA	0.18	1.94	NA	XXX
96150		A	Assess hlth/behave, init	0.50	0.18	0.18	0.01	0.69	0.69	XXX
96151		A	Assess hlth/behave, subseq	0.48	0.18	0.17	0.01	0.67	0.66	XXX
96152		A	Intervene hlth/behave, indiv	0.46	0.17	0.16	0.01	0.64	0.63	XXX
96153		A	Intervene hlth/behave, group	0.10	0.04	0.03	0.01	0.15	0.14	XXX
96154		A	Interv hlth/behav, fam w/pt	0.45	0.17	0.16	0.01	0.63	0.62	XXX
96155		N	Interv hlth/behav fam no pt	+0.44	0.18	0.17	0.02	0.64	0.63	XXX
96400		I	Chemotherapy, sc/im	+0.17	1.12	1.12	0.01	1.30	1.30	XXX
96405		A	Intralesional chemo admin	0.52	2.30	0.24	0.03	2.85	0.79	000
96406		A	Intralesional chemo admin	0.80	3.01	0.29	0.03	3.84	1.12	000
96408		I	Chemotherapy, push technique	+0.17	2.91	2.91	0.06	3.14	3.14	XXX
96410		I	Chemotherapy,infusion method	+0.17	4.16	4.16	0.08	4.41	4.41	XXX
96412		I	Chemo, infuse method add-on	+0.17	0.74	0.74	0.07	0.98	0.98	ZZZ
96414		I	Chemo, infuse method add-on	+0.17	5.22	5.22	0.08	5.47	5.47	XXX
96420		A	Chemotherapy, push technique	0.17	2.65	NA	0.08	2.90	NA	XXX
96422		A	Chemotherapy,infusion method	0.17	4.83	NA	0.08	5.08	NA	XXX
96423		A	Chemo, infuse method add-on	0.17	1.88	NA	0.02	2.07	NA	ZZZ
96425		A	Chemotherapy,infusion method	0.17	4.47	NA	0.08	4.72	NA	XXX
96440		A	Chemotherapy, intracavitary	2.37	7.93	1.23	0.16	10.46	3.76	000
96445		A	Chemotherapy, intracavitary	2.20	8.03	1.18	0.14	10.37	3.52	000
96450		A	Chemotherapy, into CNS	1.89	6.94	1.09	0.09	8.92	3.07	000
96520		A	Port pump refill & main	0.21	3.76	NA	0.06	4.03	NA	XXX
96530		A	Syst pump refill & main	0.21	2.64	NA	0.06	2.91	NA	XXX
96542		A	Chemotherapy injection	1.42	4.23	0.66	0.07	5.72	2.15	XXX
96545		B	Provide chemotherapy agent	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
96549		C	Chemotherapy, unspecified	0.00	0.00	0.00	0.00	0.00	0.00	XXX
96567		A	Photodynamic tx, skin	0.00	0.96	NA	0.04	1.00	NA	XXX
96570		A	Photodynamic tx, 30 min	1.10	NA	0.37	0.11	NA	1.58	ZZZ
96571		A	Photodynamic tx, addl 15 min	0.55	NA	0.19	0.03	NA	0.77	ZZZ
96900		A	Ultraviolet light therapy	0.00	0.44	NA	0.02	0.46	NA	XXX
96902		B	Trichogram	+0.41	0.18	0.16	0.01	0.60	0.58	XXX
96910		A	Photochemotherapy with UV-B	0.00	0.99	NA	0.04	1.03	NA	XXX
96912		A	Photochemotherapy with UV-A	0.00	1.26	NA	0.05	1.31	NA	XXX
96913		A	Photochemotherapy, UV-A or B	0.00	1.68	NA	0.10	1.78	NA	XXX
96920		A	Laser tx, skin < 250 sq cm	1.15	2.53	0.56	0.03	3.71	1.74	000
96921		A	Laser tx, skin 250-500 sq cm	1.17	2.60	0.57	0.03	3.80	1.77	000
96922		A	Laser tx, skin > 500 sq cm	2.10	3.48	0.62	0.05	5.63	2.77	000
96999		C	Dermatological procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97001		A	Pt evaluation	1.20	0.75	0.45	0.05	2.00	1.70	XXX
97002		A	Pt re-evaluation	0.60	0.44	0.23	0.02	1.06	0.85	XXX
97003		A	Ot evaluation	1.20	0.88	0.40	0.06	2.14	1.66	XXX
97004		A	Ot re-evaluation	0.60	0.67	0.19	0.02	1.29	0.81	XXX
97005		I	Athletic train eval	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97006		I	Athletic train reeval	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97010		B	Hot or cold packs therapy	+0.06	0.05	NA	0.01	0.12	NA	XXX
97012		A	Mechanical traction therapy	0.25	0.13	NA	0.01	0.39	NA	XXX
97014		I	Electric stimulation therapy	+0.18	0.19	0.19	0.01	0.38	0.38	XXX
97016		A	Vasopneumatic device therapy	0.18	0.18	NA	0.01	0.37	NA	XXX
97018		A	Paraffin bath therapy	0.06	0.10	NA	0.01	0.17	NA	XXX
97020		A	Microwave therapy	0.06	0.06	NA	0.01	0.13	NA	XXX
97022		A	Whirlpool therapy	0.17	0.21	NA	0.01	0.39	NA	XXX
97024		A	Diathermy treatment	0.06	0.07	NA	0.01	0.14	NA	XXX
97026		A	Infrared therapy	0.06	0.06	NA	0.01	0.13	NA	XXX
97028		A	Ultraviolet therapy	0.08	0.07	NA	0.01	0.16	NA	XXX
97032		A	Electrical stimulation	0.25	0.16	NA	0.01	0.42	NA	XXX
97033		A	Electric current therapy	0.26	0.27	NA	0.01	0.54	NA	XXX
97034		A	Contrast bath therapy	0.21	0.15	NA	0.01	0.37	NA	XXX
97035		A	Ultrasound therapy	0.21	0.10	NA	0.01	0.32	NA	XXX
97036		A	Hydrotherapy	0.28	0.32	NA	0.01	0.61	NA	XXX
97039		A	Physical therapy treatment	0.20	0.10	NA	0.01	0.31	NA	XXX
97110		A	Therapeutic exercises	0.45	0.27	NA	0.02	0.74	NA	XXX
97112		A	Neuromuscular reeducation	0.45	0.31	NA	0.02	0.78	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
97113		A	Aquatic therapy/exercises	0.44	0.39	NA	0.02	0.85	NA	XXX
97116		A	Gait training therapy	0.40	0.24	NA	0.01	0.65	NA	XXX
97124		A	Massage therapy	0.35	0.23	NA	0.01	0.59	NA	XXX
97139		A	Physical medicine procedure	0.21	0.20	NA	0.01	0.42	NA	XXX
97140		A	Manual therapy	0.43	0.25	NA	0.02	0.70	NA	XXX
97150		A	Group therapeutic procedures	0.27	0.18	NA	0.01	0.46	NA	XXX
97504		A	Orthotic training	0.45	0.33	NA	0.03	0.81	NA	XXX
97520		A	Prosthetic training	0.45	0.27	NA	0.02	0.74	NA	XXX
97530		A	Therapeutic activities	0.44	0.32	NA	0.02	0.78	NA	XXX
97532		A	Cognitive skills development	0.44	0.20	NA	0.01	0.65	NA	XXX
97533		A	Sensory integration	0.44	0.24	NA	0.01	0.69	NA	XXX
97535		A	Self care mngment training	0.45	0.33	NA	0.01	0.79	NA	XXX
97537		A	Community/work reintegration	0.45	0.26	NA	0.01	0.72	NA	XXX
97542		A	Wheelchair mngment training	0.45	0.28	NA	0.01	0.74	NA	XXX
97545		R	Work hardening	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97546		R	Work hardening add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
97597		A	Active wound care/20 cm or <	0.58	0.66	NA	0.05	1.29	NA	XXX
97598		A	Active wound care > 20 cm	0.80	0.79	NA	0.05	1.64	NA	XXX
97602		B	Wound(s) care non-selective	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97605		B	Neg press wound tx, < 50 cm	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97606		B	Neg press wound tx, > 50 cm	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97703		A	Prosthetic checkout	0.25	0.41	NA	0.02	0.68	NA	XXX
97750		A	Physical performance test	0.45	0.32	NA	0.02	0.79	NA	XXX
97755		A	Assistive technology assess	0.62	0.28	NA	0.02	0.92	NA	XXX
97799		C	Physical medicine procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97802		A	Medical nutrition, indiv, in	0.00	0.47	NA	0.01	0.48	NA	XXX
97803		A	Med nutrition, indiv, subseq	0.00	0.47	NA	0.01	0.48	NA	XXX
97804		A	Medical nutrition, group	0.00	0.18	NA	0.01	0.19	NA	XXX
97810		N	Acupunct w/o stimul 15 min	+0.60	0.00	0.00	0.03	0.63	0.63	XXX
97811		N	Acupunct w/o stimul addl 15m	+0.50	0.00	0.00	0.03	0.53	0.53	ZZZ
97813		N	Acupunct w/stimul 15 min	+0.65	0.00	0.00	0.03	0.68	0.68	XXX
97814		N	Acupunct w/stimul addl 15m	+0.55	0.00	0.00	0.03	0.58	0.58	ZZZ
98925		A	Osteopathic manipulation	0.45	0.32	0.14	0.02	0.79	0.61	000
98926		A	Osteopathic manipulation	0.65	0.41	0.25	0.03	1.09	0.93	000
98927		A	Osteopathic manipulation	0.87	0.50	0.29	0.03	1.40	1.19	000
98928		A	Osteopathic manipulation	1.03	0.59	0.34	0.04	1.66	1.41	000
98929		A	Osteopathic manipulation	1.19	0.67	0.37	0.05	1.91	1.61	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
98940		A	Chiropractic manipulation	0.45	0.23	0.12	0.01	0.69	0.58	000
98941		A	Chiropractic manipulation	0.65	0.30	0.17	0.02	0.97	0.84	000
98942		A	Chiropractic manipulation	0.87	0.36	0.23	0.02	1.25	1.12	000
98943		N	Chiropractic manipulation	+0.40	0.24	0.16	0.01	0.65	0.57	XXX
99000		B	Specimen handling	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99001		B	Specimen handling	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99002		B	Device handling	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99024		B	Postop follow-up visit	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99026		N	In-hospital on call service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99027		N	Out-of-hosp on call service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99050		B	Medical services after hrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99052		B	Medical services at night	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99054		B	Medical servcs, unusual hrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99056		B	Non-office medical services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99058		B	Office emergency care	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99070		B	Special supplies	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99071		B	Patient education materials	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99075		N	Medical testimony	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99078		B	Group health education	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99080		B	Special reports or forms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99082		C	Unusual physician travel	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99090		B	Computer data analysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99091		B	Collect/review data from pt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99100		B	Special anesthesia service	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99116		B	Anesthesia with hypothermia	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99135		B	Special anesthesia procedure	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99140		B	Emergency anesthesia	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99141		B	Sedation, iv/im or inhalant	+0.80	1.87	0.38	0.05	2.72	1.23	XXX
99142		B	Sedation, oral/rectal/nasal	+0.60	0.95	0.30	0.04	1.59	0.94	XXX
99170		A	Anogenital exam, child	1.75	1.76	0.55	0.08	3.59	2.38	000
99172		N	Ocular function screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99173		N	Visual acuity screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99175		A	Induction of vomiting	0.00	1.39	NA	0.10	1.49	NA	XXX
99183		A	Hyperbaric oxygen therapy	2.34	3.24	0.72	0.16	5.74	3.22	XXX
99185		A	Regional hypothermia	0.00	0.64	NA	0.04	0.68	NA	XXX
99186		A	Total body hypothermia	0.00	1.78	NA	0.45	2.23	NA	XXX
99190		X	Special pump services	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
99191		X	Special pump services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99192		X	Special pump services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99195		A	Phlebotomy	0.00	0.44	NA	0.02	0.46	NA	XXX
99199		C	Special service/proc/report	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99201		A	Office/outpatient visit, new	0.45	0.49	0.15	0.03	0.97	0.63	XXX
99202		A	Office/outpatient visit, new	0.88	0.79	0.31	0.05	1.72	1.24	XXX
99203		A	Office/outpatient visit, new	1.34	1.13	0.48	0.09	2.56	1.91	XXX
99204		A	Office/outpatient visit, new	2.00	1.50	0.71	0.12	3.62	2.83	XXX
99205		A	Office/outpatient visit, new	2.67	1.77	0.95	0.14	4.58	3.76	XXX
99211		A	Office/outpatient visit, est	0.17	0.39	0.06	0.01	0.57	0.24	XXX
99212		A	Office/outpatient visit, est	0.45	0.54	0.16	0.03	1.02	0.64	XXX
99213		A	Office/outpatient visit, est	0.67	0.69	0.24	0.03	1.39	0.94	XXX
99214		A	Office/outpatient visit, est	1.10	1.03	0.41	0.05	2.18	1.56	XXX
99215		A	Office/outpatient visit, est	1.77	1.32	0.65	0.08	3.17	2.50	XXX
99217		A	Observation care discharge	1.28	NA	0.53	0.06	NA	1.87	XXX
99218		A	Observation care	1.28	NA	0.44	0.06	NA	1.78	XXX
99219		A	Observation care	2.14	NA	0.72	0.10	NA	2.96	XXX
99220		A	Observation care	2.99	NA	1.03	0.14	NA	4.16	XXX
99221		A	Initial hospital care	1.28	NA	0.45	0.07	NA	1.80	XXX
99222		A	Initial hospital care	2.14	NA	0.74	0.10	NA	2.98	XXX
99223		A	Initial hospital care	2.99	NA	1.03	0.13	NA	4.15	XXX
99231		A	Subsequent hospital care	0.64	NA	0.23	0.03	NA	0.90	XXX
99232		A	Subsequent hospital care	1.06	NA	0.37	0.04	NA	1.47	XXX
99233		A	Subsequent hospital care	1.51	NA	0.52	0.06	NA	2.09	XXX
99234		A	Observ/hosp same date	2.56	NA	0.89	0.13	NA	3.58	XXX
99235		A	Observ/hosp same date	3.41	NA	1.15	0.16	NA	4.72	XXX
99236		A	Observ/hosp same date	4.26	NA	1.44	0.19	NA	5.89	XXX
99238		A	Hospital discharge day	1.28	NA	0.54	0.05	NA	1.87	XXX
99239		A	Hospital discharge day	1.75	NA	0.73	0.07	NA	2.55	XXX
99241		A	Office consultation	0.64	0.64	0.22	0.05	1.33	0.91	XXX
99242		A	Office consultation	1.29	1.04	0.46	0.10	2.43	1.85	XXX
99243		A	Office consultation	1.72	1.39	0.63	0.13	3.24	2.48	XXX
99244		A	Office consultation	2.58	1.82	0.92	0.16	4.56	3.66	XXX
99245		A	Office consultation	3.42	2.27	1.24	0.21	5.90	4.87	XXX
99251		A	Initial inpatient consult	0.66	NA	0.24	0.05	NA	0.95	XXX
99252		A	Initial inpatient consult	1.32	NA	0.50	0.09	NA	1.91	XXX
99253		A	Initial inpatient consult	1.82	NA	0.68	0.11	NA	2.61	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
99254		A	Initial inpatient consult	2.64	NA	0.98	0.13	NA	3.75	XXX
99255		A	Initial inpatient consult	3.64	NA	1.35	0.18	NA	5.17	XXX
99261		A	Follow-up inpatient consult	0.42	NA	0.15	0.02	NA	0.59	XXX
99262		A	Follow-up inpatient consult	0.85	NA	0.31	0.04	NA	1.20	XXX
99263		A	Follow-up inpatient consult	1.27	NA	0.45	0.06	NA	1.78	XXX
99271		A	Confirmatory consultation	0.45	0.55	0.16	0.03	1.03	0.64	XXX
99272		A	Confirmatory consultation	0.84	0.83	0.31	0.06	1.73	1.21	XXX
99273		A	Confirmatory consultation	1.19	1.11	0.45	0.10	2.40	1.74	XXX
99274		A	Confirmatory consultation	1.73	1.37	0.64	0.12	3.22	2.49	XXX
99275		A	Confirmatory consultation	2.31	1.65	0.84	0.14	4.10	3.29	XXX
99281		A	Emergency dept visit	0.33	NA	0.09	0.02	NA	0.44	XXX
99282		A	Emergency dept visit	0.55	NA	0.14	0.04	NA	0.73	XXX
99283		A	Emergency dept visit	1.24	NA	0.31	0.09	NA	1.64	XXX
99284		A	Emergency dept visit	1.95	NA	0.47	0.14	NA	2.56	XXX
99285		A	Emergency dept visit	3.06	NA	0.72	0.23	NA	4.01	XXX
99288		B	Direct advanced life support	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99289		A	Ped crit care transport	4.79	NA	1.45	0.24	NA	6.48	XXX
99290		A	Ped crit care transport addl	2.40	NA	0.81	0.12	NA	3.33	ZZZ
99291		A	Critical care, first hour	3.99	2.57	1.28	0.21	6.77	5.48	XXX
99292		A	Critical care, add'l 30 min	2.00	0.90	0.64	0.10	3.00	2.74	ZZZ
99293		A	Ped critical care, initial	15.98	NA	4.75	1.09	NA	21.82	XXX
99294		A	Ped critical care, subseq	7.99	NA	2.40	0.45	NA	10.84	XXX
99295		A	Neonate crit care, initial	18.46	NA	5.37	1.15	NA	24.98	XXX
99296		A	Neonate critical care subseq	7.99	NA	2.54	0.32	NA	10.85	XXX
99298		A	Ic for lbw infant < 1500 gm	2.75	NA	0.93	0.16	NA	3.84	XXX
99299		A	Ic, lbw infant 1500-2500 gm	2.50	NA	0.86	0.16	NA	3.52	XXX
99301		A	Nursing facility care	1.20	0.50	0.50	0.05	1.75	1.75	XXX
99302		A	Nursing facility care	1.61	0.64	0.64	0.07	2.32	2.32	XXX
99303		A	Nursing facility care	2.01	0.76	0.76	0.09	2.86	2.86	XXX
99311		A	Nursing fac care, subseq	0.60	0.27	0.27	0.03	0.90	0.90	XXX
99312		A	Nursing fac care, subseq	1.00	0.45	0.45	0.04	1.49	1.49	XXX
99313		A	Nursing fac care, subseq	1.42	0.62	0.62	0.06	2.10	2.10	XXX
99315		A	Nursing fac discharge day	1.13	0.45	0.45	0.05	1.63	1.63	XXX
99316		A	Nursing fac discharge day	1.50	0.59	0.59	0.07	2.16	2.16	XXX
99321		A	Rest home visit, new patient	0.71	0.34	NA	0.03	1.08	NA	XXX
99322		A	Rest home visit, new patient	1.01	0.46	NA	0.05	1.52	NA	XXX
99323		A	Rest home visit, new patient	1.28	0.55	NA	0.05	1.88	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
99331		A	Rest home visit, est pat	0.60	0.32	NA	0.03	0.95	NA	XXX
99332		A	Rest home visit, est pat	0.80	0.38	NA	0.03	1.21	NA	XXX
99333		A	Rest home visit, est pat	1.00	0.46	NA	0.04	1.50	NA	XXX
99341		A	Home visit, new patient	1.01	0.48	NA	0.05	1.54	NA	XXX
99342		A	Home visit, new patient	1.52	0.68	NA	0.07	2.27	NA	XXX
99343		A	Home visit, new patient	2.27	0.94	NA	0.10	3.31	NA	XXX
99344		A	Home visit, new patient	3.03	1.18	NA	0.13	4.34	NA	XXX
99345		A	Home visit, new patient	3.78	1.43	NA	0.16	5.37	NA	XXX
99347		A	Home visit, est patient	0.76	0.40	NA	0.04	1.20	NA	XXX
99348		A	Home visit, est patient	1.26	0.58	NA	0.06	1.90	NA	XXX
99349		A	Home visit, est patient	2.02	0.83	NA	0.09	2.94	NA	XXX
99350		A	Home visit, est patient	3.03	1.18	NA	0.13	4.34	NA	XXX
99354		A	Prolonged service, office	1.77	0.77	0.66	0.08	2.62	2.51	ZZZ
99355		A	Prolonged service, office	1.77	0.75	0.62	0.07	2.59	2.46	ZZZ
99356		A	Prolonged service, inpatient	1.71	NA	0.62	0.07	NA	2.40	ZZZ
99357		A	Prolonged service, inpatient	1.71	NA	0.63	0.08	NA	2.42	ZZZ
99358		B	Prolonged serv, w/o contact	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99359		B	Prolonged serv, w/o contact	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99360		X	Physician standby services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99361		B	Physician/team conference	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99362		B	Physician/team conference	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99371		B	Physician phone consultation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99372		B	Physician phone consultation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99373		B	Physician phone consultation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99374		B	Home health care supervision	+1.10	0.70	0.42	0.05	1.85	1.57	XXX
99375		I	Home health care supervision	+1.73	1.55	1.55	0.07	3.35	3.35	XXX
99377		B	Hospice care supervision	+1.10	0.70	0.42	0.05	1.85	1.57	XXX
99378		I	Hospice care supervision	+1.73	1.94	1.94	0.07	3.74	3.74	XXX
99379		B	Nursing fac care supervision	+1.10	0.70	0.42	0.04	1.84	1.56	XXX
99380		B	Nursing fac care supervision	+1.73	0.99	0.66	0.06	2.78	2.45	XXX
99381		N	Prev visit, new, infant	+1.19	1.50	0.45	0.05	2.74	1.69	XXX
99382		N	Prev visit, new, age 1-4	+1.36	1.54	0.52	0.05	2.95	1.93	XXX
99383		N	Prev visit, new, age 5-11	+1.36	1.48	0.52	0.05	2.89	1.93	XXX
99384		N	Prev visit, new, age 12-17	+1.53	1.55	0.59	0.06	3.14	2.18	XXX
99385		N	Prev visit, new, age 18-39	+1.53	1.55	0.59	0.06	3.14	2.18	XXX
99386		N	Prev visit, new, age 40-64	+1.88	1.74	0.72	0.07	3.69	2.67	XXX
99387		N	Prev visit, new, 65 & over	+2.06	1.87	0.79	0.07	4.00	2.92	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
99391		N	Prev visit, est, infant	+1.02	1.02	0.39	0.04	2.08	1.45	XXX
99392		N	Prev visit, est, age 1-4	+1.19	1.09	0.45	0.05	2.33	1.69	XXX
99393		N	Prev visit, est, age 5-11	+1.19	1.06	0.45	0.05	2.30	1.69	XXX
99394		N	Prev visit, est, age 12-17	+1.36	1.13	0.52	0.05	2.54	1.93	XXX
99395		N	Prev visit, est, age 18-39	+1.36	1.16	0.52	0.05	2.57	1.93	XXX
99396		N	Prev visit, est, age 40-64	+1.53	1.25	0.59	0.06	2.84	2.18	XXX
99397		N	Prev visit, est, 65 & over	+1.71	1.36	0.66	0.06	3.13	2.43	XXX
99401		N	Preventive counseling, indiv	+0.48	0.62	0.19	0.01	1.11	0.68	XXX
99402		N	Preventive counseling, indiv	+0.98	0.87	0.37	0.02	1.87	1.37	XXX
99403		N	Preventive counseling, indiv	+1.46	1.09	0.56	0.04	2.59	2.06	XXX
99404		N	Preventive counseling, indiv	+1.95	1.32	0.75	0.05	3.32	2.75	XXX
99411		N	Preventive counseling, group	+0.15	0.18	0.06	0.01	0.34	0.22	XXX
99412		N	Preventive counseling, group	+0.25	0.25	0.10	0.01	0.51	0.36	XXX
99420		N	Health risk assessment test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99429		N	Unlisted preventive service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99431		A	Initial care, normal newborn	1.17	NA	0.38	0.05	NA	1.60	XXX
99432		A	Newborn care, not in hosp	1.26	0.93	0.40	0.07	2.26	1.73	XXX
99433		A	Normal newborn care/hospital	0.62	NA	0.20	0.02	NA	0.84	XXX
99435		A	Newborn discharge day hosp	1.50	NA	0.59	0.06	NA	2.15	XXX
99436		A	Attendance, birth	1.50	NA	0.47	0.06	NA	2.03	XXX
99440		A	Newborn resuscitation	2.93	NA	0.93	0.12	NA	3.98	XXX
99450		N	Life/disability evaluation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99455		R	Disability examination	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99456		R	Disability examination	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99499		C	Unlisted e&m service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99500		I	Home visit, prenatal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99501		I	Home visit, postnatal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99502		I	Home visit, nb care	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99503		I	Home visit, resp therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99504		I	Home visit mech ventilator	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99505		I	Home visit, stoma care	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99506		I	Home visit, im injection	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99507		I	Home visit, cath maintain	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99509		I	Home visit day life activity	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99510		I	Home visit, sing/m/fam couns	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99511		I	Home visit, fecal/enema mgmt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99512		I	Home visit for hemodialysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
99600		I	Home visit nos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99601		I	Home infusion/visit, 2 hrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99602		I	Home infusion, each addtl hr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A4890		R	Repair/maint cont hemo equip	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0150		R	Comprehensve oral evaluation	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D0240		R	Intraoral occlusal film	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D0250		R	Extraoral first film	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D0260		R	Extraoral ea additional film	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D0270		R	Dental bitewing single film	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D0272		R	Dental bitewings two films	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D0274		R	Dental bitewings four films	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D0277		R	Vert bitewings-sev to eight	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0416		R	Viral culture	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0421		R	Gen tst suscept oral disease	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0431		R	Diag tst detect mucos abnorm	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0460		R	Pulp vitality test	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D0472		R	Gross exam, prep & report	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0473		R	Micro exam, prep & report	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0474		R	Micro w exam of surg margins	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0475		R	Decalcification procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0476		R	Spec stains for microorganis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0477		R	Spec stains not for microorg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0478		R	Immunohistochemical stains	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0479		R	Tissue in-situ hybridization	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0480		R	Cytopath smear prep & report	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0481		R	Electron microscopy diagnost	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0482		R	Direct immunofluorescence	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0483		R	Indirect immunofluorescence	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0484		R	Consult slides prep elsewher	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0485		R	Consult inc prep of slides	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0502		R	Other oral pathology procedu	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D0999		R	Unspecified diagnostic proce	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D1510		R	Space maintainer fxd unilat	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D1515		R	Fixed bilat space maintainer	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D1520		R	Remove unilat space maintain	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D1525		R	Remove bilat space maintain	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D1550		R	Recement space maintainer	0.00	0.00	0.00	0.00	0.00	0.00	YYY

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
D2999		R	Dental unspec restorative pr	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D3460		R	Endodontic endosseous implan	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D3999		R	Endodontic procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D4260		R	Osseous surgery per quadrant	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D4263		R	Bone replce graft first site	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D4264		R	Bone replce graft each add	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D4268		R	Surgical revision procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D4270		R	Pedicle soft tissue graft pr	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D4271		R	Free soft tissue graft proc	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D4273		R	Subepithelial tissue graft	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D4355		R	Full mouth debridement	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D4381		R	Localized delivery antimicro	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D5911		R	Facial moulage sectional	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D5912		R	Facial moulage complete	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D5951		R	Feeding aid	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D5983		R	Radiation applicator	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D5984		R	Radiation shield	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D5985		R	Radiation cone locator	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D5987		R	Commissure splint	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D6920		R	Dental connector bar	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D7111		R	Extraction coronal remnants	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D7140		R	Extraction erupted tooth/exr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D7210		R	Rem imp tooth w mucoper flp	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D7220		R	Impact tooth remov soft tiss	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D7230		R	Impact tooth remov part bony	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D7240		R	Impact tooth remov comp bony	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D7241		R	Impact tooth rem bony w/comp	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D7250		R	Tooth root removal	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D7260		R	Oral antral fistula closure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D7261		R	Primary closure sinus perf	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D7283		R	Place device impacted tooth	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D7288		R	Brush biopsy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D7291		R	Transseptal fiberotomy	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D7321		R	Alveoloplasty not w/extracts	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D7511		R	Incision/drain abscess intra	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D7521		R	Incision/drain abscess extra	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D7940		R	Reshaping bone orthognathic	0.00	0.00	0.00	0.00	0.00	0.00	YYY

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
D9110		R	Tx dental pain minor proc	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D9230		R	Analgesia	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D9248		R	Sedation (non-iv)	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D9630		R	Other drugs/medicaments	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D9930		R	Treatment of complications	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D9940		R	Dental occlusal guard	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D9950		R	Occlusion analysis	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D9951		R	Limited occlusal adjustment	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D9952		R	Complete occlusal adjustment	0.00	0.00	0.00	0.00	0.00	0.00	YYY
G0008		X	Admin influenza virus vac	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0009		X	Admin pneumococcal vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0010		X	Admin hepatitis b vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0027		X	Semen analysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0030		C	PET imaging prev PET single	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0030	26	A	PET imaging prev PET single	1.50	0.58	0.58	0.06	2.14	2.14	XXX
G0030	TC	C	PET imaging prev PET single	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0031		C	PET imaging prev PET multple	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0031	26	A	PET imaging prev PET multple	1.87	0.72	0.72	0.07	2.66	2.66	XXX
G0031	TC	C	PET imaging prev PET multple	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0032		C	PET follow SPECT 78464 singl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0032	26	A	PET follow SPECT 78464 singl	1.50	0.54	0.54	0.06	2.10	2.10	XXX
G0032	TC	C	PET follow SPECT 78464 singl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0033		C	PET follow SPECT 78464 mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0033	26	A	PET follow SPECT 78464 mult	1.87	0.74	0.74	0.07	2.68	2.68	XXX
G0033	TC	C	PET follow SPECT 78464 mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0034		C	PET follow SPECT 76865 singl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0034	26	A	PET follow SPECT 76865 singl	1.50	0.57	0.57	0.05	2.12	2.12	XXX
G0034	TC	C	PET follow SPECT 76865 singl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0035		C	PET follow SPECT 78465 mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0035	26	A	PET follow SPECT 78465 mult	1.87	0.73	0.73	0.06	2.66	2.66	XXX
G0035	TC	C	PET follow SPECT 78465 mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0036		C	PET follow comry angio sing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0036	26	A	PET follow comry angio sing	1.50	0.56	0.56	0.05	2.11	2.11	XXX
G0036	TC	C	PET follow comry angio sing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0037		C	PET follow comry angio mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0037	26	A	PET follow comry angio mult	1.87	0.71	0.71	0.06	2.64	2.64	XXX
G0037	TC	C	PET follow comry angio mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
G0038		C	PET follow myocard perf sing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0038	26	A	PET follow myocard perf sing	1.50	0.52	0.52	0.07	2.09	2.09	XXX
G0038	TC	C	PET follow myocard perf sing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0039		C	PET follow myocard perf mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0039	26	A	PET follow myocard perf mult	1.87	0.71	0.71	0.07	2.65	2.65	XXX
G0039	TC	C	PET follow myocard perf mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0040		C	PET follow stress echo singl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0040	26	A	PET follow stress echo singl	1.50	0.59	0.59	0.06	2.15	2.15	XXX
G0040	TC	C	PET follow stress echo singl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0041		C	PET follow stress echo mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0041	26	A	PET follow stress echo mult	1.87	0.73	0.73	0.06	2.66	2.66	XXX
G0041	TC	C	PET follow stress echo mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0042		C	PET follow ventriculogm sing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0042	26	A	PET follow ventriculogm sing	1.50	0.61	0.61	0.05	2.16	2.16	XXX
G0042	TC	C	PET follow ventriculogm sing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0043		C	PET follow ventriculogm mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0043	26	A	PET follow ventriculogm mult	1.87	0.75	0.75	0.07	2.69	2.69	XXX
G0043	TC	C	PET follow ventriculogm mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0044		C	PET following rest ECG singl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0044	26	A	PET following rest ECG singl	1.50	0.59	0.59	0.05	2.14	2.14	XXX
G0044	TC	C	PET following rest ECG singl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0045		C	PET following rest ECG mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0045	26	A	PET following rest ECG mult	1.87	0.72	0.72	0.06	2.65	2.65	XXX
G0045	TC	C	PET following rest ECG mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0046		C	PET follow stress ECG singl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0046	26	A	PET follow stress ECG singl	1.50	0.59	0.59	0.05	2.14	2.14	XXX
G0046	TC	C	PET follow stress ECG singl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0047		C	PET follow stress ECG mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0047	26	A	PET follow stress ECG mult	1.87	0.73	0.73	0.06	2.66	2.66	XXX
G0047	TC	C	PET follow stress ECG mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0101		A	CA screen;pelvic/breast exam	0.45	0.52	0.17	0.02	0.99	0.64	XXX
G0102		A	Prostate ca screening; dre	0.17	0.39	0.06	0.01	0.57	0.24	XXX
G0103		X	Psa, total screening	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0104		A	CA screen;flexi sigmoidscope	0.96	2.27	0.50	0.08	3.31	1.54	000
G0105		A	Colorectal scrn; hi risk ind	3.69	6.14	1.47	0.30	10.13	5.46	000
G0105	53	A	Colorectal scrn; hi risk ind	0.96	2.27	0.50	0.08	3.31	1.54	000
G0106		A	Colon CA screen;barium enema	0.99	2.55	NA	0.17	3.71	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
G0106	26	A	Colon CA screen;barium enema	0.99	0.32	0.32	0.04	1.35	1.35	XXX
G0106	TC	A	Colon CA screen;barium enema	0.00	2.23	NA	0.13	2.36	NA	XXX
G0107		X	CA screen; fecal blood test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0108		A	Diab manage trn per indiv	0.00	0.83	NA	0.01	0.84	NA	XXX
G0109		A	Diab manage trn ind/group	0.00	0.48	NA	0.01	0.49	NA	XXX
G0110		R	Nett pulm-rehab educ; ind	0.90	0.68	0.29	0.04	1.62	1.23	XXX
G0111		R	Nett pulm-rehab educ; group	0.27	0.29	0.13	0.01	0.57	0.41	XXX
G0112		R	Nett;nutrition guid, initial	1.72	1.21	0.65	0.05	2.98	2.42	XXX
G0113		R	Nett;nutrition guid,subseqnt	1.29	0.81	0.41	0.05	2.15	1.75	XXX
G0114		R	Nett; psychosocial consult	1.20	0.48	0.37	0.05	1.73	1.62	XXX
G0115		R	Nett; psychological testing	1.20	0.82	0.37	0.03	2.05	1.60	XXX
G0116		R	Nett; psychosocial counsel	1.11	0.95	0.33	0.05	2.11	1.49	XXX
G0117		T	Glaucoma scrn hgh risk direc	0.45	0.72	0.19	0.01	1.18	0.65	XXX
G0118		T	Glaucoma scrn hgh risk direc	0.17	0.53	0.06	0.01	0.71	0.24	XXX
G0120		A	Colon ca scrn; barium enema	0.99	2.55	NA	0.17	3.71	NA	XXX
G0120	26	A	Colon ca scrn; barium enema	0.99	0.32	0.32	0.04	1.35	1.35	XXX
G0120	TC	A	Colon ca scrn; barium enema	0.00	2.23	NA	0.13	2.36	NA	XXX
G0121		A	Colon ca scrn not hi rsk ind	3.69	6.14	1.47	0.30	10.13	5.46	000
G0121	53	A	Colon ca scrn not hi rsk ind	0.96	2.27	0.50	0.08	3.31	1.54	000
G0122		N	Colon ca scrn; barium enema	+0.99	2.57	2.57	0.18	3.74	3.74	XXX
G0122	26	N	Colon ca scrn; barium enema	+0.99	0.38	0.38	0.05	1.42	1.42	XXX
G0122	TC	N	Colon ca scrn; barium enema	+0.00	2.19	2.19	0.13	2.32	2.32	XXX
G0123		X	Screen cerv/vag thin layer	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0124		A	Screen c/v thin layer by MD	0.42	0.15	0.15	0.02	0.59	0.59	XXX
G0125		C	PET image pulmonary nodule	0.00	0.00	NA	0.00	0.00	NA	XXX
G0125	26	A	PET image pulmonary nodule	1.50	0.52	0.52	0.06	2.08	2.08	XXX
G0125	TC	C	PET image pulmonary nodule	0.00	0.00	NA	0.00	0.00	NA	XXX
G0127		R	Trim nail(s)	0.17	0.25	0.07	0.01	0.43	0.25	000
G0128		R	CORF skilled nursing service	0.08	0.03	0.03	0.01	0.12	0.12	XXX
G0130		A	Single energy x-ray study	0.22	0.87	NA	0.06	1.15	NA	XXX
G0130	26	A	Single energy x-ray study	0.22	0.07	0.07	0.01	0.30	0.30	XXX
G0130	TC	A	Single energy x-ray study	0.00	0.80	NA	0.05	0.85	NA	XXX
G0141		A	Scr c/v cyto,autosys and md	0.42	0.15	0.15	0.02	0.59	0.59	XXX
G0143		X	Scr c/v cyto,thinlayer,rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0144		X	Scr c/v cyto,thinlayer,rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0145		X	Scr c/v cyto,thinlayer,rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0147		X	Scr c/v cyto, automated sys	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
G0148		X	Scr c/v cyto, autosys, rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0166		A	Extrnl counterpulse, per tx	0.07	3.57	0.03	0.01	3.65	0.11	XXX
G0168		A	Wound closure by adhesive	0.45	1.93	0.22	0.03	2.41	0.70	000
G0173		X	Linear acc stereo radsur com	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0175		X	OPPS Service,sched team conf	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0176		X	OPPS/PHP;activity therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0177		X	OPPS/PHP; train & educ serv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0179		A	MD recertification HHA PT	0.45	1.03	NA	0.02	1.50	NA	XXX
G0180		A	MD certification HHA patient	0.67	1.26	NA	0.03	1.96	NA	XXX
G0181		A	Home health care supervision	1.73	1.48	NA	0.07	3.28	NA	XXX
G0182		A	Hospice care supervision	1.73	1.66	NA	0.07	3.46	NA	XXX
G0186		C	Dstry eye lesn,fdr vssl tech	0.00	0.00	0.00	0.00	0.00	0.00	YYY
G0202		A	Screeningmammographydigital	0.70	2.77	NA	0.10	3.57	NA	XXX
G0202	26	A	Screeningmammographydigital	0.70	0.23	0.23	0.03	0.96	0.96	XXX
G0202	TC	A	Screeningmammographydigital	0.00	2.54	NA	0.07	2.61	NA	XXX
G0204		A	Diagnosticmammographydigital	0.87	2.78	NA	0.11	3.76	NA	XXX
G0204	26	A	Diagnosticmammographydigital	0.87	0.28	0.28	0.04	1.19	1.19	XXX
G0204	TC	A	Diagnosticmammographydigital	0.00	2.50	NA	0.07	2.57	NA	XXX
G0206		A	Diagnosticmammographydigital	0.70	2.25	NA	0.09	3.04	NA	XXX
G0206	26	A	Diagnosticmammographydigital	0.70	0.23	0.23	0.03	0.96	0.96	XXX
G0206	TC	A	Diagnosticmammographydigital	0.00	2.02	NA	0.06	2.08	NA	XXX
G0210		C	PET img wholebody dxlung	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0210	26	A	PET img wholebody dxlung	1.50	0.51	0.51	0.06	2.07	2.07	XXX
G0210	TC	C	PET img wholebody dxlung	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0211		C	PET img wholbody init lung	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0211	26	A	PET img wholbody init lung	1.50	0.51	0.51	0.06	2.07	2.07	XXX
G0211	TC	C	PET img wholbody init lung	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0212		C	PET img wholebod restag lung	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0212	26	A	PET img wholebod restag lung	1.50	0.51	0.51	0.06	2.07	2.07	XXX
G0212	TC	C	PET img wholebod restag lung	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0213		C	PET img wholbody dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0213	26	A	PET img wholbody dx	1.50	0.51	0.51	0.06	2.07	2.07	XXX
G0213	TC	C	PET img wholbody dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0214		C	PET img wholebod init	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0214	26	A	PET img wholebod init	1.50	0.51	0.51	0.06	2.07	2.07	XXX
G0214	TC	C	PET img wholebod init	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0215		C	PETimg wholebod restag	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
G0215	26	A	PETimg wholebod restag	1.50	0.51	0.51	0.06	2.07	2.07	XXX
G0215	TC	C	PETimg wholebod restag	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0216		C	PET img wholebod dx melanoma	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0216	26	A	PET img wholebod dx melanoma	1.50	0.51	0.51	0.06	2.07	2.07	XXX
G0216	TC	C	PET img wholebod dx melanoma	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0217		C	PET img wholebod init melan	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0217	26	A	PET img wholebod init melan	1.50	0.51	0.51	0.06	2.07	2.07	XXX
G0217	TC	C	PET img wholebod init melan	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0218		C	PET img wholebod restag mela	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0218	26	A	PET img wholebod restag mela	1.50	0.52	0.52	0.06	2.08	2.08	XXX
G0218	TC	C	PET img wholebod restag mela	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0219		N	PET img wholbod melano nonco	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0219	26	N	PET img wholbod melano nonco	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0219	TC	N	PET img wholbod melano nonco	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0220		C	PET img wholebod dx lymphoma	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0220	26	A	PET img wholebod dx lymphoma	1.50	0.51	0.51	0.06	2.07	2.07	XXX
G0220	TC	C	PET img wholebod dx lymphoma	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0221		C	PET imag wholbod init lympho	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0221	26	A	PET imag wholbod init lympho	1.50	0.51	0.51	0.06	2.07	2.07	XXX
G0221	TC	C	PET imag wholbod init lympho	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0222		C	PET imag wholbod resta lymph	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0222	26	A	PET imag wholbod resta lymph	1.50	0.52	0.52	0.06	2.08	2.08	XXX
G0222	TC	C	PET imag wholbod resta lymph	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0223		C	PET imag wholbod reg dx head	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0223	26	A	PET imag wholbod reg dx head	1.50	0.51	0.51	0.06	2.07	2.07	XXX
G0223	TC	C	PET imag wholbod reg dx head	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0224		C	PET imag wholbod reg ini hea	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0224	26	A	PET imag wholbod reg ini hea	1.50	0.51	0.51	0.06	2.07	2.07	XXX
G0224	TC	C	PET imag wholbod reg ini hea	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0225		C	PET whol restag headneckonly	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0225	26	A	PET whol restag headneckonly	1.50	0.52	0.52	0.06	2.08	2.08	XXX
G0225	TC	C	PET whol restag headneckonly	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0226		C	PET img wholbody dx esophagl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0226	26	A	PET img wholbody dx esophagl	1.50	0.53	0.53	0.06	2.09	2.09	XXX
G0226	TC	C	PET img wholbody dx esophagl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0227		C	PET img wholbod ini esophage	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0227	26	A	PET img wholbod ini esophage	1.50	0.52	0.52	0.06	2.08	2.08	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
G0227	TC	C	PET img wholbod ini esophage	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0228		C	PET img wholbod restg esopha	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0228	26	A	PET img wholbod restg esopha	1.50	0.51	0.51	0.06	2.07	2.07	XXX
G0228	TC	C	PET img wholbod restg esopha	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0229		C	PET img metaboloc brain pres	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0229	26	A	PET img metaboloc brain pres	1.50	0.52	0.52	0.06	2.08	2.08	XXX
G0229	TC	C	PET img metaboloc brain pres	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0230		C	PET myocard viability post	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0230	26	A	PET myocard viability post	1.50	0.53	0.53	0.06	2.09	2.09	XXX
G0230	TC	C	PET myocard viability post	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0231		C	PET WhBD colorec; gamma cam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0231	26	A	PET WhBD colorec; gamma cam	1.50	0.51	0.51	0.06	2.07	2.07	XXX
G0231	TC	C	PET WhBD colorec; gamma cam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0232		C	PET whbd lymphoma; gamma cam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0232	26	A	PET whbd lymphoma; gamma cam	1.50	0.52	0.52	0.06	2.08	2.08	XXX
G0232	TC	C	PET whbd lymphoma; gamma cam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0233		C	PET whbd melanoma; gamma cam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0233	26	A	PET whbd melanoma; gamma cam	1.50	0.52	0.52	0.06	2.08	2.08	XXX
G0233	TC	C	PET whbd melanoma; gamma cam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0234		C	PET WhBD pulm nod; gamma cam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0234	26	A	PET WhBD pulm nod; gamma cam	1.50	0.52	0.52	0.06	2.08	2.08	XXX
G0234	TC	C	PET WhBD pulm nod; gamma cam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0237		A	Therapeutic procd strg endur	0.00	0.47	NA	0.02	0.49	NA	XXX
G0238		A	Oth resp proc, indiv	0.00	0.49	NA	0.02	0.51	NA	XXX
G0239		A	Oth resp proc, group	0.00	0.33	NA	0.02	0.35	NA	XXX
G0242		X	Multisource photon ster plan	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0243		X	Multisour photon stero treat	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0244		E	Observ care by facility topt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0245		R	Initial foot exam pt lops	0.88	0.79	0.31	0.04	1.71	1.23	XXX
G0246		R	Followup eval of foot pt lop	0.45	0.54	0.16	0.02	1.01	0.63	XXX
G0247		R	Routine footcare pt w lops	0.50	0.52	0.21	0.02	1.04	0.73	ZZZ
G0248		R	Demonstrate use home inr mon	0.00	6.61	NA	0.01	6.62	NA	XXX
G0249		R	Provide test material,equipm	0.00	3.96	NA	0.01	3.97	NA	XXX
G0250		R	MD review interpret of test	0.18	0.06	0.06	0.01	0.25	0.25	XXX
G0251		E	Linear acc based stero radio	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0252		N	PET imaging initial dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0252	26	N	PET imaging initial dx	+1.50	0.60	0.60	0.04	2.14	2.14	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
G0252	TC	N	PET imaging initial dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0253		C	PET image brst dection recur	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0253	26	A	PET image brst dection recur	1.87	0.63	0.63	0.08	2.58	2.58	XXX
G0253	TC	C	PET image brst dection recur	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0254		C	PET image brst eval to tx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0254	26	A	PET image brst eval to tx	1.87	0.65	0.65	0.08	2.60	2.60	XXX
G0254	TC	C	PET image brst eval to tx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0255		N	Current percep threshold tst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0255	26	N	Current percep threshold tst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0255	TC	N	Current percep threshold tst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0257		E	Unsched dialysis ESRD pt hos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0258		E	IV infusion during obs stay	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0259		E	Inject for sacroiliac joint	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0260		E	Inj for sacroiliac jt anesth	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0263		E	Adm with CHF, CP, asthma	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0264		E	Assmt otr CHF, CP, asthma	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0265		X	Cryopresevation Freeze+stora	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0266		X	Thawing + expansion froz cel	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0267		X	Bone marrow or psc harvest	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0268		A	Removal of impacted wax md	0.61	0.63	0.24	0.02	1.26	0.87	000
G0269		B	Occlusive device in vein art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0270		A	MNT subs tx for change dx	0.00	0.47	NA	0.01	0.48	NA	XXX
G0271		A	Group MNT 2 or more 30 mins	0.00	0.18	NA	0.01	0.19	NA	XXX
G0275		A	Renal angio, cardiac cath	0.25	NA	0.10	0.01	NA	0.36	ZZZ
G0278		A	Iliac art angio,cardiac cath	0.25	NA	0.10	0.01	NA	0.36	ZZZ
G0279		C	Excorp shock tx, elbow epi	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0280		C	Excorp shock tx other than	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0281		A	Elec stim unattend for press	0.18	0.11	NA	0.01	0.30	NA	XXX
G0282		N	Elect stim wound care not pd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0283		A	Elec stim other than wound	0.18	0.11	NA	0.01	0.30	NA	XXX
G0288		A	Recon, CTA for surg plan	0.00	10.61	NA	0.18	10.79	NA	XXX
G0289		A	Arthro, loose body + chondro	1.48	NA	0.80	0.25	NA	2.53	ZZZ
G0290		E	Drug-eluting stents, single	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0291		E	Drug-eluting stents,each add	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0293		E	Non-cov surg proc,clin trial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0294		E	Non-cov proc, clinical trial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0295		N	Electromagnetic therapy onc	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
G0296		C	PET imge restag thyrod cance	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0296	26	A	PET imge restag thyrod cance	1.87	0.71	0.71	0.08	2.66	2.66	XXX
G0296	TC	C	PET imge restag thyrod cance	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0297		X	Insert single chamber/cd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0298		X	Insert dual chamber/cd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0299		X	Inser/repos single icd+leads	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0300		X	Insert reposit lead dual+gen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0302		X	Pre-op service LVRS complete	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0303		X	Pre-op service LVRS 10-15dos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0304		X	Pre-op service LVRS 1-9 dos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0305		X	Post op service LVRS min 6	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0306		X	CBC/diffwbc w/o platelet	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0307		X	CBC without platelet	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0308		A	ESRD related svc 4+mo < 2yrs	12.74	8.54	8.54	0.42	21.70	21.70	XXX
G0309		A	ESRD related svc 2-3mo <2yrs	10.61	7.10	7.10	0.36	18.07	18.07	XXX
G0310		A	ESRD related svc 1 vst <2yrs	8.49	5.68	5.68	0.28	14.45	14.45	XXX
G0311		A	ESRD related svs 4+mo 2-11yr	9.73	4.72	4.72	0.34	14.79	14.79	XXX
G0312		A	ESRD relate svs 2-3 mo 2-11y	8.11	3.92	3.92	0.29	12.32	12.32	XXX
G0313		A	ESRD related svs 1 mon 2-11y	6.49	3.14	3.14	0.22	9.85	9.85	XXX
G0314		A	ESRD related svs 4+ mo 12-19	8.28	4.42	4.42	0.27	12.97	12.97	XXX
G0315		A	ESRD related svs 2-3mo/12-19	6.90	3.67	3.67	0.23	10.80	10.80	XXX
G0316		A	ESRD related svs 1vis/12-19y	5.52	2.94	2.94	0.17	8.63	8.63	XXX
G0317		A	ESRD related svs 4+mo 20+yrs	5.09	2.86	2.86	0.17	8.12	8.12	XXX
G0318		A	ESRD related svs 2-3 mo 20+y	4.24	2.38	2.38	0.14	6.76	6.76	XXX
G0319		A	ESRD related svs 1visit 20+y	3.39	1.90	1.90	0.11	5.40	5.40	XXX
G0320		A	ESD related svs home undr 2	10.61	7.10	7.10	0.36	18.07	18.07	XXX
G0321		A	ESRDrelatedsvs home mo 2-11y	8.11	3.92	3.92	0.29	12.32	12.32	XXX
G0322		A	ESRD related svs hom mo12-19	6.90	3.67	3.67	0.23	10.80	10.80	XXX
G0323		A	ESRD related svs home mo 20+	4.24	2.38	2.38	0.14	6.76	6.76	XXX
G0324		A	ESRD relate svs home/dy <2yr	0.35	0.24	0.24	0.01	0.60	0.60	XXX
G0325		A	ESRD relate home/day/ 2-11yr	0.23	0.12	0.12	0.01	0.36	0.36	XXX
G0326		A	ESRD relate home/dy 12-19yr	0.27	0.13	0.13	0.01	0.41	0.41	XXX
G0327		A	ESRD relate home/dy 20+yrs	0.14	0.08	0.08	0.01	0.23	0.23	XXX
G0328		X	Fecal blood scrn immunoassay	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0329		A	Electromagntic tx for ulcers	0.06	0.14	0.02	0.01	0.21	0.09	XXX
G0336		C	PET imaging brain alzheimers	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0336	26	A	PET imaging brain alzheimers	1.50	0.49	0.49	0.05	2.04	2.04	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
G0336	TC	C	PET imaging brain alzheimers	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0337		X	Hospice evaluation preelecti	+1.34	0.51	0.51	0.09	1.94	1.94	XXX
G0338		X	Linear accelerator stero pln	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0339		X	Robot lin-radsurg com, first	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0340		X	Robt lin-radsurg fractx 2-5	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0341		A	Percutaneous islet celltrans	6.98	5.73	2.59	0.48	13.19	10.05	000
G0342		A	Laparoscopy islet cell trans	11.92	NA	5.29	1.46	NA	18.67	090
G0343		A	Laparotomy islet cell transp	19.85	NA	8.75	2.05	NA	30.65	090
G0344		A	Initial preventive exam	1.34	1.13	0.48	0.10	2.57	1.92	XXX
G0345		A	IV infuse hydration, initial	0.17	1.42	NA	0.07	1.66	NA	XXX
G0346		A	Each additional infuse hour	0.09	0.40	NA	0.04	0.53	NA	ZZZ
G0347		A	IV infusion therapy/diagnost	0.21	1.75	NA	0.07	2.03	NA	XXX
G0348		A	Each additional hr up to 8hr	0.18	0.46	NA	0.04	0.68	NA	ZZZ
G0349		A	Additional sequential infuse	0.19	0.89	NA	0.04	1.12	NA	ZZZ
G0350		A	Concurrent infusion	0.17	0.44	NA	0.04	0.65	NA	XXX
G0351		A	Therapeutic/diagnostic injec	0.17	0.31	NA	0.01	0.49	NA	XXX
G0353		A	IV push,single orinitial dru	0.18	1.29	NA	0.04	1.51	NA	XXX
G0354		A	Each addition sequential IV	0.10	0.57	NA	0.04	0.71	NA	XXX
G0355		A	Chemo adminisrate subcut/IM	0.21	1.14	NA	0.01	1.36	NA	XXX
G0356		A	Hormonal anti-neoplastic	0.19	0.74	NA	0.01	0.94	NA	XXX
G0357		A	IV push single/initial subst	0.24	2.92	NA	0.06	3.22	NA	XXX
G0358		A	IV push each additional drug	0.20	1.61	NA	0.06	1.87	NA	XXX
G0359		A	Chemotherapy IV one hr initi	0.28	4.19	NA	0.08	4.55	NA	XXX
G0360		A	Each additional hr 1-8 hrs	0.19	0.77	NA	0.07	1.03	NA	ZZZ
G0361		A	Prolong chemo infuse>8hrs pu	0.21	4.60	NA	0.08	4.89	NA	XXX
G0362		A	Each add sequential infusion	0.21	1.94	NA	0.07	2.22	NA	ZZZ
G0363		A	Irrigate implanted venous de	0.04	0.69	NA	0.01	0.74	NA	XXX
G0364		A	Bone marrow aspirate &biopsy	0.16	0.14	0.06	0.04	0.34	0.26	ZZZ
G0365		A	Vessel mapping hemo access	0.25	3.99	NA	0.25	4.49	NA	XXX
G0365	26	A	Vessel mapping hemo access	0.25	0.09	0.09	0.02	0.36	0.36	XXX
G0365	TC	A	Vessel mapping hemo access	0.00	3.90	NA	0.23	4.13	NA	XXX
G0366		A	EKG for initial prevent exam	0.17	0.51	NA	0.03	0.71	NA	XXX
G0367		A	EKG tracing for initial prev	0.00	0.45	NA	0.02	0.47	NA	XXX
G0368		A	EKG interpret & report preve	0.17	0.06	0.06	0.01	0.24	0.24	XXX
G3001		X	Admin + supply, tositumomab	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9001		X	MCCD, initial rate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9002		X	MCCD,maintenance rate	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
G9003		X	MCCD, risk adj hi, initial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9004		X	MCCD, risk adj lo, initial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9005		X	MCCD, risk adj, maintenance	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9006		X	MCCD, Home monitoring	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9007		X	MCCD, sch team conf	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9008		X	Mccd,phys coor-care ovrsght	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9009		X	MCCD, risk adj, level 3	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9010		X	MCCD, risk adj, level 4	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9011		X	MCCD, risk adj, level 5	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9012		X	Other Specified Case Mgmt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9013		N	ESRD demo bundle level I	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9014		N	ESRD demo bundle-level II	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9016		N	Demo-smoking cessation coun	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9017		X	Amantadine HCL, oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9018		X	Zanamivir, inh pwdr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9019		X	Oseltamivir phosp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9020		X	Rimantadine HCL	0.00	0.00	0.00	0.00	0.00	0.00	XXX
M0064		A	Visit for drug monitoring	0.37	0.34	0.12	0.01	0.72	0.50	XXX
P3001		A	Screening pap smear by phys	0.42	0.15	0.15	0.02	0.59	0.59	XXX
Q0035		A	Cardiokymography	0.17	0.45	NA	0.03	0.65	NA	XXX
Q0035	26	A	Cardiokymography	0.17	0.06	0.06	0.01	0.24	0.24	XXX
Q0035	TC	A	Cardiokymography	0.00	0.39	NA	0.02	0.41	NA	XXX
Q0091		A	Obtaining screen pap smear	0.37	0.67	0.14	0.02	1.06	0.53	XXX
Q0092		A	Set up port xray equipment	0.00	0.32	NA	0.01	0.33	NA	XXX
Q3001		C	Brachytherapy Radioelements	0.00	0.00	0.00	0.00	0.00	0.00	XXX
Q3014		X	Telehealth facility fee	0.00	0.00	0.00	0.00	0.00	0.00	XXX
R0070		C	Transport portable x-ray	0.00	0.00	0.00	0.00	0.00	0.00	XXX
R0075		C	Transport port x-ray multipl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
R0076		B	Transport portable EKG	0.00	0.00	0.00	0.00	0.00	0.00	XXX
V5299		R	Hearing service	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM C. - CODES WITH INTERIM RVUs

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
0073T		A	Delivery, comp imrt	0.00	18.02	NA	0.13	18.15	NA	XXX
11004		A	Debride genitalia & perineum	10.31	NA	3.90	0.67	NA	14.88	000
11005		A	Debride abdom wall	13.75	NA	5.56	0.96	NA	20.27	000
11006		A	Debride genit/per/abdom wall	12.61	NA	4.85	1.28	NA	18.74	000
11008		A	Remove mesh from abd wall	5.00	NA	2.02	0.61	NA	7.63	ZZZ
19296		A	Place po breast cath for rad	3.63	125.39	1.53	0.36	129.38	5.52	000
19297		A	Place breast cath for rad	1.72	NA	0.64	0.17	NA	2.53	ZZZ
19298		A	Place breast rad tube/caths	6.00	42.16	2.41	0.43	48.59	8.84	000
27412		A	Autochondrocyte implant knee	23.23	NA	14.80	4.33	NA	42.36	090
27415		A	Osteochondral knee allograft	18.49	NA	12.55	4.33	NA	35.37	090
29866		A	Autgrft implnt, knee w/scope	13.88	NA	11.35	2.38	NA	27.61	090
29867		A	Allgrft implnt, knee w/scope	17.00	NA	13.22	2.76	NA	32.98	090
29868		A	Meniscal trnspl, knee w/scpe	23.59	NA	16.79	4.33	NA	44.71	090
31545		A	Remove vc lesion w/scope	6.30	NA	3.47	0.37	NA	10.14	000
31546		A	Remove vc lesion scope/graft	9.73	NA	4.97	0.78	NA	15.48	000
31620		A	Endobronchial us add-on	1.40	5.64	0.55	0.11	7.15	2.06	ZZZ
31630		A	Bronchoscopy dilate/fx repr	3.81	NA	1.72	0.34	NA	5.87	000
31631		A	Bronchoscopy, dilate w/stent	4.36	NA	1.76	0.36	NA	6.48	000
31636		A	Bronchoscopy, bronch stents	4.30	NA	1.76	0.31	NA	6.37	000
31637		A	Bronchoscopy, stent add-on	1.58	NA	0.56	0.13	NA	2.27	ZZZ
31638		A	Bronchoscopy, revise stent	4.88	NA	1.97	0.22	NA	7.07	000
32019		A	Insert pleural catheter	4.17	19.96	1.65	0.42	24.55	6.24	000
34803		A	Endovas aaa repr w/3-p part	24.00	NA	10.21	1.99	NA	36.20	090
36475		A	Endovenous rf, 1st vein	6.72	51.39	2.53	0.37	58.48	9.62	000
36476		A	Endovenous rf, vein add-on	3.38	7.88	1.14	0.18	11.44	4.70	ZZZ
36478		A	Endovenous laser, 1st vein	6.72	46.77	2.53	0.37	53.86	9.62	000
36479		A	Endovenous laser vein addon	3.38	7.99	1.14	0.18	11.55	4.70	ZZZ
36818		A	Av fuse, uppr arm, cephalic	11.52	NA	6.03	1.88	NA	19.43	090
36819		A	Av fuse, uppr arm, basilic	13.98	NA	6.37	1.92	NA	22.27	090
37205		A	Transcath iv stent, percut	8.27	NA	3.75	0.61	NA	12.63	000
37206		A	Transcath iv stent/perc addl	4.12	NA	1.43	0.32	NA	5.87	ZZZ
37215		R	Transcath stent, cca w/eps	18.71	NA	9.09	1.09	NA	28.89	090
37216		R	Transcath stent, cca w/o eps	17.98	NA	8.81	1.04	NA	27.83	090
43257		A	Uppr gi scope w/thrml txmnt	5.50	NA	2.20	0.36	NA	8.06	000

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ADDENDUM C. - CODES WITH INTERIM RVUs

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
43644		A	Lap gastric bypass/roux-en-y	27.83	NA	11.21	3.13	NA	42.17	090
43645		A	Lap gastr bypass incl smll i	29.96	NA	12.01	3.51	NA	45.48	090
44137		C	Remove intestinal allograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44720		A	Prep donor intestine/venous	5.00	NA	1.71	0.37	NA	7.08	XXX
44721		A	Prep donor intestine/artery	7.00	NA	2.39	0.97	NA	10.36	XXX
45391		A	Colonoscopy w/endoscope us	5.09	NA	1.97	0.42	NA	7.48	000
45392		A	Colonoscopy w/endoscopic fnb	6.54	NA	2.48	0.42	NA	9.44	000
46947		A	Hemorrhoidopexy by stapling	5.20	NA	2.71	0.75	NA	8.66	090
47140		A	Partial removal, donor liver	54.92	NA	22.27	5.13	NA	82.32	090
47141		A	Partial removal, donor liver	67.40	NA	26.90	5.13	NA	99.43	090
47142		A	Partial removal, donor liver	74.89	NA	29.46	5.13	NA	109.48	090
47146		A	Prep donor liver/venous	6.00	NA	2.05	0.83	NA	8.88	XXX
47147		A	Prep donor liver/arterial	7.00	NA	2.39	0.97	NA	10.36	XXX
48552		A	Prep donor pancreas/venous	4.30	NA	1.46	0.31	NA	6.07	XXX
50327		A	Prep renal graft/venous	4.00	NA	1.35	0.29	NA	5.64	XXX
50328		A	Prep renal graft/arterial	3.50	NA	1.18	0.26	NA	4.94	XXX
50329		A	Prep renal graft/ureteral	3.34	NA	1.13	0.25	NA	4.72	XXX
50360		A	Transplantation of kidney	31.48	NA	15.47	3.78	NA	50.73	090
50365		A	Transplantation of kidney	36.75	NA	18.19	4.39	NA	59.33	090
50391		A	Instll rx agnt into rnal tub	1.96	1.58	0.63	0.14	3.68	2.73	000
50547		A	Laparo removal donor kidney	25.46	NA	11.10	2.74	NA	39.30	090
57267		A	Insert mesh/pelvic flr addon	4.88	NA	1.97	0.64	NA	7.49	ZZZ
57282		A	Colpopexy, extraperitoneal	6.86	NA	4.50	1.02	NA	12.38	090
57283		A	Colpopexy, intraperitoneal	10.84	NA	5.91	1.02	NA	17.77	090
58356		A	Endometrial cryoablation	6.36	6.84	2.65	0.82	14.02	9.83	010
58565		A	Hysteroscopy, sterilization	7.02	49.56	3.90	1.19	57.77	12.11	090
58956		A	Bso, omentectomy w/tah	20.78	NA	10.31	3.98	NA	35.07	090
63050		A	Cervical laminoplasty	20.75	NA	11.84	4.64	NA	37.23	090
63051		A	C-laminoplasty w/graft/plate	24.25	NA	13.47	4.64	NA	42.36	090
63295		A	Repair of laminectomy defect	5.25	NA	2.14	1.03	NA	8.42	ZZZ
66710		A	Ciliary transsleral therapy	4.77	5.17	3.84	0.23	10.17	8.84	090
66711		A	Ciliary endoscopic ablation	6.60	NA	6.47	0.30	NA	13.37	090
75960	26	A	Transcath iv stent rs&i	0.82	0.28	0.28	0.05	1.15	1.15	XXX
76075	26	A	Dxa bone density, axial	0.30	0.10	0.10	0.01	0.41	0.41	XXX

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ADDENDUM C. - CODES WITH INTERIM RVUs

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
76076	26	A	Dxa bone density/peripheral	0.22	0.08	0.08	0.01	0.31	0.31	XXX
76077	26	A	Dxa bone density/v-fracture	0.17	0.06	0.06	0.01	0.24	0.24	XXX
76510	26	A	Ophth us, b & quant a	1.55	0.68	0.68	0.03	2.26	2.26	XXX
76511	26	A	Ophth us, quant a only	0.94	0.40	0.40	0.03	1.37	1.37	XXX
76512	26	A	Ophth us, b w/non-quant a	0.94	0.42	0.42	0.02	1.38	1.38	XXX
76513	26	A	Echo exam of eye, water bath	0.66	0.29	0.29	0.02	0.97	0.97	XXX
76514	26	A	Echo exam of eye, thickness	0.17	0.08	0.08	0.01	0.26	0.26	XXX
76820	26	A	Umbilical artery echo	0.50	0.19	0.19	0.03	0.72	0.72	XXX
76821	26	A	Middle cerebral artery echo	0.70	0.27	0.27	0.03	1.00	1.00	XXX
76827	26	A	Echo exam of fetal heart	0.58	0.21	0.21	0.03	0.82	0.82	XXX
76828	26	A	Echo exam of fetal heart	0.56	0.22	0.22	0.03	0.81	0.81	XXX
77750	26	A	Infuse radioactive materials	4.90	1.58	1.58	0.25	6.73	6.73	090
78811	26	I	Tumor imaging (pet), limited	+1.54	0.00	0.00	0.11	1.65	1.65	XXX
78812	26	I	Tumor image (pet)/skul-thigh	+1.93	0.00	0.00	0.11	2.04	2.04	XXX
78813	26	I	Tumor image (pet) full body	+2.00	0.00	0.00	0.11	2.11	2.11	XXX
78814	26	I	Tumor image pet/ct, limited	+2.20	0.00	0.00	0.11	2.31	2.31	XXX
78815	26	I	Tumorimage pet/ct skul-thigh	+2.44	0.00	0.00	0.11	2.55	2.55	XXX
78816	26	I	Tumor image pet/ct full body	+2.50	0.00	0.00	0.11	2.61	2.61	XXX
79005	26	A	Nuclear rx, oral admin	1.80	0.60	0.60	0.08	2.48	2.48	XXX
79101	26	A	Nuclear rx, iv admin	1.96	0.67	0.67	0.08	2.71	2.71	XXX
79200	26	A	Nuclear rx, intracav admin	1.99	0.69	0.69	0.09	2.77	2.77	XXX
79300	26	A	Nuclr rx, interstit colloid	1.60	0.56	0.56	0.13	2.29	2.29	XXX
79440	26	A	Nuclear rx, intra-articular	1.99	0.72	0.72	0.08	2.79	2.79	XXX
79445	26	A	Nuclear rx, intra-arterial	2.40	0.82	0.82	0.12	3.34	3.34	XXX
79999	26	C	Nuclear medicine therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
84165	26	A	Protein e-phoresis, serum	0.37	0.14	0.14	0.01	0.52	0.52	XXX
84166	26	A	Protein e-phoresis/urine/csf	0.37	0.14	0.14	0.01	0.52	0.52	XXX
86334	26	A	Immunofix e-phoresis, serum	0.37	0.15	0.15	0.01	0.53	0.53	XXX
86335	26	A	Immunfix e-phorsis/urine/csf	0.37	0.14	0.14	0.01	0.52	0.52	XXX
88184		A	Flowcytometry/ tc, 1 marker	0.00	1.32	NA	0.02	1.34	NA	XXX
88185		A	Flowcytometry/tc, add-on	0.00	0.64	NA	0.02	0.66	NA	ZZZ
88187		A	Flowcytometry/read, 2-8	1.36	0.45	0.45	0.01	1.82	1.82	XXX
88188		A	Flowcytometry/read, 9-15	1.69	0.57	0.57	0.01	2.27	2.27	XXX
88189		A	Flowcytometry/read, 16 & >	2.23	0.75	0.75	0.01	2.99	2.99	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM C. - CODES WITH INTERIM RVUs

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
88360	26	A	Tumor immunohistochem/manual	1.10	0.47	0.47	0.06	1.63	1.63	XXX
88361	26	A	Tumor immunohistochem/comput	1.18	0.49	0.49	0.11	1.78	1.78	XXX
88365	26	A	Insitu hybridization (fish)	1.20	0.51	0.51	0.03	1.74	1.74	XXX
88367	26	A	Insitu hybridization, auto	1.30	0.54	0.54	0.06	1.90	1.90	XXX
88368	26	A	Insitu hybridization, manual	1.40	0.60	0.60	0.06	2.06	2.06	XXX
90465		A	Immune admin 1 inj, < 8 yrs	0.17	0.31	NA	0.01	0.49	NA	XXX
90466		A	Immune admin addl inj, < 8 y	0.15	0.13	NA	0.01	0.29	NA	ZZZ
90471		A	Immunization admin	0.17	0.31	NA	0.01	0.49	NA	XXX
90472		A	Immunization admin, each add	0.15	0.13	NA	0.01	0.29	NA	ZZZ
91034	26	A	Gastroesophageal reflux test	0.97	0.34	0.34	0.06	1.37	1.37	XXX
91035	26	A	G-esoph reflx tst w/electrod	1.59	0.56	0.56	0.06	2.21	2.21	XXX
91037	26	A	Esoph imped function test	0.97	0.34	0.34	0.06	1.37	1.37	XXX
91038	26	A	Esoph imped funct test > 1h	1.10	0.39	0.39	0.06	1.55	1.55	XXX
91040	26	A	Esoph balloon distension tst	0.97	0.34	0.34	0.06	1.37	1.37	XXX
91120	26	A	Rectal sensation test	0.97	0.34	0.34	0.07	1.38	1.38	XXX
93741	26	A	Analyze ht pace device sngl	0.80	0.31	0.31	0.03	1.14	1.14	XXX
93742	26	A	Analyze ht pace device sngl	0.91	0.36	0.36	0.03	1.30	1.30	XXX
93890	26	A	Tcd, vasoreactivity study	1.00	0.40	0.40	0.06	1.46	1.46	XXX
93892	26	A	Tcd, emboli detect w/o inj	1.15	0.46	0.46	0.06	1.67	1.67	XXX
93893	26	A	Tcd, emboli detect w/inj	1.15	0.46	0.46	0.06	1.67	1.67	XXX
94452	26	A	Hast w/report	0.31	0.09	0.09	0.02	0.42	0.42	XXX
94453	26	A	Hast w/oxygen titrate	0.40	0.12	0.12	0.02	0.54	0.54	XXX
95928	26	A	C motor evoked, uppr limbs	1.50	0.65	0.65	0.06	2.21	2.21	XXX
95929	26	A	C motor evoked, lwr limbs	1.50	0.65	0.65	0.06	2.21	2.21	XXX
95971		A	Analyze neurostim, simple	0.78	0.68	0.22	0.07	1.53	1.07	XXX
95972		A	Analyze neurostim, complex	1.50	1.21	0.49	0.14	2.85	2.13	XXX
95973		A	Analyze neurostim, complex	0.92	0.62	0.34	0.07	1.61	1.33	ZZZ
95978		A	Analyze neurostim brain/1h	3.50	1.93	1.30	0.18	5.61	4.98	XXX
95979		A	Analyz neurostim brain addon	1.64	0.87	0.69	0.08	2.59	2.41	ZZZ
96520		A	Port pump refill & main	0.21	3.76	NA	0.06	4.03	NA	XXX
96530		A	Syst pump refill & main	0.21	2.64	NA	0.06	2.91	NA	XXX
97597		A	Active wound care/20 cm or <	0.58	0.66	NA	0.05	1.29	NA	XXX
97598		A	Active wound care > 20 cm	0.80	0.79	NA	0.05	1.64	NA	XXX
97605		B	Neg press wound tx, < 50 cm	0.00	0.00	0.00	0.00	0.00	0.00	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM C. - CODES WITH INTERIM RVUs

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
97606		B	Neg press wound tx, > 50 cm	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0344		A	Initial preventive exam	1.34	1.13	0.48	0.10	2.57	1.92	XXX
G0345		A	IV infuse hydration, initial	0.17	1.42	NA	0.07	1.66	NA	XXX
G0346		A	Each additional infuse hour	0.09	0.40	NA	0.04	0.53	NA	ZZZ
G0347		A	IV infusion therapy/diagnost	0.21	1.75	NA	0.07	2.03	NA	XXX
G0348		A	Each additional hr up to 8hr	0.18	0.46	NA	0.04	0.68	NA	ZZZ
G0349		A	Additional sequential infuse	0.19	0.89	NA	0.04	1.12	NA	ZZZ
G0350		A	Concurrent infusion	0.17	0.44	NA	0.04	0.65	NA	XXX
G0351		A	Therapeutic/diagnostic injec	0.17	0.31	NA	0.01	0.49	NA	XXX
G0353		A	IV push,single orinitial dru	0.18	1.29	NA	0.04	1.51	NA	XXX
G0354		A	Each addition sequential IV	0.10	0.57	NA	0.04	0.71	NA	XXX
G0355		A	Chemo administrate subcut/IM	0.21	1.14	NA	0.01	1.36	NA	XXX
G0356		A	Hormonal anti-neoplastic	0.19	0.74	NA	0.01	0.94	NA	XXX
G0357		A	IV push single/initial subst	0.24	2.92	NA	0.06	3.22	NA	XXX
G0358		A	IV push each additional drug	0.20	1.61	NA	0.06	1.87	NA	XXX
G0359		A	Chemotherapy IV one hr initi	0.28	4.19	NA	0.08	4.55	NA	XXX
G0360		A	Each additional hr 1-8 hrs	0.19	0.77	NA	0.07	1.03	NA	ZZZ
G0361		A	Prolong chemo infuse>8hrs pu	0.21	4.60	NA	0.08	4.89	NA	XXX
G0362		A	Each add sequential infusion	0.21	1.94	NA	0.07	2.22	NA	ZZZ
G0363		A	Irngate implanted venous de	0.04	0.69	NA	0.01	0.74	NA	XXX
G0364		A	Bone marrow aspirate &biopsy	0.16	0.14	0.06	0.04	0.34	0.26	ZZZ
G0365	26	A	Vessel mapping hemo access	0.25	0.09	0.09	0.02	0.36	0.36	XXX
G0366		A	EKG for initial prevent exam	0.17	0.51	NA	0.03	0.71	NA	XXX
G0367		A	EKG tracing for initial prev	0.00	0.45	NA	0.02	0.47	NA	XXX
G0368		A	EKG interpret & report preve	0.17	0.06	0.06	0.01	0.24	0.24	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM D -- 2005 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY

Carrier Number	Locality Number	Locality Name	[1]Work GPCI	PE GPCI	MP GPCI
00510	00	Alabama	1.000	0.858	0.752
00831	01	[2]Alaska	1.670	1.670	1.670
00832	00	Arizona	1.000	0.985	1.069
00520	13	Arkansas	1.000	0.839	0.438
31146	26	Anaheim/Santa Ana, CA	1.036	1.210	0.954
31146	18	Los Angeles, CA	1.049	1.147	0.954
31140	03	Marin/Napa/Solano, CA	1.025	1.294	0.651
31140	07	Oakland/Berkley, CA	1.048	1.303	0.651
31140	05	San Francisco, CA	1.064	1.501	0.651
31140	06	San Mateo, CA	1.061	1.484	0.639
31140	09	Santa Clara, CA	1.073	1.460	0.604
31146	17	Ventura, CA	1.028	1.152	0.744
31146	99	Rest of California*	1.007	1.043	0.733
31140	99	Rest of California*	1.007	1.043	0.733
00824	01	Colorado	1.000	1.003	0.803
00591	00	Connecticut	1.044	1.163	0.900
00902	01	Delaware	1.016	1.026	0.892
00903	01	DC + MD/VA Suburbs	1.049	1.208	0.926
00590	03	Fort Lauderdale, FL	1.000	1.003	1.703
00590	04	Miami, FL	1.008	1.049	2.269
00590	99	Rest of Florida	1.000	0.940	1.272
00511	01	Atlanta, GA	1.008	1.074	0.966
00511	99	Rest of Georgia	1.000	0.882	0.966
00833	01	Hawaii/Guam	1.001	1.118	0.800
05130	00	Idaho	1.000	0.874	0.459
00952	16	Chicago, IL	1.027	1.109	1.867
00952	12	East St. Louis, IL	1.000	0.931	1.750
00952	15	Suburban Chicago, IL	1.012	1.093	1.652
00952	99	Rest of Illinois	1.000	0.881	1.193
00630	00	Indiana	1.000	0.914	0.436
00826	00	Iowa	1.000	0.872	0.589
00650	00	Kansas*	1.000	0.887	0.721
00740	04	Kansas*	1.000	0.887	0.721
00660	00	Kentucky	1.000	0.860	0.873
00528	01	New Orleans, LA	1.000	0.945	1.197
00528	99	Rest of Louisiana	1.000	0.858	1.058
31142	03	Southern Maine	1.000	1.006	0.637
31142	99	Rest of Maine	1.000	0.898	0.637
00901	01	Baltimore/Surr. Cntys, MD	1.017	1.058	0.947
00901	99	Rest of Maryland	1.000	0.976	0.760
31143	01	Metropolitan Boston	1.036	1.284	0.823
31143	99	Rest of Massachusetts	1.009	1.116	0.823
00953	01	Detroit, MI	1.040	1.046	2.744
00953	99	Rest of Michigan	1.000	0.929	1.518
00954	00	Minnesota	1.000	0.990	0.410
00512	00	Mississippi	1.000	0.838	0.722

[1] 1.0 Floor on Work GPCI set by MMA.

[2] 1.67 Floor on all indices set by MMA.

GPCIs scaled by following factors: Work = 0.9965, Practice Expense = 0.9929, Malpractice = 1.0021.

* States are served by more than one carrier.

ADDENDUM D -- 2005 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY

Carrier Number	Locality Number	Locality Name	[1]Work GPCI	PE GPCI	MP GPCI
00740	02	Metropolitan Kansas City, MO	1.000	0.971	0.946
00523	01	Metropolitan St. Louis, MO	1.000	0.946	0.941
00523	99	Rest of Missouri*	1.000	0.813	0.892
00740	99	Rest of Missouri*	1.000	0.813	0.892
00751	01	Montana	1.000	0.860	0.904
00655	00	Nebraska	1.000	0.876	0.454
00834	00	Nevada	1.004	1.041	1.068
31144	40	New Hampshire	1.000	1.029	0.942
00805	01	Northern NJ	1.058	1.207	0.973
00805	99	Rest of New Jersey	1.036	1.115	0.973
00521	05	New Mexico	1.000	0.893	0.895
00803	01	Manhattan, NY	1.079	1.324	1.504
00803	02	NYC Suburbs/Long I., NY	1.060	1.266	1.785
00803	03	Poughkpsie/N NYC Suburbs, NY	1.013	1.074	1.167
14330	04	Queens, NY	1.045	1.228	1.710
00801	99	Rest of New York	1.000	0.930	0.677
05535	00	North Carolina	1.000	0.925	0.640
00820	01	North Dakota	1.000	0.870	0.602
00883	00	Ohio	1.000	0.938	0.976
00522	00	Oklahoma	1.000	0.865	0.382
00835	01	Portland, OR	1.000	1.053	0.441
00835	99	Rest of Oregon	1.000	0.929	0.441
00865	01	Metropolitan Philadelphia, PA	1.020	1.098	1.386
00865	99	Rest of Pennsylvania	1.000	0.916	0.806
00973	20	Puerto Rico	1.000	0.705	0.261
00870	01	Rhode Island	1.031	1.027	0.909
00880	01	South Carolina	1.000	0.898	0.394
00820	02	South Dakota	1.000	0.877	0.365
05440	35	Tennessee	1.000	0.890	0.631
00900	31	Austin, TX	1.000	1.021	0.986
00900	20	Beaumont, TX	1.000	0.875	1.298
00900	09	Brazoria, TX	1.006	0.970	1.298
00900	11	Dallas, TX	1.010	1.063	1.061
00900	28	Fort Worth, TX	1.000	0.985	1.061
00900	15	Galveston, TX	1.000	0.960	1.298
00900	18	Houston, TX	1.018	1.011	1.297
00900	99	Rest of Texas	1.000	0.873	1.138
00910	09	Utah	1.000	0.939	0.662
31145	50	Vermont	1.000	0.977	0.514
00973	50	Virgin Islands	1.000	1.018	1.003
00904	00	Virginia	1.000	0.939	0.579
00836	02	Seattle (King Cnty), WA	1.010	1.115	0.819
00836	99	Rest of Washington	1.000	0.975	0.819
00884	16	West Virginia	1.000	0.835	1.547
00951	00	Wisconsin	1.000	0.924	0.790
00825	21	Wyoming	1.000	0.874	0.935

[1] 1.0 Floor on Work GPCI set by MMA.

[2] 1.67 Floor on all indices set by MMA.

GPCIs scaled by following factors: Work = 0.9965, Practice Expense = 0.9929, Malpractice = 1.0021.

* States are served by more than one carrier.

ADDENDUM E -- 2006 GEOGRAPHIC PRACTICE COST INDICES
BY MEDICARE CARRIER AND LOCALITY

Carrier Number	Locality Number	Locality Name	[1]Work GPCI	PE GPCI	MP GPCI
00510	00	Alabama	1.000	0.846	0.752
00831	01	Alaska	1.017	1.103	1.029
00832	00	Arizona	1.000	0.992	1.069
00520	13	Arkansas	1.000	0.831	0.438
31146	26	Anaheim/Santa Ana, CA	1.034	1.236	0.954
31146	18	Los Angeles, CA	1.041	1.156	0.954
31140	03	Marin/Napa/Solano, CA	1.035	1.340	0.651
31140	07	Oakland/Berkley, CA	1.054	1.371	0.651
31140	05	San Francisco, CA	1.060	1.543	0.651
31140	06	San Mateo, CA	1.073	1.536	0.639
31140	09	Santa Clara, CA	1.083	1.540	0.604
31146	17	Ventura, CA	1.028	1.179	0.744
31140	99	Rest of California*	1.007	1.053	0.733
31146	99	Rest of California*	1.007	1.053	0.733
00824	01	Colorado	1.000	1.014	0.803
00591	00	Connecticut	1.038	1.170	0.900
00902	01	Delaware	1.012	1.018	0.892
00903	01	DC + MD/VA Suburbs	1.048	1.250	0.926
00590	03	Fort Lauderdale, FL	1.000	0.988	1.703
00590	04	Miami, FL	1.000	1.046	2.269
00590	99	Rest of Florida	1.000	0.934	1.272
00511	01	Atlanta, GA	1.010	1.089	0.966
00511	99	Rest of Georgia	1.000	0.872	0.966
00833	01	Hawaii/Guam	1.005	1.111	0.800
05130	00	Idaho	1.000	0.868	0.459
00952	16	Chicago, IL	1.025	1.126	1.867
00952	12	East St. Louis, IL	1.000	0.939	1.750
00952	15	Suburban Chicago, IL	1.018	1.115	1.652
00952	99	Rest of Illinois	1.000	0.872	1.193
00630	00	Indiana	1.000	0.906	0.436
00826	00	Iowa	1.000	0.868	0.589
00650	00	Kansas*	1.000	0.878	0.721
00740	04	Kansas*	1.000	0.878	0.721
00660	00	Kentucky	1.000	0.854	0.873
00528	01	New Orleans, LA	1.000	0.946	1.197
00528	99	Rest of Louisiana	1.000	0.847	1.058
31142	03	Southern Maine	1.000	1.013	0.637
31142	99	Rest of Maine	1.000	0.886	0.637
00901	01	Baltimore/Surr. Cntys, MD	1.012	1.078	0.947
00901	99	Rest of Maryland	1.000	0.980	0.760
31143	01	Metropolitan Boston	1.030	1.329	0.823
31143	99	Rest of Massachusetts	1.007	1.103	0.823
00953	01	Detroit, MI	1.037	1.054	2.744
00953	99	Rest of Michigan	1.000	0.921	1.518
00954	00	Minnesota	1.000	1.005	0.410
00512	00	Mississippi	1.000	0.839	0.722
00740	02	Metropolitan Kansas City, MO	1.000	0.975	0.946
00523	01	Metropolitan St. Louis, MO	1.000	0.955	0.941
00523	99	Rest of Missouri*	1.000	0.802	0.892

[1] 1.0 Floor on Work GPCI set by MMA.
GPCIs scaled by following factors: Work = 0.9965, Practice Expense = 0.9929, Malpractice = 1.0021.
* States are served by more than one carrier.

ADDENDUM E -- 2006 GEOGRAPHIC PRACTICE COST INDICES
BY MEDICARE CARRIER AND LOCALITY

Carrier Number	Locality Number	Locality Name	[1]Work GPCI	PE GPCI	MP GPCI
00740	99	Rest of Missouri*	1.000	0.802	0.892
00751	01	Montana	1.000	0.844	0.904
00655	00	Nebraska	1.000	0.875	0.454
00834	00	Nevada	1.003	1.043	1.068
31144	40	New Hampshire	1.000	1.027	0.942
00805	01	Northern NJ	1.058	1.220	0.973
00805	99	Rest of New Jersey	1.043	1.119	0.973
00521	05	New Mexico	1.000	0.887	0.895
00803	01	Manhattan, NY	1.065	1.298	1.504
00803	02	NYC Suburbs/Long I., NY	1.052	1.280	1.785
00803	03	Poughkpsie/N NYC Suburbs, NY	1.014	1.074	1.167
14330	04	Queens, NY	1.032	1.228	1.710
00801	99	Rest of New York	1.000	0.917	0.677
05535	00	North Carolina	1.000	0.920	0.640
00820	01	North Dakota	1.000	0.860	0.602
00883	00	Ohio	1.000	0.933	0.976
00522	00	Oklahoma	1.000	0.854	0.382
00835	01	Portland, OR	1.002	1.057	0.441
00835	99	Rest of Oregon	1.000	0.925	0.441
00865	01	Metropolitan Philadelphia, PA	1.016	1.104	1.386
00865	99	Rest of Pennsylvania	1.000	0.902	0.806
00973	20	Puerto Rico	1.000	0.698	0.261
00870	01	Rhode Island	1.045	0.989	0.909
00880	01	South Carolina	1.000	0.893	0.394
00820	02	South Dakota	1.000	0.876	0.365
05440	35	Tennessee	1.000	0.879	0.631
00900	31	Austin, TX	1.000	1.046	0.986
00900	20	Beaumont, TX	1.000	0.860	1.298
00900	09	Brazoria, TX	1.020	0.961	1.298
00900	11	Dallas, TX	1.009	1.062	1.061
00900	28	Fort Worth, TX	1.000	0.989	1.061
00900	15	Galveston, TX	1.000	0.952	1.298
00900	18	Houston, TX	1.016	1.014	1.297
00900	99	Rest of Texas	1.000	0.865	1.138
00910	09	Utah	1.000	0.937	0.662
31145	50	Vermont	1.000	0.968	0.514
00973	50	Virgin Islands	1.000	1.014	1.003
00904	00	Virginia	1.000	0.940	0.579
00836	02	Seattle (King Cnty), WA	1.014	1.131	0.819
00836	99	Rest of Washington	1.000	0.978	0.819
00884	16	West Virginia	1.000	0.819	1.547
00951	00	Wisconsin	1.000	0.918	0.790
00825	21	Wyoming	1.000	0.853	0.935

[1] 1.0 Floor on Work GPCI set by MMA.
GPCIs scaled by following factors: Work = 0.9965, Practice Expense = 0.9929, Malpractice = 1.0021.
* States are served by more than one carrier.

ADDENDUM F -- COMPARISON OF 2004 GAFs TO 2005 GAFs

Carrier Number	Locality Number	Locality Name	2004 GAF	2005 GAF	Difference	Percent Difference
31140	09	Santa Clara, CA	1.184	1.224	0.040	0.034
31140	07	Oakland/Berkley, CA	1.111	1.144	0.033	0.030
31140	06	San Mateo, CA	1.201	1.230	0.029	0.024
31140	03	Marin/Napa/Solano, CA	1.103	1.128	0.025	0.023
00903	01	DC + MD/VA Suburbs	1.096	1.114	0.019	0.017
31143	01	Metropolitan Boston	1.118	1.136	0.018	0.016
31140	05	San Francisco, CA	1.223	1.239	0.016	0.013
00900	31	Austin, TX	0.995	1.009	0.014	0.014
00952	15	Suburban Chicago, IL	1.059	1.072	0.013	0.012
31146	17	Ventura, CA	1.060	1.072	0.011	0.011
31146	26	Anaheim/Santa Ana, CA	1.098	1.109	0.011	0.010
00836	02	Seattle (King Cnty), WA	1.039	1.049	0.010	0.010
00805	01	Northern NJ	1.111	1.120	0.009	0.008
00952	16	Chicago, IL	1.087	1.096	0.009	0.008
00511	01	Atlanta, GA	1.027	1.036	0.009	0.008
00805	99	Rest of New Jersey	1.060	1.068	0.008	0.008
00901	01	Baltimore/Surr. Cntys, MD	1.025	1.033	0.008	0.007
00954	00	Minnesota	0.967	0.973	0.006	0.007
00523	01	Metropolitan St. Louis, MO	0.969	0.974	0.006	0.006
00820	01	North Dakota	0.923	0.928	0.005	0.006
00900	28	Fort Worth, TX	0.992	0.996	0.005	0.005
00952	12	East St. Louis, IL	0.995	0.999	0.004	0.005
00824	01	Colorado	0.990	0.994	0.004	0.004
31146	99	Rest of California*	1.008	1.012	0.004	0.004
31140	99	Rest of California*	1.008	1.012	0.004	0.004
00740	02	Metropolitan Kansas City, MO	0.982	0.986	0.004	0.004
31142	03	Southern Maine	0.986	0.989	0.003	0.003
00832	00	Arizona	0.994	0.996	0.003	0.003
00953	01	Detroit, MI	1.106	1.109	0.002	0.002
00904	00	Virginia	0.955	0.957	0.002	0.002
00836	99	Rest of Washington	0.980	0.982	0.002	0.002
00835	01	Portland, OR	1.000	1.002	0.002	0.002
31144	40	New Hampshire	1.009	1.011	0.002	0.002
00900	11	Dallas, TX	1.033	1.035	0.002	0.002
00901	99	Rest of Maryland	0.979	0.981	0.002	0.002
00865	01	Metropolitan Philadelphia, PA	1.068	1.069	0.001	0.001
00900	99	Rest of Texas	0.949	0.950	0.001	0.001
00655	00	Nebraska	0.925	0.925	0.000	0.000
00900	18	Houston, TX	1.026	1.026	0.000	0.000
31146	18	Los Angeles, CA	1.088	1.088	0.000	0.000
00831	01	Alaska	1.670	1.670	0.000	0.000
00880	01	South Carolina	0.932	0.932	0.000	0.000
00910	09	Utah	0.961	0.961	0.000	0.000
00512	00	Mississippi	0.919	0.919	0.000	0.000
00803	02	NYC Suburbs/Long I., NY	1.179	1.178	-0.001	0.000
00900	09	Brazoria, TX	1.003	1.002	-0.001	-0.001
00591	00	Connecticut	1.092	1.091	-0.001	-0.001
00803	03	Poughkpsie/N NYC Suburbs, NY	1.047	1.046	-0.001	-0.001
00520	13	Arkansas	0.910	0.908	-0.001	-0.001

* States are served by more than one carrier.

ADDENDUM F -- COMPARISON OF 2004 GAFs TO 2005 GAFs

Carrier Number	Locality Number	Locality Name	2004 GAF	2005 GAF	Difference	Percent Difference
00835	99	Rest of Oregon	0.949	0.948	-0.001	-0.001
00528	01	New Orleans, LA	0.985	0.984	-0.001	-0.001
05535	00	North Carolina	0.955	0.954	-0.001	-0.002
00826	00	Iowa	0.930	0.928	-0.002	-0.002
00902	01	Delaware	1.018	1.016	-0.002	-0.002
00973	50	Virgin Islands	1.010	1.008	-0.002	-0.002
00883	00	Ohio	0.974	0.972	-0.002	-0.002
00834	00	Nevada	1.025	1.023	-0.002	-0.002
00590	99	Rest of Florida	0.987	0.985	-0.002	-0.002
00833	01	Hawaii/Guam	1.047	1.045	-0.002	-0.002
00660	00	Kentucky	0.937	0.934	-0.002	-0.003
00952	99	Rest of Illinois	0.958	0.956	-0.003	-0.003
00521	05	New Mexico	0.952	0.949	-0.003	-0.003
00884	16	West Virginia	0.952	0.949	-0.003	-0.003
00740	99	Rest of Missouri*	0.917	0.914	-0.003	-0.003
00523	99	Rest of Missouri*	0.917	0.914	-0.003	-0.003
00973	20	Puerto Rico	0.846	0.843	-0.003	-0.004
00751	01	Montana	0.939	0.935	-0.003	-0.004
05440	35	Tennessee	0.941	0.938	-0.003	-0.004
00511	99	Rest of Georgia	0.951	0.947	-0.004	-0.004
05130	00	Idaho	0.928	0.924	-0.004	-0.004
00740	04	Kansas*	0.944	0.940	-0.004	-0.004
00650	00	Kansas*	0.944	0.940	-0.004	-0.004
00630	00	Indiana	0.945	0.941	-0.004	-0.004
31145	50	Vermont	0.976	0.971	-0.004	-0.004
00900	15	Galveston, TX	0.999	0.994	-0.004	-0.004
00953	99	Rest of Michigan	0.994	0.989	-0.005	-0.005
00865	99	Rest of Pennsylvania	0.961	0.956	-0.005	-0.005
00951	00	Wisconsin	0.964	0.959	-0.005	-0.005
31143	99	Rest of Massachusetts	1.054	1.049	-0.005	-0.005
00528	99	Rest of Louisiana	0.946	0.940	-0.005	-0.006
31142	99	Rest of Maine	0.947	0.942	-0.006	-0.006
00522	00	Oklahoma	0.923	0.917	-0.006	-0.006
00510	00	Alabama	0.935	0.929	-0.006	-0.006
00900	20	Beaumont, TX	0.964	0.957	-0.007	-0.007
00801	99	Rest of New York	0.965	0.957	-0.007	-0.008
00870	01	Rhode Island	1.033	1.025	-0.008	-0.008
14330	04	Queens, NY	1.161	1.151	-0.010	-0.008
00590	03	Fort Lauderdale, FL	1.038	1.029	-0.010	-0.009
00590	04	Miami, FL	1.085	1.075	-0.010	-0.009
00825	21	Wyoming	0.953	0.943	-0.010	-0.011
00820	02	South Dakota	0.933	0.922	-0.011	-0.012
00803	01	Manhattan, NY	1.225	1.203	-0.022	-0.018

* States are served by more than one carrier.

ADDENDUM G -- COMPARISON OF 2004 GAFs TO 2006 GAFs

Carrier Number	Locality Number	Locality Name	2004 GAF	2006 GAF	Difference	Percent Difference
31140	09	Santa Clara, CA	1.184	1.265	0.080	0.068
31140	07	Oakland/Berkley, CA	1.111	1.177	0.066	0.059
31140	06	San Mateo, CA	1.201	1.259	0.058	0.048
31140	03	Marin/Napa/Solano, CA	1.103	1.154	0.050	0.046
00903	01	DC + MD/VA Suburbs	1.096	1.132	0.036	0.033
31143	01	Metropolitan Boston	1.118	1.153	0.035	0.031
31140	05	San Francisco, CA	1.223	1.256	0.033	0.027
00900	31	Austin, TX	0.995	1.020	0.025	0.025
00952	15	Suburban Chicago, IL	1.059	1.085	0.026	0.025
31146	17	Ventura, CA	1.060	1.083	0.023	0.022
31146	26	Anaheim/Santa Ana, CA	1.098	1.119	0.021	0.020
00836	02	Seattle (King Cnty), WA	1.039	1.058	0.019	0.019
00511	01	Atlanta, GA	1.027	1.043	0.016	0.016
00952	16	Chicago, IL	1.087	1.102	0.015	0.014
00954	00	Minnesota	0.967	0.980	0.013	0.013
00901	01	Baltimore/Surr. Cntys, MD	1.025	1.039	0.014	0.013
00805	99	Rest of New Jersey	1.060	1.074	0.014	0.013
00805	01	Northern NJ	1.111	1.126	0.014	0.013
00523	01	Metropolitan St. Louis, MO	0.969	0.978	0.010	0.010
00824	01	Colorado	0.990	0.999	0.009	0.009
31146	99	Rest of California*	1.008	1.017	0.008	0.008
31140	99	Rest of California*	1.008	1.017	0.008	0.008
00952	12	East St. Louis, IL	0.995	1.003	0.008	0.008
00900	28	Fort Worth, TX	0.992	0.998	0.006	0.006
31142	03	Southern Maine	0.986	0.992	0.006	0.006
00740	02	Metropolitan Kansas City, MO	0.982	0.987	0.006	0.006
00832	00	Arizona	0.994	0.999	0.006	0.006
00835	01	Portland, OR	1.000	1.005	0.005	0.005
00953	01	Detroit, MI	1.106	1.111	0.004	0.004
00836	99	Rest of Washington	0.980	0.984	0.004	0.004
00901	99	Rest of Maryland	0.979	0.982	0.004	0.004
00904	00	Virginia	0.955	0.958	0.003	0.003
00900	09	Brazoria, TX	1.003	1.005	0.003	0.003
00865	01	Metropolitan Philadelphia, PA	1.068	1.069	0.001	0.001
31144	40	New Hampshire	1.009	1.010	0.001	0.001
00803	02	NYC Suburbs/Long I., NY	1.179	1.180	0.001	0.001
00900	11	Dallas, TX	1.033	1.034	0.001	0.001
00820	01	North Dakota	0.923	0.924	0.001	0.001
00900	18	Houston, TX	1.026	1.026	0.001	0.001
00512	00	Mississippi	0.919	0.919	0.000	0.000
31146	18	Los Angeles, CA	1.088	1.088	0.000	0.000
00655	00	Nebraska	0.925	0.925	0.000	0.000
00803	03	Poughkpsie/N NYC Suburbs, NY	1.047	1.046	-0.001	-0.001
00528	01	New Orleans, LA	0.985	0.984	-0.001	-0.001
00591	00	Connecticut	1.092	1.091	-0.001	-0.001
00910	09	Utah	0.961	0.960	-0.001	-0.001
00834	00	Nevada	1.025	1.023	-0.002	-0.002
00880	01	South Carolina	0.932	0.930	-0.002	-0.002
00900	99	Rest of Texas	0.949	0.947	-0.003	-0.003

Note: The Percent Difference in the GAF for Alaska is the result of the termination of the favorable 2-Year MMA provision for the state of Alaska.

* States are served by more than one carrier.

ADDENDUM G -- COMPARISON OF 2004 GAFs TO 2006 GAFs

Carrier Number	Locality Number	Locality Name	2004 GAF	2006 GAF	Difference	Percent Difference
00833	01	Hawaii/Guam	1.047	1.044	-0.003	-0.003
00835	99	Rest of Oregon	0.949	0.946	-0.003	-0.003
00973	50	Virgin Islands	1.010	1.007	-0.004	-0.004
00826	00	Iowa	0.930	0.927	-0.003	-0.004
05535	00	North Carolina	0.955	0.951	-0.004	-0.004
00883	00	Ohio	0.974	0.970	-0.004	-0.004
00590	99	Rest of Florida	0.987	0.982	-0.005	-0.005
00520	13	Arkansas	0.910	0.905	-0.005	-0.005
00660	00	Kentucky	0.937	0.932	-0.005	-0.005
00521	05	New Mexico	0.952	0.947	-0.006	-0.006
05130	00	Idaho	0.928	0.922	-0.006	-0.007
00952	99	Rest of Illinois	0.958	0.952	-0.006	-0.007
00902	01	Delaware	1.018	1.010	-0.007	-0.007
00973	20	Puerto Rico	0.846	0.840	-0.006	-0.007
00951	00	Wisconsin	0.964	0.956	-0.007	-0.008
00900	15	Galveston, TX	0.999	0.991	-0.008	-0.008
00630	00	Indiana	0.945	0.937	-0.008	-0.008
00953	99	Rest of Michigan	0.994	0.986	-0.008	-0.008
31145	50	Vermont	0.976	0.968	-0.008	-0.008
00740	04	Kansas*	0.944	0.936	-0.008	-0.008
00650	00	Kansas*	0.944	0.936	-0.008	-0.008
00511	99	Rest of Georgia	0.951	0.943	-0.008	-0.008
00740	99	Rest of Missouri*	0.917	0.910	-0.008	-0.009
00523	99	Rest of Missouri*	0.917	0.910	-0.008	-0.009
05440	35	Tennessee	0.941	0.933	-0.008	-0.009
00884	16	West Virginia	0.952	0.942	-0.010	-0.011
00528	99	Rest of Louisiana	0.946	0.936	-0.010	-0.011
00751	01	Montana	0.939	0.928	-0.010	-0.011
31143	99	Rest of Massachusetts	1.054	1.042	-0.012	-0.011
00865	99	Rest of Pennsylvania	0.961	0.950	-0.011	-0.011
31142	99	Rest of Maine	0.947	0.936	-0.011	-0.011
00522	00	Oklahoma	0.923	0.913	-0.011	-0.011
00510	00	Alabama	0.935	0.923	-0.011	-0.012
00820	02	South Dakota	0.933	0.922	-0.012	-0.013
00801	99	Rest of New York	0.965	0.952	-0.013	-0.014
00590	04	Miami, FL	1.085	1.069	-0.015	-0.014
00900	20	Beaumont, TX	0.964	0.951	-0.014	-0.014
14330	04	Queens, NY	1.161	1.144	-0.016	-0.014
00590	03	Fort Lauderdale, FL	1.038	1.022	-0.016	-0.016
00870	01	Rhode Island	1.033	1.016	-0.018	-0.017
00825	21	Wyoming	0.953	0.934	-0.019	-0.020
00803	01	Manhattan, NY	1.225	1.184	-0.041	-0.034
00831	01	Alaska	1.670	1.055	-0.615	-0.368

Note: The Percent Difference in the GAF for Alaska is the result of the termination of the favorable 2-Year MMA provision for the state of Alaska.

* States are served by more than one carrier.

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
00601	PR	00766	PR	04290	ME	04654	ME
00606	PR	00767	PR	04292	ME	04655	ME
00610	PR	00769	PR	04406	ME	04657	ME
00611	PR	00771	PR	04413	ME	04658	ME
00617	PR	00772	PR	04414	ME	04666	ME
00624	PR	00777	PR	04415	ME	04667	ME
00627	PR	00782	PR	04424	ME	04668	ME
00631	PR	00783	PR	04426	ME	04671	ME
00637	PR	00794	PR	04430	ME	04680	ME
00638	PR	00795	PR	04441	ME	04686	ME
00641	PR	00953	PR	04442	ME	04691	ME
00647	PR	00954	PR	04443	ME	04694	ME
00650	PR	04010	ME	04448	ME	04765	ME
00653	PR	04016	ME	04451	ME	04777	ME
00659	PR	04022	ME	04454	ME	04782	ME
00660	PR	04037	ME	04455	ME	04911	ME
00662	PR	04041	ME	04457	ME	04912	ME
00664	PR	04051	ME	04459	ME	04920	ME
00667	PR	04068	ME	04460	ME	04923	ME
00669	PR	04088	ME	04462	ME	04924	ME
00670	PR	04216	ME	04463	ME	04925	ME
00676	PR	04217	ME	04464	ME	04928	ME
00677	PR	04219	ME	04478	ME	04929	ME
00678	PR	04220	ME	04479	ME	04930	ME
00685	PR	04221	ME	04481	ME	04933	ME
00687	PR	04222	ME	04485	ME	04937	ME
00692	PR	04224	ME	04487	ME	04942	ME
00693	PR	04226	ME	04490	ME	04943	ME
00694	PR	04228	ME	04491	ME	04944	ME
00703	PR	04231	ME	04492	ME	04945	ME
00707	PR	04237	ME	04493	ME	04950	ME
00714	PR	04238	ME	04495	ME	04953	ME
00718	PR	04254	ME	04606	ME	04954	ME
00719	PR	04255	ME	04611	ME	04957	ME
00720	PR	04257	ME	04619	ME	04958	ME
00721	PR	04261	ME	04622	ME	04961	ME
00723	PR	04267	ME	04623	ME	04965	ME
00729	PR	04268	ME	04626	ME	04967	ME
00735	PR	04270	ME	04628	ME	04971	ME
00742	PR	04271	ME	04630	ME	04975	ME
00744	PR	04275	ME	04631	ME	04976	ME
00745	PR	04276	ME	04637	ME	04978	ME
00751	PR	04278	ME	04643	ME	04979	ME
00754	PR	04281	ME	04648	ME	04985	ME
00757	PR	04286	ME	04649	ME	05444	VT
00765	PR	04289	ME	04652	ME	05824	VT

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
05837	VT	12032	NY	12427	NY	12843	NY
05840	VT	12035	NY	12430	NY	12845	NY
05846	VT	12036	NY	12431	NY	12848	NY
05858	VT	12040	NY	12434	NY	12849	NY
05901	VT	12042	NY	12436	NY	12851	NY
05902	VT	12043	NY	12438	NY	12852	NY
05903	VT	12051	NY	12439	NY	12853	NY
05904	VT	12057	NY	12442	NY	12854	NY
05905	VT	12058	NY	12444	NY	12855	NY
05906	VT	12066	NY	12450	NY	12856	NY
05907	VT	12071	NY	12451	NY	12857	NY
08001	NJ	12073	NY	12452	NY	12858	NY
08023	NJ	12076	NY	12454	NY	12860	NY
08038	NJ	12078	NY	12455	NY	12861	NY
08067	NJ	12083	NY	12459	NY	12862	NY
08069	NJ	12087	NY	12460	NY	12865	NY
08070	NJ	12089	NY	12463	NY	12870	NY
08072	NJ	12090	NY	12468	NY	12872	NY
08098	NJ	12092	NY	12470	NY	12873	NY
08202	NJ	12093	NY	12473	NY	12874	NY
08204	NJ	12095	NY	12474	NY	12878	NY
08210	NJ	12117	NY	12482	NY	12879	NY
08212	NJ	12122	NY	12485	NY	12883	NY
08214	NJ	12124	NY	12492	NY	12885	NY
08218	NJ	12131	NY	12496	NY	12886	NY
08219	NJ	12133	NY	12808	NY	12887	NY
08242	NJ	12134	NY	12809	NY	12913	NY
08243	NJ	12149	NY	12810	NY	12928	NY
08247	NJ	12157	NY	12811	NY	12932	NY
08251	NJ	12160	NY	12814	NY	12936	NY
08252	NJ	12167	NY	12815	NY	12941	NY
08260	NJ	12175	NY	12816	NY	12942	NY
08270	NJ	12176	NY	12817	NY	12943	NY
08318	NJ	12187	NY	12819	NY	12946	NY
08343	NJ	12192	NY	12821	NY	12950	NY
08347	NJ	12194	NY	12823	NY	12956	NY
08530	NJ	12405	NY	12824	NY	12960	NY
08556	NJ	12406	NY	12827	NY	12961	NY
08557	NJ	12407	NY	12828	NY	12964	NY
08559	NJ	12413	NY	12832	NY	12974	NY
12015	NY	12414	NY	12834	NY	12975	NY
12022	NY	12418	NY	12836	NY	12977	NY
12024	NY	12421	NY	12837	NY	12987	NY
12025	NY	12422	NY	12838	NY	12993	NY
12028	NY	12423	NY	12839	NY	12996	NY
12031	NY	12424	NY	12841	NY	12997	NY

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
12998	NY	13343	NY	13751	NY	14414	NY
13028	NY	13345	NY	13752	NY	14415	NY
13032	NY	13350	NY	13753	NY	14416	NY
13033	NY	13357	NY	13754	NY	14418	NY
13035	NY	13361	NY	13755	NY	14422	NY
13036	NY	13364	NY	13756	NY	14423	NY
13037	NY	13365	NY	13757	NY	14429	NY
13042	NY	13367	NY	13758	NY	14433	NY
13043	NY	13368	NY	13774	NY	14435	NY
13044	NY	13404	NY	13775	NY	14441	NY
13064	NY	13406	NY	13778	NY	14449	NY
13065	NY	13407	NY	13780	NY	14452	NY
13076	NY	13409	NY	13782	NY	14466	NY
13103	NY	13411	NY	13783	NY	14470	NY
13111	NY	13416	NY	13786	NY	14476	NY
13113	NY	13418	NY	13788	NY	14477	NY
13122	NY	13420	NY	13801	NY	14478	NY
13124	NY	13431	NY	13804	NY	14480	NY
13131	NY	13433	NY	13806	NY	14485	NY
13132	NY	13454	NY	13809	NY	14486	NY
13134	NY	13459	NY	13811	NY	14487	NY
13135	NY	13460	NY	13812	NY	14488	NY
13136	NY	13461	NY	13814	NY	14489	NY
13143	NY	13464	NY	13815	NY	14502	NY
13146	NY	13470	NY	13827	NY	14505	NY
13148	NY	13472	NY	13830	NY	14507	NY
13154	NY	13473	NY	13832	NY	14513	NY
13155	NY	13475	NY	13835	NY	14516	NY
13156	NY	13489	NY	13837	NY	14519	NY
13165	NY	13491	NY	13838	NY	14520	NY
13166	NY	13493	NY	13839	NY	14521	NY
13167	NY	13620	NY	13840	NY	14522	NY
13301	NY	13626	NY	13841	NY	14527	NY
13302	NY	13627	NY	13842	NY	14533	NY
13305	NY	13631	NY	13843	NY	14538	NY
13309	NY	13648	NY	13844	NY	14539	NY
13312	NY	13730	NY	13845	NY	14541	NY
13314	NY	13731	NY	13846	NY	14542	NY
13316	NY	13732	NY	13847	NY	14544	NY
13324	NY	13733	NY	13856	NY	14551	NY
13325	NY	13734	NY	13860	NY	14555	NY
13327	NY	13736	NY	13864	NY	14557	NY
13329	NY	13739	NY	14029	NY	14558	NY
13331	NY	13740	NY	14098	NY	14560	NY
13332	NY	13743	NY	14143	NY	14563	NY
13340	NY	13750	NY	14413	NY	14568	NY

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
14571	NY	15325	PA	15446	PA	15534	PA
14588	NY	15327	PA	15447	PA	15535	PA
14589	NY	15334	PA	15449	PA	15536	PA
14590	NY	15337	PA	15450	PA	15537	PA
14592	NY	15338	PA	15451	PA	15538	PA
14707	NY	15341	PA	15454	PA	15539	PA
14708	NY	15344	PA	15455	PA	15540	PA
14709	NY	15346	PA	15456	PA	15541	PA
14711	NY	15348	PA	15458	PA	15542	PA
14714	NY	15349	PA	15459	PA	15544	PA
14715	NY	15351	PA	15460	PA	15545	PA
14717	NY	15352	PA	15461	PA	15546	PA
14721	NY	15353	PA	15462	PA	15547	PA
14727	NY	15354	PA	15463	PA	15548	PA
14735	NY	15357	PA	15464	PA	15549	PA
14739	NY	15359	PA	15465	PA	15550	PA
14744	NY	15362	PA	15466	PA	15551	PA
14745	NY	15364	PA	15467	PA	15552	PA
14754	NY	15370	PA	15468	PA	15553	PA
14774	NY	15380	PA	15469	PA	15554	PA
14777	NY	15401	PA	15470	PA	15555	PA
14786	NY	15410	PA	15472	PA	15557	PA
14802	NY	15411	PA	15473	PA	15558	PA
14803	NY	15413	PA	15474	PA	15559	PA
14804	NY	15415	PA	15475	PA	15560	PA
14806	NY	15416	PA	15476	PA	15561	PA
14813	NY	15417	PA	15478	PA	15562	PA
14822	NY	15420	PA	15480	PA	15563	PA
14837	NY	15421	PA	15482	PA	15564	PA
14842	NY	15422	PA	15484	PA	15565	PA
14847	NY	15424	PA	15485	PA	15630	PA
14857	NY	15425	PA	15486	PA	15631	PA
14859	NY	15428	PA	15488	PA	15656	PA
14860	NY	15430	PA	15489	PA	15673	PA
14880	NY	15431	PA	15490	PA	15682	PA
14883	NY	15433	PA	15492	PA	15686	PA
14884	NY	15435	PA	15501	PA	15714	PA
14892	NY	15436	PA	15502	PA	15722	PA
14895	NY	15437	PA	15510	PA	15736	PA
14897	NY	15438	PA	15520	PA	15737	PA
15012	PA	15439	PA	15521	PA	15738	PA
15310	PA	15440	PA	15522	PA	15760	PA
15315	PA	15442	PA	15530	PA	15762	PA
15316	PA	15443	PA	15531	PA	15773	PA
15320	PA	15444	PA	15532	PA	15775	PA
15322	PA	15445	PA	15533	PA	15828	PA

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
15832	PA	16215	PA	16375	PA	16693	PA
15834	PA	16217	PA	16401	PA	16694	PA
15861	PA	16218	PA	16407	PA	16695	PA
15924	PA	16220	PA	16412	PA	16699	PA
15926	PA	16221	PA	16413	PA	16822	PA
15927	PA	16222	PA	16423	PA	16848	PA
15928	PA	16223	PA	16438	PA	16877	PA
15931	PA	16224	PA	16444	PA	16901	PA
15935	PA	16225	PA	16475	PA	16911	PA
15936	PA	16226	PA	16611	PA	16912	PA
15937	PA	16228	PA	16614	PA	16917	PA
15940	PA	16229	PA	16621	PA	16918	PA
15943	PA	16230	PA	16622	PA	16920	PA
15948	PA	16232	PA	16623	PA	16921	PA
15953	PA	16233	PA	16624	PA	16928	PA
15959	PA	16234	PA	16630	PA	16929	PA
15961	PA	16235	PA	16631	PA	16930	PA
15963	PA	16236	PA	16633	PA	16932	PA
16028	PA	16238	PA	16634	PA	16933	PA
16036	PA	16239	PA	16636	PA	16935	PA
16049	PA	16240	PA	16638	PA	16936	PA
16054	PA	16242	PA	16646	PA	16938	PA
16058	PA	16244	PA	16647	PA	16939	PA
16101	PA	16245	PA	16650	PA	16940	PA
16102	PA	16248	PA	16652	PA	16942	PA
16103	PA	16249	PA	16654	PA	16943	PA
16105	PA	16250	PA	16655	PA	16946	PA
16107	PA	16253	PA	16657	PA	16950	PA
16108	PA	16254	PA	16659	PA	17003	PA
16112	PA	16255	PA	16660	PA	17006	PA
16116	PA	16257	PA	16662	PA	17010	PA
16117	PA	16258	PA	16664	PA	17014	PA
16120	PA	16259	PA	16667	PA	17017	PA
16132	PA	16260	PA	16668	PA	17020	PA
16140	PA	16261	PA	16669	PA	17021	PA
16142	PA	16262	PA	16670	PA	17024	PA
16143	PA	16263	PA	16672	PA	17031	PA
16155	PA	16321	PA	16673	PA	17035	PA
16156	PA	16322	PA	16674	PA	17037	PA
16157	PA	16326	PA	16675	PA	17038	PA
16160	PA	16331	PA	16678	PA	17040	PA
16201	PA	16332	PA	16679	PA	17041	PA
16210	PA	16334	PA	16683	PA	17045	PA
16212	PA	16353	PA	16685	PA	17047	PA
16213	PA	16361	PA	16689	PA	17048	PA
16214	PA	16370	PA	16691	PA	17049	PA

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Specialty Physician PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
17052	PA	17320	PA	17751	PA	17870	PA
17053	PA	17324	PA	17752	PA	17872	PA
17056	PA	17325	PA	17756	PA	17876	PA
17058	PA	17326	PA	17758	PA	17877	PA
17059	PA	17337	PA	17760	PA	17881	PA
17060	PA	17340	PA	17762	PA	17882	PA
17062	PA	17343	PA	17764	PA	17901	PA
17066	PA	17344	PA	17765	PA	17921	PA
17068	PA	17350	PA	17767	PA	17922	PA
17069	PA	17353	PA	17768	PA	17923	PA
17071	PA	17372	PA	17769	PA	17925	PA
17074	PA	17375	PA	17772	PA	17929	PA
17076	PA	17503	PA	17773	PA	17930	PA
17077	PA	17506	PA	17774	PA	17931	PA
17078	PA	17507	PA	17777	PA	17932	PA
17082	PA	17509	PA	17778	PA	17933	PA
17086	PA	17517	PA	17779	PA	17934	PA
17090	PA	17519	PA	17801	PA	17935	PA
17091	PA	17522	PA	17812	PA	17936	PA
17094	PA	17527	PA	17813	PA	17938	PA
17097	PA	17528	PA	17823	PA	17941	PA
17098	PA	17529	PA	17824	PA	17942	PA
17211	PA	17534	PA	17825	PA	17943	PA
17212	PA	17535	PA	17827	PA	17944	PA
17213	PA	17536	PA	17830	PA	17945	PA
17215	PA	17549	PA	17831	PA	17946	PA
17223	PA	17555	PA	17832	PA	17948	PA
17228	PA	17557	PA	17833	PA	17949	PA
17229	PA	17566	PA	17834	PA	17951	PA
17233	PA	17567	PA	17836	PA	17952	PA
17238	PA	17569	PA	17840	PA	17953	PA
17239	PA	17578	PA	17842	PA	17954	PA
17243	PA	17581	PA	17843	PA	17957	PA
17249	PA	17721	PA	17847	PA	17959	PA
17253	PA	17726	PA	17850	PA	17960	PA
17255	PA	17730	PA	17851	PA	17961	PA
17260	PA	17731	PA	17853	PA	17963	PA
17264	PA	17737	PA	17857	PA	17964	PA
17267	PA	17738	PA	17860	PA	17965	PA
17301	PA	17740	PA	17861	PA	17966	PA
17303	PA	17742	PA	17862	PA	17967	PA
17304	PA	17745	PA	17864	PA	17968	PA
17306	PA	17747	PA	17865	PA	17970	PA
17307	PA	17748	PA	17866	PA	17972	PA
17310	PA	17749	PA	17867	PA	17974	PA
17316	PA	17750	PA	17868	PA	17976	PA

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Specialty Physician PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
17978	PA	18419	PA	19311	PA	21656	MD
17979	PA	18421	PA	19362	PA	21657	MD
17980	PA	18425	PA	19363	PA	21658	MD
17981	PA	18426	PA	19374	PA	21660	MD
17982	PA	18428	PA	19501	PA	21666	MD
17983	PA	18430	PA	19507	PA	21668	MD
17985	PA	18435	PA	19543	PA	21670	MD
18010	PA	18441	PA	19544	PA	21681	MD
18012	PA	18446	PA	19549	PA	21682	MD
18013	PA	18451	PA	19559	PA	21683	MD
18030	PA	18457	PA	20106	VA	21684	MD
18050	PA	18458	PA	20113	VA	21685	MD
18071	PA	18464	PA	20130	VA	21686	MD
18210	PA	18465	PA	20135	VA	21687	MD
18211	PA	18470	PA	20137	VA	21688	MD
18212	PA	18614	PA	20140	VA	21690	MD
18214	PA	18615	PA	20184	VA	21727	MD
18216	PA	18616	PA	20185	VA	21750	MD
18218	PA	18619	PA	20188	VA	21759	MD
18220	PA	18624	PA	20198	VA	21811	MD
18229	PA	18625	PA	20682	MD	21813	MD
18230	PA	18626	PA	21520	MD	21822	MD
18231	PA	18628	PA	21522	MD	21829	MD
18232	PA	18632	PA	21523	MD	21841	MD
18235	PA	18636	PA	21531	MD	21842	MD
18237	PA	18801	PA	21536	MD	21843	MD
18240	PA	18812	PA	21538	MD	21851	MD
18241	PA	18813	PA	21541	MD	21862	MD
18242	PA	18816	PA	21550	MD	21863	MD
18244	PA	18818	PA	21561	MD	21864	MD
18245	PA	18820	PA	21607	MD	21872	MD
18248	PA	18821	PA	21609	MD	22002	VA
18250	PA	18822	PA	21617	MD	22134	VA
18252	PA	18823	PA	21619	MD	22427	VA
18254	PA	18824	PA	21623	MD	22428	VA
18255	PA	18825	PA	21628	MD	22432	VA
18324	PA	18826	PA	21629	MD	22433	VA
18328	PA	18827	PA	21632	MD	22435	VA
18336	PA	18828	PA	21636	MD	22442	VA
18337	PA	18830	PA	21638	MD	22443	VA
18340	PA	18834	PA	21639	MD	22446	VA
18343	PA	18839	PA	21640	MD	22448	VA
18351	PA	18842	PA	21641	MD	22451	VA
18371	PA	18843	PA	21644	MD	22456	VA
18373	PA	18844	PA	21649	MD	22460	VA
18413	PA	18847	PA	21655	MD	22469	VA

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22472	VA	22652	VA	22846	VA	23050	VA
22473	VA	22654	VA	22847	VA	23055	VA
22481	VA	22655	VA	22848	VA	23056	VA
22485	VA	22656	VA	22849	VA	23061	VA
22488	VA	22657	VA	22850	VA	23062	VA
22501	VA	22660	VA	22851	VA	23064	VA
22508	VA	22664	VA	22853	VA	23066	VA
22511	VA	22709	VA	22923	VA	23068	VA
22514	VA	22711	VA	22935	VA	23070	VA
22520	VA	22715	VA	22942	VA	23071	VA
22524	VA	22716	VA	22948	VA	23072	VA
22526	VA	22719	VA	22953	VA	23076	VA
22529	VA	22721	VA	22957	VA	23079	VA
22530	VA	22722	VA	22960	VA	23083	VA
22535	VA	22723	VA	22963	VA	23084	VA
22538	VA	22725	VA	22965	VA	23085	VA
22539	VA	22727	VA	22968	VA	23086	VA
22542	VA	22730	VA	22972	VA	23089	VA
22544	VA	22731	VA	22973	VA	23091	VA
22546	VA	22732	VA	22974	VA	23092	VA
22547	VA	22735	VA	22989	VA	23093	VA
22548	VA	22738	VA	23001	VA	23101	VA
22552	VA	22740	VA	23002	VA	23105	VA
22558	VA	22743	VA	23003	VA	23106	VA
22567	VA	22747	VA	23004	VA	23107	VA
22570	VA	22748	VA	23005	VA	23108	VA
22572	VA	22749	VA	23009	VA	23109	VA
22577	VA	22810	VA	23011	VA	23110	VA
22579	VA	22811	VA	23015	VA	23117	VA
22580	VA	22812	VA	23017	VA	23119	VA
22581	VA	22815	VA	23018	VA	23123	VA
22602	VA	22820	VA	23021	VA	23124	VA
22603	VA	22821	VA	23022	VA	23125	VA
22622	VA	22824	VA	23023	VA	23126	VA
22623	VA	22827	VA	23024	VA	23128	VA
22624	VA	22830	VA	23025	VA	23130	VA
22625	VA	22831	VA	23027	VA	23131	VA
22626	VA	22832	VA	23030	VA	23138	VA
22627	VA	22833	VA	23031	VA	23139	VA
22637	VA	22834	VA	23032	VA	23140	VA
22640	VA	22835	VA	23035	VA	23141	VA
22641	VA	22840	VA	23038	VA	23147	VA
22642	VA	22841	VA	23040	VA	23148	VA
22644	VA	22842	VA	23043	VA	23149	VA
22645	VA	22844	VA	23045	VA	23154	VA
22650	VA	22845	VA	23047	VA	23155	VA

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23156	VA	23418	VA	23875	VA	23968	VA
23161	VA	23420	VA	23876	VA	23970	VA
23163	VA	23421	VA	23878	VA	23974	VA
23169	VA	23422	VA	23879	VA	23976	VA
23170	VA	23423	VA	23881	VA	24053	VA
23175	VA	23424	VA	23882	VA	24054	VA
23176	VA	23426	VA	23883	VA	24055	VA
23177	VA	23427	VA	23884	VA	24064	VA
23178	VA	23430	VA	23885	VA	24065	VA
23180	VA	23431	VA	23887	VA	24066	VA
23181	VA	23440	VA	23888	VA	24067	VA
23183	VA	23441	VA	23889	VA	24069	VA
23184	VA	23442	VA	23890	VA	24072	VA
23190	VA	23480	VA	23891	VA	24076	VA
23191	VA	23483	VA	23893	VA	24077	VA
23301	VA	23487	VA	23894	VA	24078	VA
23302	VA	23488	VA	23897	VA	24079	VA
23303	VA	23801	VA	23898	VA	24082	VA
23304	VA	23821	VA	23899	VA	24083	VA
23306	VA	23822	VA	23915	VA	24085	VA
23308	VA	23824	VA	23917	VA	24086	VA
23314	VA	23827	VA	23919	VA	24088	VA
23315	VA	23828	VA	23920	VA	24089	VA
23336	VA	23829	VA	23921	VA	24090	VA
23337	VA	23830	VA	23922	VA	24091	VA
23341	VA	23833	VA	23923	VA	24092	VA
23345	VA	23837	VA	23924	VA	24093	VA
23356	VA	23839	VA	23927	VA	24094	VA
23357	VA	23840	VA	23930	VA	24101	VA
23358	VA	23841	VA	23934	VA	24102	VA
23359	VA	23842	VA	23936	VA	24104	VA
23389	VA	23843	VA	23937	VA	24105	VA
23395	VA	23844	VA	23938	VA	24120	VA
23396	VA	23845	VA	23939	VA	24121	VA
23397	VA	23846	VA	23941	VA	24124	VA
23399	VA	23847	VA	23944	VA	24127	VA
23401	VA	23850	VA	23947	VA	24128	VA
23404	VA	23856	VA	23950	VA	24130	VA
23407	VA	23857	VA	23952	VA	24131	VA
23409	VA	23866	VA	23955	VA	24133	VA
23410	VA	23867	VA	23958	VA	24134	VA
23412	VA	23868	VA	23959	VA	24136	VA
23414	VA	23870	VA	23962	VA	24137	VA
23415	VA	23872	VA	23963	VA	24139	VA
23416	VA	23873	VA	23964	VA	24146	VA
23417	VA	23874	VA	23967	VA	24147	VA

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24148	VA	24271	VA	24441	VA	24594	VA
24150	VA	24272	VA	24442	VA	24595	VA
24151	VA	24277	VA	24445	VA	24599	VA
24161	VA	24279	VA	24458	VA	24603	VA
24165	VA	24280	VA	24460	VA	24607	VA
24167	VA	24281	VA	24465	VA	24614	VA
24168	VA	24282	VA	24468	VA	24618	VA
24171	VA	24283	VA	24471	VA	24620	VA
24174	VA	24285	VA	24472	VA	24624	VA
24175	VA	24289	VA	24473	VA	24627	VA
24176	VA	24290	VA	24483	VA	24628	VA
24177	VA	24292	VA	24484	VA	24631	VA
24184	VA	24293	VA	24487	VA	24634	VA
24185	VA	24311	VA	24517	VA	24639	VA
24201	VA	24314	VA	24521	VA	24646	VA
24202	VA	24315	VA	24522	VA	24647	VA
24203	VA	24317	VA	24523	VA	24649	VA
24209	VA	24318	VA	24526	VA	24656	VA
24215	VA	24319	VA	24527	VA	24657	VA
24216	VA	24325	VA	24528	VA	24658	VA
24217	VA	24326	VA	24529	VA	24716	WV
24218	VA	24328	VA	24530	VA	24719	WV
24219	VA	24330	VA	24531	VA	24726	WV
24220	VA	24343	VA	24533	VA	24801	WV
24221	VA	24348	VA	24538	VA	24808	WV
24224	VA	24351	VA	24549	VA	24811	WV
24225	VA	24352	VA	24550	VA	24813	WV
24226	VA	24354	VA	24554	VA	24815	WV
24228	VA	24363	VA	24555	VA	24816	WV
24230	VA	24366	VA	24557	VA	24817	WV
24237	VA	24370	VA	24562	VA	24818	WV
24239	VA	24373	VA	24563	VA	24820	WV
24243	VA	24375	VA	24565	VA	24821	WV
24244	VA	24378	VA	24566	VA	24822	WV
24245	VA	24379	VA	24569	VA	24823	WV
24246	VA	24380	VA	24570	VA	24824	WV
24248	VA	24381	VA	24571	VA	24825	WV
24250	VA	24412	VA	24572	VA	24826	WV
24251	VA	24413	VA	24574	VA	24827	WV
24256	VA	24415	VA	24576	VA	24828	WV
24258	VA	24416	VA	24578	VA	24829	WV
24260	VA	24426	VA	24579	VA	24830	WV
24263	VA	24433	VA	24580	VA	24831	WV
24265	VA	24435	VA	24586	VA	24832	WV
24266	VA	24438	VA	24588	VA	24834	WV
24269	VA	24439	VA	24593	VA	24836	WV

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
24839	WV	24897	WV	25063	WV	25231	WV
24841	WV	24898	WV	25081	WV	25234	WV
24842	WV	24899	WV	25085	WV	25235	WV
24843	WV	24915	WV	25088	WV	25239	WV
24844	WV	24918	WV	25090	WV	25241	WV
24845	WV	24919	WV	25093	WV	25243	WV
24846	WV	24920	WV	25095	WV	25244	WV
24847	WV	24924	WV	25106	WV	25245	WV
24848	WV	24927	WV	25108	WV	25247	WV
24849	WV	24934	WV	25111	WV	25248	WV
24850	WV	24935	WV	25113	WV	25250	WV
24851	WV	24941	WV	25114	WV	25251	WV
24852	WV	24942	WV	25115	WV	25252	WV
24853	WV	24944	WV	25118	WV	25253	WV
24854	WV	24945	WV	25119	WV	25256	WV
24855	WV	24946	WV	25123	WV	25258	WV
24856	WV	24951	WV	25125	WV	25259	WV
24857	WV	24954	WV	25130	WV	25260	WV
24859	WV	24962	WV	25133	WV	25261	WV
24860	WV	24963	WV	25136	WV	25262	WV
24861	WV	24974	WV	25139	WV	25264	WV
24862	WV	24976	WV	25141	WV	25265	WV
24866	WV	24981	WV	25142	WV	25266	WV
24867	WV	24983	WV	25148	WV	25267	WV
24868	WV	24984	WV	25149	WV	25268	WV
24869	WV	24985	WV	25150	WV	25270	WV
24870	WV	24993	WV	25152	WV	25271	WV
24871	WV	25002	WV	25154	WV	25275	WV
24872	WV	25005	WV	25161	WV	25276	WV
24873	WV	25009	WV	25164	WV	25279	WV
24874	WV	25010	WV	25165	WV	25281	WV
24877	WV	25018	WV	25169	WV	25283	WV
24878	WV	25019	WV	25173	WV	25285	WV
24879	WV	25021	WV	25180	WV	25286	WV
24880	WV	25024	WV	25181	WV	25287	WV
24881	WV	25028	WV	25185	WV	25410	WV
24882	WV	25030	WV	25186	WV	25411	WV
24883	WV	25031	WV	25187	WV	25414	WV
24884	WV	25036	WV	25193	WV	25419	WV
24887	WV	25040	WV	25203	WV	25422	WV
24888	WV	25043	WV	25204	WV	25423	WV
24889	WV	25049	WV	25205	WV	25425	WV
24892	WV	25051	WV	25206	WV	25429	WV
24894	WV	25053	WV	25208	WV	25430	WV
24895	WV	25057	WV	25209	WV	25431	WV
24896	WV	25059	WV	25211	WV	25432	WV

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
25434	WV	25666	WV	25880	WV	26135	WV
25437	WV	25667	WV	25882	WV	26136	WV
25438	WV	25669	WV	25901	WV	26137	WV
25441	WV	25670	WV	25904	WV	26138	WV
25442	WV	25671	WV	25907	WV	26141	WV
25443	WV	25672	WV	25912	WV	26143	WV
25444	WV	25674	WV	25913	WV	26146	WV
25446	WV	25676	WV	25914	WV	26147	WV
25501	WV	25678	WV	25916	WV	26148	WV
25502	WV	25682	WV	25917	WV	26149	WV
25503	WV	25685	WV	25928	WV	26151	WV
25506	WV	25686	WV	25931	WV	26152	WV
25507	WV	25687	WV	25936	WV	26155	WV
25511	WV	25688	WV	25938	WV	26159	WV
25512	WV	25690	WV	25942	WV	26160	WV
25514	WV	25691	WV	25943	WV	26161	WV
25515	WV	25692	WV	25951	WV	26162	WV
25517	WV	25694	WV	25965	WV	26164	WV
25519	WV	25696	WV	25966	WV	26167	WV
25520	WV	25697	WV	25969	WV	26170	WV
25521	WV	25699	WV	25976	WV	26173	WV
25523	WV	25704	WV	25977	WV	26175	WV
25524	WV	25770	WV	25978	WV	26178	WV
25529	WV	25771	WV	25979	WV	26186	WV
25530	WV	25810	WV	25985	WV	26187	WV
25534	WV	25811	WV	25986	WV	26201	WV
25535	WV	25812	WV	25988	WV	26202	WV
25540	WV	25826	WV	26030	WV	26203	WV
25544	WV	25831	WV	26031	WV	26205	WV
25550	WV	25833	WV	26032	WV	26206	WV
25555	WV	25837	WV	26033	WV	26208	WV
25557	WV	25840	WV	26034	WV	26209	WV
25562	WV	25845	WV	26035	WV	26210	WV
25564	WV	25846	WV	26036	WV	26215	WV
25565	WV	25848	WV	26037	WV	26217	WV
25567	WV	25854	WV	26038	WV	26218	WV
25570	WV	25855	WV	26039	WV	26219	WV
25571	WV	25859	WV	26040	WV	26222	WV
25573	WV	25862	WV	26041	WV	26228	WV
25608	WV	25864	WV	26050	WV	26229	WV
25621	WV	25866	WV	26055	WV	26234	WV
25623	WV	25868	WV	26056	WV	26236	WV
25650	WV	25870	WV	26058	WV	26237	WV
25651	WV	25875	WV	26070	WV	26238	WV
25661	WV	25876	WV	26075	WV	26250	WV
25665	WV	25879	WV	26134	WV	26254	WV

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Specialty Physician PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
26260	WV	26419	WV	26651	WV	26812	WV
26261	WV	26421	WV	26656	WV	26814	WV
26264	WV	26424	WV	26660	WV	26815	WV
26266	WV	26425	WV	26662	WV	26817	WV
26269	WV	26430	WV	26667	WV	26818	WV
26271	WV	26434	WV	26671	WV	26823	WV
26275	WV	26435	WV	26674	WV	26824	WV
26287	WV	26436	WV	26675	WV	26833	WV
26288	WV	26437	WV	26676	WV	26836	WV
26289	WV	26440	WV	26678	WV	26838	WV
26291	WV	26443	WV	26679	WV	26845	WV
26292	WV	26444	WV	26680	WV	26847	WV
26298	WV	26447	WV	26681	WV	26851	WV
26320	WV	26452	WV	26684	WV	26852	WV
26321	WV	26456	WV	26690	WV	26855	WV
26325	WV	26519	WV	26691	WV	26865	WV
26327	WV	26520	WV	26704	WV	26866	WV
26328	WV	26524	WV	26705	WV	26884	WV
26334	WV	26525	WV	26707	WV	26886	WV
26335	WV	26535	WV	26710	WV	27007	NC
26337	WV	26537	WV	26711	WV	27011	NC
26338	WV	26542	WV	26714	WV	27014	NC
26339	WV	26547	WV	26716	WV	27016	NC
26342	WV	26561	WV	26717	WV	27017	NC
26343	WV	26562	WV	26719	WV	27018	NC
26346	WV	26575	WV	26720	WV	27019	NC
26347	WV	26581	WV	26722	WV	27020	NC
26348	WV	26601	WV	26726	WV	27021	NC
26349	WV	26610	WV	26731	WV	27022	NC
26350	WV	26611	WV	26734	WV	27024	NC
26351	WV	26612	WV	26739	WV	27025	NC
26354	WV	26615	WV	26743	WV	27027	NC
26362	WV	26617	WV	26750	WV	27028	NC
26372	WV	26618	WV	26753	WV	27030	NC
26374	WV	26619	WV	26755	WV	27031	NC
26376	WV	26621	WV	26757	WV	27041	NC
26377	WV	26623	WV	26761	WV	27042	NC
26378	WV	26624	WV	26763	WV	27043	NC
26384	WV	26627	WV	26764	WV	27046	NC
26405	WV	26629	WV	26767	WV	27047	NC
26407	WV	26631	WV	26801	WV	27048	NC
26410	WV	26634	WV	26802	WV	27049	NC
26411	WV	26636	WV	26804	WV	27052	NC
26412	WV	26638	WV	26807	WV	27053	NC
26415	WV	26639	WV	26808	WV	27055	NC
26416	WV	26641	WV	26810	WV	27207	NC

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
27208	NC	27520	NC	27832	NC	27921	NC
27209	NC	27521	NC	27838	NC	27922	NC
27212	NC	27522	NC	27839	NC	27923	NC
27213	NC	27524	NC	27840	NC	27924	NC
27228	NC	27525	NC	27841	NC	27925	NC
27229	NC	27541	NC	27842	NC	27926	NC
27247	NC	27542	NC	27843	NC	27927	NC
27252	NC	27543	NC	27844	NC	27928	NC
27256	NC	27546	NC	27845	NC	27929	NC
27288	NC	27551	NC	27846	NC	27930	NC
27289	NC	27552	NC	27847	NC	27932	NC
27291	NC	27555	NC	27849	NC	27935	NC
27292	NC	27559	NC	27850	NC	27936	NC
27293	NC	27563	NC	27852	NC	27937	NC
27294	NC	27564	NC	27853	NC	27938	NC
27295	NC	27565	NC	27854	NC	27939	NC
27299	NC	27568	NC	27855	NC	27941	NC
27305	NC	27569	NC	27857	NC	27942	NC
27306	NC	27570	NC	27861	NC	27943	NC
27311	NC	27573	NC	27862	NC	27944	NC
27312	NC	27574	NC	27864	NC	27946	NC
27314	NC	27576	NC	27866	NC	27947	NC
27315	NC	27577	NC	27867	NC	27948	NC
27316	NC	27581	NC	27869	NC	27949	NC
27320	NC	27582	NC	27870	NC	27950	NC
27321	NC	27583	NC	27871	NC	27953	NC
27322	NC	27586	NC	27872	NC	27954	NC
27323	NC	27589	NC	27874	NC	27956	NC
27326	NC	27593	NC	27875	NC	27957	NC
27343	NC	27594	NC	27876	NC	27958	NC
27344	NC	27596	NC	27877	NC	27959	NC
27350	NC	27801	NC	27881	NC	27960	NC
27351	NC	27802	NC	27882	NC	27962	NC
27355	NC	27805	NC	27885	NC	27964	NC
27356	NC	27807	NC	27886	NC	27965	NC
27370	NC	27809	NC	27887	NC	27966	NC
27371	NC	27816	NC	27888	NC	27967	NC
27374	NC	27818	NC	27890	NC	27968	NC
27375	NC	27819	NC	27892	NC	27969	NC
27379	NC	27820	NC	27897	NC	27970	NC
27501	NC	27823	NC	27910	NC	27972	NC
27504	NC	27824	NC	27915	NC	27973	NC
27506	NC	27825	NC	27916	NC	27974	NC
27507	NC	27826	NC	27917	NC	27976	NC
27508	NC	27828	NC	27919	NC	27978	NC
27509	NC	27831	NC	27920	NC	27979	NC

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Specialty Physician PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
27980	NC	28337	NC	28432	NC	28537	NC
27981	NC	28338	NC	28433	NC	28538	NC
27982	NC	28339	NC	28434	NC	28552	NC
27983	NC	28340	NC	28435	NC	28554	NC
27985	NC	28341	NC	28436	NC	28555	NC
27986	NC	28344	NC	28438	NC	28556	NC
28001	NC	28345	NC	28439	NC	28571	NC
28002	NC	28347	NC	28441	NC	28573	NC
28007	NC	28349	NC	28442	NC	28580	NC
28009	NC	28357	NC	28443	NC	28583	NC
28021	NC	28358	NC	28444	NC	28585	NC
28023	NC	28359	NC	28446	NC	28587	NC
28037	NC	28360	NC	28447	NC	28604	NC
28079	NC	28361	NC	28448	NC	28606	NC
28080	NC	28362	NC	28450	NC	28612	NC
28088	NC	28363	NC	28451	NC	28615	NC
28091	NC	28364	NC	28452	NC	28616	NC
28097	NC	28366	NC	28453	NC	28617	NC
28102	NC	28367	NC	28454	NC	28621	NC
28104	NC	28368	NC	28455	NC	28622	NC
28108	NC	28369	NC	28456	NC	28623	NC
28109	NC	28371	NC	28457	NC	28624	NC
28119	NC	28372	NC	28458	NC	28626	NC
28127	NC	28375	NC	28459	NC	28627	NC
28128	NC	28376	NC	28461	NC	28629	NC
28129	NC	28377	NC	28462	NC	28630	NC
28133	NC	28378	NC	28463	NC	28631	NC
28135	NC	28379	NC	28464	NC	28635	NC
28137	NC	28380	NC	28465	NC	28636	NC
28163	NC	28382	NC	28466	NC	28637	NC
28168	NC	28383	NC	28467	NC	28640	NC
28170	NC	28384	NC	28468	NC	28642	NC
28173	NC	28385	NC	28469	NC	28643	NC
28261	NC	28386	NC	28470	NC	28644	NC
28318	NC	28392	NC	28471	NC	28646	NC
28319	NC	28393	NC	28472	NC	28649	NC
28320	NC	28398	NC	28478	NC	28651	NC
28323	NC	28399	NC	28479	NC	28652	NC
28325	NC	28420	NC	28508	NC	28653	NC
28326	NC	28421	NC	28509	NC	28654	NC
28328	NC	28422	NC	28510	NC	28656	NC
28329	NC	28423	NC	28515	NC	28657	NC
28330	NC	28424	NC	28518	NC	28659	NC
28332	NC	28425	NC	28521	NC	28662	NC
28334	NC	28430	NC	28522	NC	28663	NC
28335	NC	28431	NC	28529	NC	28664	NC

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
28665	NC	28904	NC	29180	SC	29484	SC
28666	NC	28905	NC	29321	SC	29485	SC
28667	NC	28906	NC	29325	SC	29488	SC
28668	NC	28909	NC	29332	SC	29492	SC
28669	NC	29001	SC	29340	SC	29493	SC
28670	NC	29003	SC	29341	SC	29512	SC
28672	NC	29006	SC	29342	SC	29516	SC
28674	NC	29010	SC	29351	SC	29518	SC
28675	NC	29014	SC	29353	SC	29519	SC
28676	NC	29015	SC	29355	SC	29520	SC
28678	NC	29030	SC	29360	SC	29525	SC
28681	NC	29031	SC	29364	SC	29532	SC
28683	NC	29037	SC	29370	SC	29536	SC
28684	NC	29041	SC	29379	SC	29540	SC
28685	NC	29042	SC	29384	SC	29542	SC
28693	NC	29046	SC	29395	SC	29543	SC
28694	NC	29051	SC	29410	SC	29546	SC
28697	NC	29055	SC	29420	SC	29547	SC
28702	NC	29056	SC	29430	SC	29550	SC
28705	NC	29065	SC	29431	SC	29551	SC
28713	NC	29069	SC	29433	SC	29554	SC
28714	NC	29075	SC	29434	SC	29556	SC
28719	NC	29079	SC	29435	SC	29560	SC
28722	NC	29080	SC	29436	SC	29563	SC
28733	NC	29081	SC	29437	SC	29564	SC
28737	NC	29082	SC	29438	SC	29565	SC
28740	NC	29101	SC	29445	SC	29567	SC
28743	NC	29102	SC	29446	SC	29570	SC
28749	NC	29106	SC	29447	SC	29571	SC
28750	NC	29108	SC	29448	SC	29573	SC
28752	NC	29111	SC	29450	SC	29574	SC
28753	NC	29122	SC	29452	SC	29580	SC
28754	NC	29126	SC	29453	SC	29584	SC
28755	NC	29127	SC	29456	SC	29589	SC
28756	NC	29129	SC	29461	SC	29590	SC
28761	NC	29130	SC	29468	SC	29592	SC
28762	NC	29132	SC	29469	SC	29593	SC
28765	NC	29135	SC	29471	SC	29594	SC
28771	NC	29138	SC	29472	SC	29596	SC
28773	NC	29143	SC	29474	SC	29620	SC
28777	NC	29145	SC	29475	SC	29628	SC
28781	NC	29148	SC	29476	SC	29638	SC
28782	NC	29162	SC	29477	SC	29639	SC
28901	NC	29166	SC	29479	SC	29642	SC
28902	NC	29176	SC	29481	SC	29645	SC
28903	NC	29178	SC	29483	SC	29659	SC

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
29697	SC	29929	SC	30222	GA	30457	GA
29702	SC	29932	SC	30229	GA	30464	GA
29706	SC	29933	SC	30233	GA	30467	GA
29709	SC	29934	SC	30234	GA	30470	GA
29712	SC	29936	SC	30251	GA	30471	GA
29714	SC	29939	SC	30256	GA	30473	GA
29717	SC	29943	SC	30257	GA	30477	GA
29718	SC	29944	SC	30258	GA	30499	GA
29724	SC	29945	SC	30265	GA	30510	GA
29727	SC	30011	GA	30276	GA	30511	GA
29728	SC	30016	GA	30277	GA	30512	GA
29729	SC	30052	GA	30284	GA	30513	GA
29741	SC	30055	GA	30289	GA	30514	GA
29742	SC	30103	GA	30292	GA	30516	GA
29743	SC	30104	GA	30293	GA	30517	GA
29810	SC	30110	GA	30295	GA	30520	GA
29812	SC	30113	GA	30401	GA	30521	GA
29813	SC	30120	GA	30410	GA	30522	GA
29817	SC	30121	GA	30411	GA	30523	GA
29821	SC	30123	GA	30412	GA	30525	GA
29824	SC	30125	GA	30413	GA	30528	GA
29826	SC	30132	GA	30414	GA	30529	GA
29827	SC	30137	GA	30417	GA	30530	GA
29832	SC	30138	GA	30420	GA	30531	GA
29835	SC	30140	GA	30421	GA	30534	GA
29836	SC	30141	GA	30423	GA	30535	GA
29838	SC	30143	GA	30424	GA	30537	GA
29840	SC	30145	GA	30425	GA	30539	GA
29843	SC	30148	GA	30426	GA	30540	GA
29844	SC	30153	GA	30427	GA	30541	GA
29845	SC	30157	GA	30428	GA	30544	GA
29846	SC	30171	GA	30429	GA	30545	GA
29847	SC	30175	GA	30434	GA	30546	GA
29849	SC	30176	GA	30438	GA	30547	GA
29853	SC	30177	GA	30439	GA	30548	GA
29899	SC	30178	GA	30441	GA	30549	GA
29911	SC	30179	GA	30442	GA	30552	GA
29912	SC	30180	GA	30445	GA	30553	GA
29913	SC	30182	GA	30446	GA	30555	GA
29916	SC	30184	GA	30447	GA	30558	GA
29918	SC	30204	GA	30448	GA	30559	GA
29921	SC	30206	GA	30449	GA	30560	GA
29922	SC	30216	GA	30451	GA	30562	GA
29923	SC	30217	GA	30453	GA	30563	GA
29924	SC	30218	GA	30455	GA	30565	GA
29927	SC	30219	GA	30456	GA	30567	GA

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
30568	GA	30707	GA	31020	GA	31089	GA
30571	GA	30708	GA	31024	GA	31090	GA
30572	GA	30711	GA	31025	GA	31091	GA
30573	GA	30724	GA	31026	GA	31092	GA
30575	GA	30725	GA	31029	GA	31094	GA
30576	GA	30728	GA	31030	GA	31096	GA
30580	GA	30730	GA	31031	GA	31303	GA
30581	GA	30731	GA	31032	GA	31304	GA
30582	GA	30738	GA	31033	GA	31305	GA
30596	GA	30739	GA	31035	GA	31307	GA
30599	GA	30741	GA	31037	GA	31312	GA
30619	GA	30747	GA	31038	GA	31316	GA
30620	GA	30750	GA	31039	GA	31318	GA
30623	GA	30751	GA	31041	GA	31319	GA
30624	GA	30752	GA	31042	GA	31326	GA
30625	GA	30753	GA	31044	GA	31327	GA
30627	GA	30757	GA	31045	GA	31329	GA
30628	GA	30803	GA	31046	GA	31331	GA
30629	GA	30806	GA	31049	GA	31510	GA
30630	GA	30807	GA	31050	GA	31513	GA
30631	GA	30808	GA	31051	GA	31515	GA
30633	GA	30810	GA	31052	GA	31516	GA
30634	GA	30811	GA	31054	GA	31518	GA
30635	GA	30816	GA	31055	GA	31532	GA
30639	GA	30817	GA	31057	GA	31537	GA
30642	GA	30818	GA	31058	GA	31539	GA
30643	GA	30819	GA	31060	GA	31542	GA
30645	GA	30820	GA	31063	GA	31543	GA
30646	GA	30821	GA	31064	GA	31544	GA
30647	GA	30822	GA	31066	GA	31549	GA
30648	GA	30823	GA	31067	GA	31551	GA
30650	GA	30824	GA	31068	GA	31553	GA
30660	GA	30828	GA	31069	GA	31556	GA
30662	GA	30830	GA	31070	GA	31557	GA
30663	GA	30833	GA	31071	GA	31562	GA
30664	GA	31001	GA	31072	GA	31563	GA
30665	GA	31002	GA	31076	GA	31566	GA
30666	GA	31003	GA	31078	GA	31620	GA
30667	GA	31004	GA	31079	GA	31622	GA
30668	GA	31006	GA	31081	GA	31623	GA
30669	GA	31007	GA	31082	GA	31624	GA
30671	GA	31008	GA	31083	GA	31625	GA
30673	GA	31014	GA	31084	GA	31627	GA
30678	GA	31016	GA	31085	GA	31629	GA
30680	GA	31017	GA	31086	GA	31630	GA
30705	GA	31018	GA	31087	GA	31631	GA

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
31634	GA	31774	GA	32052	FL	32327	FL
31635	GA	31777	GA	32053	FL	32328	FL
31637	GA	31779	GA	32058	FL	32329	FL
31638	GA	31781	GA	32059	FL	32330	FL
31639	GA	31783	GA	32060	FL	32331	FL
31642	GA	31784	GA	32062	FL	32332	FL
31643	GA	31785	GA	32064	FL	32333	FL
31645	GA	31786	GA	32066	FL	32334	FL
31646	GA	31787	GA	32071	FL	32335	FL
31647	GA	31789	GA	32091	FL	32336	FL
31648	GA	31790	GA	32094	FL	32337	FL
31649	GA	31791	GA	32096	FL	32340	FL
31650	GA	31796	GA	32097	FL	32341	FL
31713	GA	31797	GA	32102	FL	32343	FL
31714	GA	31798	GA	32110	FL	32344	FL
31716	GA	31801	GA	32112	FL	32345	FL
31720	GA	31803	GA	32131	FL	32346	FL
31723	GA	31804	GA	32135	FL	32347	FL
31724	GA	31805	GA	32136	FL	32348	FL
31726	GA	31806	GA	32137	FL	32350	FL
31728	GA	31807	GA	32138	FL	32351	FL
31729	GA	31810	GA	32139	FL	32352	FL
31730	GA	31811	GA	32140	FL	32353	FL
31732	GA	31812	GA	32142	FL	32355	FL
31736	GA	31814	GA	32147	FL	32356	FL
31737	GA	31815	GA	32148	FL	32357	FL
31739	GA	31816	GA	32149	FL	32358	FL
31740	GA	31821	GA	32151	FL	32359	FL
31741	GA	31822	GA	32157	FL	32360	FL
31742	GA	31823	GA	32158	FL	32361	FL
31745	GA	31824	GA	32159	FL	32420	FL
31746	GA	31825	GA	32162	FL	32421	FL
31749	GA	31826	GA	32164	FL	32422	FL
31750	GA	31827	GA	32177	FL	32423	FL
31751	GA	31830	GA	32178	FL	32424	FL
31754	GA	31831	GA	32181	FL	32425	FL
31759	GA	31832	GA	32185	FL	32426	FL
31760	GA	31836	GA	32187	FL	32427	FL
31761	GA	32007	FL	32189	FL	32428	FL
31762	GA	32008	FL	32193	FL	32430	FL
31763	GA	32009	FL	32320	FL	32431	FL
31766	GA	32011	FL	32321	FL	32432	FL
31767	GA	32013	FL	32322	FL	32433	FL
31769	GA	32041	FL	32323	FL	32434	FL
31770	GA	32042	FL	32324	FL	32435	FL
31772	GA	32044	FL	32326	FL	32437	FL

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
32439	FL	32767	FL	33935	FL	34731	FL
32440	FL	32776	FL	33944	FL	34736	FL
32442	FL	32778	FL	33957	FL	34737	FL
32443	FL	32784	FL	33960	FL	34748	FL
32445	FL	33440	FL	33975	FL	34749	FL
32446	FL	33471	FL	34140	FL	34753	FL
32447	FL	33513	FL	34145	FL	34755	FL
32448	FL	33514	FL	34146	FL	34756	FL
32449	FL	33521	FL	34449	FL	34762	FL
32452	FL	33538	FL	34484	FL	34785	FL
32454	FL	33543	FL	34498	FL	34788	FL
32455	FL	33544	FL	34601	FL	34789	FL
32456	FL	33574	FL	34602	FL	34797	FL
32457	FL	33585	FL	34603	FL	34956	FL
32459	FL	33597	FL	34604	FL	35004	AL
32460	FL	33825	FL	34605	FL	35013	AL
32461	FL	33826	FL	34606	FL	35014	AL
32462	FL	33827	FL	34607	FL	35016	AL
32463	FL	33830	FL	34608	FL	35031	AL
32464	FL	33831	FL	34609	FL	35032	AL
32465	FL	33834	FL	34610	FL	35034	AL
32538	FL	33841	FL	34611	FL	35035	AL
32550	FL	33843	FL	34613	FL	35038	AL
32619	FL	33844	FL	34614	FL	35042	AL
32621	FL	33845	FL	34636	FL	35044	AL
32622	FL	33847	FL	34639	FL	35045	AL
32625	FL	33852	FL	34652	FL	35046	AL
32626	FL	33854	FL	34653	FL	35049	AL
32628	FL	33855	FL	34654	FL	35051	AL
32639	FL	33856	FL	34655	FL	35052	AL
32644	FL	33857	FL	34656	FL	35054	AL
32648	FL	33859	FL	34661	FL	35063	AL
32666	FL	33862	FL	34667	FL	35072	AL
32668	FL	33865	FL	34668	FL	35074	AL
32680	FL	33867	FL	34669	FL	35079	AL
32683	FL	33870	FL	34673	FL	35082	AL
32692	FL	33871	FL	34674	FL	35085	AL
32693	FL	33872	FL	34679	FL	35089	AL
32696	FL	33873	FL	34680	FL	35096	AL
32702	FL	33875	FL	34690	FL	35097	AL
32726	FL	33876	FL	34691	FL	35112	AL
32727	FL	33890	FL	34705	FL	35120	AL
32735	FL	33924	FL	34711	FL	35121	AL
32736	FL	33930	FL	34712	FL	35125	AL
32756	FL	33931	FL	34713	FL	35128	AL
32757	FL	33932	FL	34729	FL	35130	AL

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
35131	AL	35546	AL	35651	AL	35978	AL
35133	AL	35548	AL	35652	AL	35979	AL
35135	AL	35549	AL	35653	AL	35980	AL
35136	AL	35550	AL	35654	AL	35981	AL
35143	AL	35551	AL	35671	AL	35983	AL
35146	AL	35552	AL	35672	AL	35984	AL
35148	AL	35553	AL	35739	AL	35986	AL
35149	AL	35554	AL	35740	AL	35987	AL
35150	AL	35555	AL	35742	AL	35988	AL
35151	AL	35559	AL	35744	AL	35989	AL
35160	AL	35560	AL	35745	AL	36003	AL
35161	AL	35563	AL	35746	AL	36005	AL
35171	AL	35564	AL	35747	AL	36006	AL
35175	AL	35565	AL	35751	AL	36008	AL
35182	AL	35570	AL	35752	AL	36009	AL
35183	AL	35571	AL	35755	AL	36010	AL
35184	AL	35572	AL	35756	AL	36015	AL
35188	AL	35573	AL	35764	AL	36016	AL
35441	AL	35574	AL	35765	AL	36017	AL
35442	AL	35575	AL	35766	AL	36020	AL
35443	AL	35576	AL	35768	AL	36022	AL
35447	AL	35577	AL	35769	AL	36024	AL
35448	AL	35578	AL	35771	AL	36025	AL
35459	AL	35579	AL	35772	AL	36026	AL
35460	AL	35580	AL	35774	AL	36027	AL
35461	AL	35581	AL	35776	AL	36028	AL
35462	AL	35582	AL	35950	AL	36029	AL
35464	AL	35584	AL	35951	AL	36030	AL
35466	AL	35585	AL	35953	AL	36031	AL
35469	AL	35586	AL	35956	AL	36032	AL
35470	AL	35587	AL	35957	AL	36033	AL
35471	AL	35592	AL	35958	AL	36034	AL
35474	AL	35593	AL	35959	AL	36035	AL
35477	AL	35594	AL	35960	AL	36037	AL
35481	AL	35610	AL	35961	AL	36038	AL
35491	AL	35611	AL	35962	AL	36039	AL
35501	AL	35612	AL	35963	AL	36040	AL
35502	AL	35613	AL	35964	AL	36041	AL
35503	AL	35614	AL	35966	AL	36042	AL
35504	AL	35615	AL	35967	AL	36045	AL
35540	AL	35618	AL	35968	AL	36047	AL
35541	AL	35620	AL	35971	AL	36048	AL
35542	AL	35643	AL	35973	AL	36049	AL
35543	AL	35647	AL	35974	AL	36051	AL
35544	AL	35649	AL	35975	AL	36053	AL
35545	AL	35650	AL	35976	AL	36054	AL

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
36061	AL	36323	AL	36467	AL	36732	AL
36062	AL	36330	AL	36470	AL	36736	AL
36066	AL	36331	AL	36471	AL	36738	AL
36067	AL	36340	AL	36473	AL	36740	AL
36068	AL	36344	AL	36474	AL	36741	AL
36071	AL	36345	AL	36475	AL	36742	AL
36072	AL	36346	AL	36476	AL	36744	AL
36075	AL	36349	AL	36477	AL	36745	AL
36078	AL	36350	AL	36480	AL	36748	AL
36079	AL	36351	AL	36481	AL	36749	AL
36080	AL	36352	AL	36482	AL	36750	AL
36081	AL	36353	AL	36483	AL	36751	AL
36082	AL	36360	AL	36501	AL	36752	AL
36083	AL	36361	AL	36502	AL	36753	AL
36087	AL	36362	AL	36503	AL	36754	AL
36088	AL	36371	AL	36504	AL	36756	AL
36089	AL	36373	AL	36509	AL	36762	AL
36091	AL	36374	AL	36513	AL	36763	AL
36092	AL	36375	AL	36515	AL	36764	AL
36093	AL	36401	AL	36518	AL	36765	AL
36251	AL	36420	AL	36522	AL	36766	AL
36255	AL	36425	AL	36524	AL	36768	AL
36258	AL	36426	AL	36529	AL	36769	AL
36261	AL	36427	AL	36538	AL	36776	AL
36262	AL	36429	AL	36539	AL	36778	AL
36263	AL	36431	AL	36540	AL	36779	AL
36264	AL	36432	AL	36543	AL	36782	AL
36266	AL	36435	AL	36545	AL	36783	AL
36267	AL	36436	AL	36548	AL	36784	AL
36268	AL	36439	AL	36553	AL	36785	AL
36269	AL	36441	AL	36556	AL	36786	AL
36270	AL	36442	AL	36558	AL	36790	AL
36273	AL	36444	AL	36569	AL	36792	AL
36274	AL	36445	AL	36570	AL	36793	AL
36275	AL	36446	AL	36581	AL	36851	AL
36276	AL	36449	AL	36583	AL	36856	AL
36278	AL	36451	AL	36584	AL	36858	AL
36280	AL	36453	AL	36585	AL	36859	AL
36310	AL	36454	AL	36586	AL	36860	AL
36311	AL	36455	AL	36720	AL	36866	AL
36313	AL	36456	AL	36721	AL	36867	AL
36314	AL	36457	AL	36722	AL	36868	AL
36316	AL	36458	AL	36723	AL	36869	AL
36317	AL	36460	AL	36726	AL	36871	AL
36318	AL	36461	AL	36727	AL	36872	AL
36322	AL	36462	AL	36728	AL	36875	AL

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
36901	AL	37095	TN	37328	TN	37691	TN
36904	AL	37096	TN	37332	TN	37692	TN
36906	AL	37097	TN	37333	TN	37694	TN
36907	AL	37098	TN	37334	TN	37707	TN
36908	AL	37101	TN	37335	TN	37708	TN
36910	AL	37110	TN	37336	TN	37709	TN
36912	AL	37111	TN	37337	TN	37711	TN
36913	AL	37121	TN	37338	TN	37713	TN
36915	AL	37122	TN	37339	TN	37714	TN
36916	AL	37134	TN	37348	TN	37715	TN
36919	AL	37137	TN	37352	TN	37719	TN
36921	AL	37140	TN	37354	TN	37722	TN
36922	AL	37143	TN	37356	TN	37724	TN
36925	AL	37144	TN	37357	TN	37725	TN
37012	TN	37145	TN	37359	TN	37726	TN
37015	TN	37146	TN	37360	TN	37727	TN
37016	TN	37147	TN	37361	TN	37729	TN
37019	TN	37149	TN	37362	TN	37730	TN
37020	TN	37150	TN	37365	TN	37731	TN
37023	TN	37151	TN	37366	TN	37732	TN
37025	TN	37152	TN	37367	TN	37733	TN
37026	TN	37160	TN	37369	TN	37738	TN
37028	TN	37161	TN	37378	TN	37742	TN
37029	TN	37162	TN	37380	TN	37743	TN
37030	TN	37166	TN	37381	TN	37744	TN
37032	TN	37167	TN	37385	TN	37745	TN
37033	TN	37175	TN	37387	TN	37748	TN
37034	TN	37178	TN	37391	TN	37752	TN
37035	TN	37180	TN	37394	TN	37753	TN
37047	TN	37183	TN	37395	TN	37754	TN
37049	TN	37185	TN	37397	TN	37755	TN
37050	TN	37187	TN	37616	TN	37756	TN
37057	TN	37188	TN	37640	TN	37757	TN
37058	TN	37190	TN	37641	TN	37760	TN
37059	TN	37301	TN	37642	TN	37762	TN
37061	TN	37305	TN	37643	TN	37763	TN
37071	TN	37307	TN	37644	TN	37764	TN
37073	TN	37313	TN	37645	TN	37765	TN
37074	TN	37314	TN	37650	TN	37766	TN
37078	TN	37316	TN	37657	TN	37770	TN
37079	TN	37317	TN	37658	TN	37771	TN
37082	TN	37321	TN	37680	TN	37772	TN
37083	TN	37322	TN	37682	TN	37773	TN
37086	TN	37325	TN	37683	TN	37774	TN
37089	TN	37326	TN	37687	TN	37779	TN
37091	TN	37327	TN	37688	TN	37807	TN

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
37809	TN	38004	TN	38223	TN	38345	TN
37810	TN	38006	TN	38224	TN	38346	TN
37811	TN	38008	TN	38231	TN	38347	TN
37818	TN	38010	TN	38232	TN	38348	TN
37819	TN	38011	TN	38233	TN	38351	TN
37820	TN	38012	TN	38235	TN	38352	TN
37821	TN	38021	TN	38236	TN	38355	TN
37822	TN	38023	TN	38240	TN	38357	TN
37824	TN	38034	TN	38242	TN	38358	TN
37825	TN	38036	TN	38251	TN	38359	TN
37829	TN	38037	TN	38253	TN	38361	TN
37840	TN	38039	TN	38254	TN	38363	TN
37841	TN	38040	TN	38256	TN	38365	TN
37843	TN	38041	TN	38257	TN	38367	TN
37845	TN	38042	TN	38258	TN	38368	TN
37846	TN	38043	TN	38260	TN	38369	TN
37847	TN	38044	TN	38261	TN	38370	TN
37848	TN	38045	TN	38271	TN	38371	TN
37851	TN	38046	TN	38281	TN	38372	TN
37852	TN	38048	TN	38310	TN	38374	TN
37854	TN	38050	TN	38311	TN	38375	TN
37857	TN	38052	TN	38315	TN	38376	TN
37861	TN	38053	TN	38316	TN	38377	TN
37862	TN	38054	TN	38317	TN	38379	TN
37863	TN	38055	TN	38318	TN	38380	TN
37864	TN	38057	TN	38320	TN	38381	TN
37865	TN	38058	TN	38321	TN	38382	TN
37866	TN	38060	TN	38324	TN	38387	TN
37867	TN	38061	TN	38326	TN	38388	TN
37868	TN	38063	TN	38327	TN	38389	TN
37869	TN	38066	TN	38328	TN	38390	TN
37870	TN	38067	TN	38329	TN	38393	TN
37871	TN	38068	TN	38330	TN	38425	TN
37872	TN	38069	TN	38331	TN	38449	TN
37873	TN	38071	TN	38332	TN	38450	TN
37874	TN	38074	TN	38333	TN	38452	TN
37876	TN	38075	TN	38334	TN	38453	TN
37879	TN	38076	TN	38336	TN	38454	TN
37880	TN	38077	TN	38337	TN	38455	TN
37881	TN	38079	TN	38338	TN	38456	TN
37885	TN	38080	TN	38339	TN	38457	TN
37887	TN	38083	TN	38340	TN	38459	TN
37888	TN	38201	TN	38341	TN	38460	TN
37890	TN	38220	TN	38342	TN	38462	TN
37892	TN	38221	TN	38343	TN	38463	TN
38001	TN	38222	TN	38344	TN	38464	TN

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
38468	TN	38589	TN	38676	MS	38843	MS
38469	TN	38602	MS	38679	MS	38844	MS
38471	TN	38603	MS	38680	MS	38847	MS
38472	TN	38606	MS	38683	MS	38848	MS
38473	TN	38609	MS	38685	MS	38850	MS
38475	TN	38610	MS	38686	MS	38851	MS
38476	TN	38611	MS	38720	MS	38852	MS
38477	TN	38618	MS	38721	MS	38854	MS
38478	TN	38619	MS	38725	MS	38855	MS
38481	TN	38620	MS	38726	MS	38856	MS
38483	TN	38621	MS	38730	MS	38858	MS
38485	TN	38622	MS	38732	MS	38859	MS
38486	TN	38623	MS	38733	MS	38860	MS
38488	TN	38625	MS	38736	MS	38863	MS
38504	TN	38626	MS	38737	MS	38864	MS
38541	TN	38627	MS	38738	MS	38869	MS
38542	TN	38628	MS	38740	MS	38870	MS
38543	TN	38629	MS	38745	MS	38871	MS
38547	TN	38632	MS	38746	MS	38873	MS
38549	TN	38633	MS	38749	MS	38875	MS
38550	TN	38634	MS	38751	MS	38876	MS
38551	TN	38635	MS	38753	MS	38877	MS
38552	TN	38637	MS	38754	MS	38878	MS
38553	TN	38638	MS	38759	MS	38880	MS
38554	TN	38641	MS	38761	MS	38901	MS
38556	TN	38642	MS	38762	MS	38902	MS
38559	TN	38643	MS	38764	MS	38912	MS
38560	TN	38646	MS	38765	MS	38913	MS
38562	TN	38647	MS	38768	MS	38914	MS
38563	TN	38649	MS	38769	MS	38915	MS
38564	TN	38650	MS	38771	MS	38916	MS
38565	TN	38651	MS	38772	MS	38917	MS
38567	TN	38652	MS	38773	MS	38920	MS
38568	TN	38654	MS	38774	MS	38921	MS
38569	TN	38658	MS	38778	MS	38922	MS
38570	TN	38659	MS	38781	MS	38923	MS
38573	TN	38661	MS	38820	MS	38924	MS
38575	TN	38663	MS	38821	MS	38925	MS
38577	TN	38664	MS	38825	MS	38926	MS
38579	TN	38665	MS	38827	MS	38927	MS
38580	TN	38666	MS	38828	MS	38928	MS
38581	TN	38668	MS	38829	MS	38929	MS
38583	TN	38670	MS	38833	MS	38940	MS
38585	TN	38671	MS	38838	MS	38943	MS
38587	TN	38672	MS	38839	MS	38947	MS
38588	TN	38674	MS	38841	MS	38948	MS

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
38950	MS	39098	MS	39341	MS	39556	MS
38951	MS	39107	MS	39345	MS	39561	MS
38953	MS	39108	MS	39346	MS	39573	MS
38954	MS	39109	MS	39347	MS	39577	MS
38955	MS	39111	MS	39348	MS	39630	MS
38957	MS	39112	MS	39350	MS	39631	MS
38958	MS	39113	MS	39352	MS	39633	MS
38960	MS	39114	MS	39354	MS	39638	MS
38961	MS	39115	MS	39355	MS	39641	MS
38962	MS	39116	MS	39356	MS	39643	MS
38963	MS	39117	MS	39358	MS	39645	MS
38964	MS	39119	MS	39359	MS	39647	MS
38965	MS	39140	MS	39360	MS	39653	MS
38966	MS	39144	MS	39361	MS	39654	MS
38967	MS	39146	MS	39362	MS	39656	MS
39038	MS	39149	MS	39363	MS	39661	MS
39039	MS	39150	MS	39365	MS	39663	MS
39040	MS	39152	MS	39366	MS	39664	MS
39044	MS	39153	MS	39367	MS	39665	MS
39046	MS	39159	MS	39421	MS	39667	MS
39051	MS	39160	MS	39422	MS	39668	MS
39054	MS	39162	MS	39423	MS	39669	MS
39057	MS	39163	MS	39426	MS	39730	MS
39059	MS	39166	MS	39427	MS	39735	MS
39061	MS	39168	MS	39428	MS	39737	MS
39062	MS	39169	MS	39429	MS	39739	MS
39063	MS	39171	MS	39439	MS	39740	MS
39067	MS	39173	MS	39451	MS	39741	MS
39069	MS	39176	MS	39452	MS	39744	MS
39074	MS	39177	MS	39455	MS	39745	MS
39077	MS	39179	MS	39456	MS	39746	MS
39078	MS	39189	MS	39457	MS	39747	MS
39079	MS	39191	MS	39460	MS	39750	MS
39080	MS	39192	MS	39461	MS	39751	MS
39081	MS	39194	MS	39462	MS	39752	MS
39082	MS	39322	MS	39463	MS	39754	MS
39083	MS	39323	MS	39466	MS	39755	MS
39086	MS	39324	MS	39470	MS	39756	MS
39087	MS	39327	MS	39474	MS	39767	MS
39088	MS	39328	MS	39475	MS	39771	MS
39090	MS	39330	MS	39476	MS	39772	MS
39092	MS	39332	MS	39478	MS	39773	MS
39094	MS	39336	MS	39479	MS	39776	MS
39095	MS	39337	MS	39481	MS	39813	GA
39096	MS	39338	MS	39482	MS	39823	GA
39097	MS	39339	MS	39483	MS	39824	GA

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
39826	GA	40109	KY	40359	KY	40807	KY
39827	GA	40110	KY	40360	KY	40808	KY
39828	GA	40111	KY	40361	KY	40810	KY
39829	GA	40115	KY	40362	KY	40815	KY
39832	GA	40117	KY	40363	KY	40816	KY
39836	GA	40119	KY	40366	KY	40818	KY
39837	GA	40129	KY	40371	KY	40819	KY
39840	GA	40140	KY	40372	KY	40820	KY
39841	GA	40142	KY	40374	KY	40823	KY
39842	GA	40143	KY	40376	KY	40824	KY
39845	GA	40144	KY	40380	KY	40826	KY
39846	GA	40145	KY	40383	KY	40827	KY
39851	GA	40146	KY	40384	KY	40828	KY
39854	GA	40150	KY	40386	KY	40829	KY
39859	GA	40152	KY	40387	KY	40830	KY
39861	GA	40153	KY	40402	KY	40831	KY
39862	GA	40155	KY	40409	KY	40840	KY
39866	GA	40157	KY	40410	KY	40843	KY
39867	GA	40161	KY	40419	KY	40844	KY
39870	GA	40164	KY	40421	KY	40847	KY
39877	GA	40165	KY	40434	KY	40849	KY
39885	GA	40170	KY	40437	KY	40854	KY
39886	GA	40171	KY	40442	KY	40855	KY
39897	GA	40176	KY	40444	KY	40858	KY
40006	KY	40178	KY	40445	KY	40862	KY
40007	KY	40310	KY	40446	KY	40863	KY
40011	KY	40311	KY	40447	KY	40865	KY
40019	KY	40312	KY	40448	KY	40868	KY
40036	KY	40316	KY	40456	KY	40870	KY
40040	KY	40322	KY	40460	KY	40873	KY
40045	KY	40330	KY	40461	KY	40874	KY
40046	KY	40334	KY	40467	KY	40903	KY
40047	KY	40336	KY	40472	KY	40906	KY
40050	KY	40337	KY	40473	KY	40914	KY
40055	KY	40339	KY	40481	KY	40915	KY
40057	KY	40340	KY	40484	KY	40921	KY
40058	KY	40342	KY	40486	KY	40923	KY
40061	KY	40346	KY	40488	KY	40927	KY
40068	KY	40347	KY	40489	KY	40930	KY
40069	KY	40348	KY	40492	KY	40931	KY
40070	KY	40350	KY	40495	KY	40932	KY
40071	KY	40353	KY	40734	KY	40935	KY
40075	KY	40355	KY	40771	KY	40941	KY
40078	KY	40356	KY	40801	KY	40943	KY
40104	KY	40357	KY	40803	KY	40944	KY
40108	KY	40358	KY	40806	KY	40946	KY

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
40949	KY	41128	KY	41255	KY	41477	KY
40951	KY	41132	KY	41256	KY	41517	KY
40953	KY	41135	KY	41257	KY	41537	KY
40962	KY	41137	KY	41260	KY	41632	KY
40964	KY	41139	KY	41262	KY	41714	KY
40972	KY	41141	KY	41263	KY	41725	KY
40979	KY	41142	KY	41264	KY	41730	KY
40982	KY	41143	KY	41265	KY	41740	KY
40983	KY	41144	KY	41267	KY	41743	KY
40995	KY	41146	KY	41268	KY	41749	KY
40997	KY	41149	KY	41271	KY	41759	KY
40999	KY	41156	KY	41274	KY	41762	KY
41002	KY	41159	KY	41301	KY	41764	KY
41003	KY	41160	KY	41311	KY	41766	KY
41004	KY	41164	KY	41313	KY	41772	KY
41006	KY	41166	KY	41314	KY	41775	KY
41008	KY	41169	KY	41332	KY	41776	KY
41010	KY	41170	KY	41333	KY	41777	KY
41030	KY	41171	KY	41338	KY	41804	KY
41031	KY	41173	KY	41342	KY	41810	KY
41033	KY	41174	KY	41344	KY	41812	KY
41035	KY	41175	KY	41347	KY	41815	KY
41037	KY	41179	KY	41351	KY	41817	KY
41039	KY	41180	KY	41352	KY	41819	KY
41040	KY	41181	KY	41360	KY	41821	KY
41041	KY	41183	KY	41362	KY	41822	KY
41043	KY	41189	KY	41364	KY	41824	KY
41044	KY	41201	KY	41365	KY	41825	KY
41045	KY	41203	KY	41368	KY	41826	KY
41046	KY	41204	KY	41386	KY	41828	KY
41049	KY	41214	KY	41397	KY	41831	KY
41052	KY	41215	KY	41408	KY	41832	KY
41054	KY	41216	KY	41410	KY	41833	KY
41061	KY	41219	KY	41413	KY	41834	KY
41064	KY	41222	KY	41419	KY	41835	KY
41065	KY	41224	KY	41421	KY	41836	KY
41081	KY	41226	KY	41422	KY	41837	KY
41083	KY	41228	KY	41425	KY	41838	KY
41086	KY	41230	KY	41426	KY	41839	KY
41093	KY	41231	KY	41433	KY	41840	KY
41095	KY	41232	KY	41444	KY	41843	KY
41097	KY	41234	KY	41451	KY	41844	KY
41098	KY	41238	KY	41459	KY	41845	KY
41121	KY	41240	KY	41464	KY	41847	KY
41124	KY	41250	KY	41465	KY	41848	KY
41127	KY	41254	KY	41472	KY	41849	KY

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Specialty Physician PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
41855	KY	42088	KY	42286	KY	42455	KY
41858	KY	42120	KY	42287	KY	42456	KY
41859	KY	42124	KY	42288	KY	42459	KY
41861	KY	42129	KY	42320	KY	42460	KY
41862	KY	42133	KY	42321	KY	42461	KY
42021	KY	42134	KY	42322	KY	42462	KY
42022	KY	42135	KY	42323	KY	42463	KY
42023	KY	42140	KY	42324	KY	42516	KY
42024	KY	42150	KY	42325	KY	42528	KY
42025	KY	42151	KY	42326	KY	42539	KY
42027	KY	42153	KY	42327	KY	42541	KY
42028	KY	42154	KY	42328	KY	42565	KY
42029	KY	42157	KY	42330	KY	42566	KY
42031	KY	42163	KY	42332	KY	42602	KY
42032	KY	42164	KY	42333	KY	42603	KY
42033	KY	42166	KY	42337	KY	42629	KY
42035	KY	42167	KY	42338	KY	42631	KY
42037	KY	42201	KY	42339	KY	42632	KY
42038	KY	42202	KY	42343	KY	42633	KY
42039	KY	42203	KY	42344	KY	42634	KY
42040	KY	42204	KY	42345	KY	42635	KY
42041	KY	42206	KY	42347	KY	42638	KY
42044	KY	42207	KY	42348	KY	42642	KY
42045	KY	42209	KY	42349	KY	42647	KY
42047	KY	42210	KY	42350	KY	42649	KY
42048	KY	42211	KY	42351	KY	42653	KY
42050	KY	42214	KY	42352	KY	42711	KY
42051	KY	42215	KY	42354	KY	42712	KY
42055	KY	42216	KY	42361	KY	42713	KY
42056	KY	42219	KY	42364	KY	42715	KY
42058	KY	42220	KY	42365	KY	42716	KY
42060	KY	42234	KY	42367	KY	42717	KY
42061	KY	42251	KY	42368	KY	42718	KY
42063	KY	42252	KY	42369	KY	42719	KY
42064	KY	42256	KY	42370	KY	42720	KY
42066	KY	42257	KY	42371	KY	42721	KY
42069	KY	42259	KY	42372	KY	42722	KY
42070	KY	42261	KY	42374	KY	42726	KY
42078	KY	42265	KY	42403	KY	42728	KY
42079	KY	42267	KY	42404	KY	42729	KY
42081	KY	42273	KY	42409	KY	42731	KY
42082	KY	42275	KY	42411	KY	42733	KY
42083	KY	42276	KY	42437	KY	42735	KY
42084	KY	42280	KY	42444	KY	42741	KY
42085	KY	42283	KY	42445	KY	42742	KY
42087	KY	42285	KY	42450	KY	42743	KY

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Specialty Physician PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
42746	KY	43140	OH	43456	OH	43754	OH
42748	KY	43142	OH	43458	OH	43756	OH
42749	KY	43143	OH	43468	OH	43757	OH
42753	KY	43144	OH	43501	OH	43758	OH
42754	KY	43145	OH	43502	OH	43759	OH
42755	KY	43146	OH	43505	OH	43760	OH
42757	KY	43149	OH	43506	OH	43761	OH
42758	KY	43151	OH	43510	OH	43764	OH
42759	KY	43152	OH	43515	OH	43766	OH
42761	KY	43153	OH	43516	OH	43779	OH
42762	KY	43156	OH	43517	OH	43782	OH
42764	KY	43158	OH	43518	OH	43783	OH
42765	KY	43160	OH	43521	OH	43786	OH
42782	KY	43162	OH	43523	OH	43787	OH
42786	KY	43164	OH	43524	OH	43788	OH
43005	OH	43315	OH	43527	OH	43789	OH
43006	OH	43316	OH	43531	OH	43793	OH
43009	OH	43317	OH	43532	OH	43803	OH
43011	OH	43320	OH	43533	OH	43804	OH
43014	OH	43321	OH	43534	OH	43805	OH
43019	OH	43323	OH	43535	OH	43811	OH
43022	OH	43325	OH	43540	OH	43812	OH
43028	OH	43326	OH	43543	OH	43824	OH
43037	OH	43330	OH	43545	OH	43828	OH
43044	OH	43334	OH	43548	OH	43832	OH
43047	OH	43338	OH	43550	OH	43836	OH
43048	OH	43340	OH	43553	OH	43837	OH
43050	OH	43345	OH	43554	OH	43840	OH
43060	OH	43346	OH	43555	OH	43843	OH
43064	OH	43349	OH	43557	OH	43844	OH
43070	OH	43350	OH	43558	OH	43845	OH
43072	OH	43351	OH	43567	OH	43902	OH
43076	OH	43359	OH	43570	OH	43905	OH
43078	OH	43408	OH	43711	OH	43906	OH
43083	OH	43412	OH	43716	OH	43907	OH
43084	OH	43416	OH	43717	OH	43909	OH
43103	OH	43430	OH	43718	OH	43912	OH
43106	OH	43432	OH	43719	OH	43914	OH
43111	OH	43433	OH	43724	OH	43915	OH
43113	OH	43436	OH	43728	OH	43916	OH
43116	OH	43439	OH	43730	OH	43927	OH
43117	OH	43440	OH	43731	OH	43928	OH
43127	OH	43445	OH	43739	OH	43931	OH
43128	OH	43446	OH	43747	OH	43933	OH
43135	OH	43449	OH	43748	OH	43934	OH
43138	OH	43452	OH	43752	OH	43935	OH

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Specialty Physician PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
43937	OH	44612	OH	44844	OH	45311	OH
43940	OH	44615	OH	44847	OH	45314	OH
43942	OH	44617	OH	44849	OH	45320	OH
43946	OH	44619	OH	44850	OH	45321	OH
43947	OH	44620	OH	44851	OH	45328	OH
43950	OH	44621	OH	44854	OH	45330	OH
43951	OH	44622	OH	44855	OH	45331	OH
43967	OH	44624	OH	44856	OH	45332	OH
43972	OH	44625	OH	44857	OH	45333	OH
43973	OH	44628	OH	44860	OH	45334	OH
43974	OH	44629	OH	44865	OH	45336	OH
43976	OH	44631	OH	44881	OH	45337	OH
43977	OH	44633	OH	44882	OH	45338	OH
43981	OH	44637	OH	44887	OH	45339	OH
43984	OH	44638	OH	44888	OH	45340	OH
43985	OH	44639	OH	44889	OH	45346	OH
43986	OH	44644	OH	44890	OH	45347	OH
43988	OH	44651	OH	45036	OH	45348	OH
44003	OH	44653	OH	45070	OH	45350	OH
44004	OH	44654	OH	45101	OH	45351	OH
44005	OH	44656	OH	45105	OH	45352	OH
44010	OH	44660	OH	45110	OH	45353	OH
44030	OH	44661	OH	45115	OH	45358	OH
44032	OH	44663	OH	45118	OH	45360	OH
44041	OH	44671	OH	45119	OH	45361	OH
44047	OH	44672	OH	45121	OH	45362	OH
44048	OH	44675	OH	45123	OH	45363	OH
44068	OH	44678	OH	45130	OH	45365	OH
44076	OH	44679	OH	45131	OH	45367	OH
44082	OH	44680	OH	45132	OH	45371	OH
44084	OH	44681	OH	45133	OH	45378	OH
44085	OH	44682	OH	45135	OH	45380	OH
44088	OH	44683	OH	45142	OH	45381	OH
44093	OH	44687	OH	45144	OH	45382	OH
44099	OH	44690	OH	45154	OH	45383	OH
44231	OH	44693	OH	45155	OH	45387	OH
44234	OH	44695	OH	45165	OH	45388	OH
44288	OH	44697	OH	45167	OH	45389	OH
44408	OH	44699	OH	45168	OH	45390	OH
44431	OH	44811	OH	45171	OH	45613	OH
44490	OH	44820	OH	45172	OH	45616	OH
44493	OH	44825	OH	45302	OH	45618	OH
44607	OH	44826	OH	45303	OH	45619	OH
44609	OH	44827	OH	45304	OH	45621	OH
44610	OH	44833	OH	45306	OH	45622	OH
44611	OH	44837	OH	45310	OH	45624	OH

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
45634	OH	45779	OH	45876	OH	46148	IN
45638	OH	45783	OH	45877	OH	46150	IN
45640	OH	45784	OH	45879	OH	46155	IN
45642	OH	45806	OH	45880	OH	46156	IN
45645	OH	45810	OH	45882	OH	46157	IN
45646	OH	45812	OH	45883	OH	46158	IN
45650	OH	45813	OH	45884	OH	46160	IN
45651	OH	45815	OH	45885	OH	46161	IN
45654	OH	45817	OH	45886	OH	46166	IN
45656	OH	45819	OH	45888	OH	46170	IN
45659	OH	45821	OH	45891	OH	46171	IN
45660	OH	45822	OH	45893	OH	46172	IN
45661	OH	45826	OH	45894	OH	46173	IN
45669	OH	45827	OH	45895	OH	46175	IN
45672	OH	45828	OH	45896	OH	46176	IN
45675	OH	45830	OH	45898	OH	46182	IN
45678	OH	45831	OH	45899	OH	46310	IN
45679	OH	45832	OH	46035	IN	46349	IN
45680	OH	45835	OH	46036	IN	46366	IN
45683	OH	45836	OH	46039	IN	46372	IN
45684	OH	45837	OH	46041	IN	46374	IN
45687	OH	45838	OH	46045	IN	46379	IN
45688	OH	45843	OH	46049	IN	46380	IN
45690	OH	45844	OH	46050	IN	46381	IN
45692	OH	45845	OH	46057	IN	46392	IN
45693	OH	45846	OH	46058	IN	46501	IN
45695	OH	45848	OH	46065	IN	46502	IN
45696	OH	45849	OH	46067	IN	46504	IN
45697	OH	45851	OH	46068	IN	46506	IN
45698	OH	45853	OH	46104	IN	46508	IN
45712	OH	45855	OH	46105	IN	46510	IN
45713	OH	45856	OH	46110	IN	46511	IN
45714	OH	45859	OH	46111	IN	46513	IN
45720	OH	45860	OH	46113	IN	46524	IN
45724	OH	45861	OH	46115	IN	46531	IN
45727	OH	45862	OH	46120	IN	46532	IN
45729	OH	45863	OH	46121	IN	46534	IN
45741	OH	45864	OH	46125	IN	46537	IN
45742	OH	45865	OH	46126	IN	46538	IN
45743	OH	45866	OH	46127	IN	46539	IN
45760	OH	45869	OH	46128	IN	46542	IN
45769	OH	45870	OH	46130	IN	46550	IN
45770	OH	45871	OH	46133	IN	46555	IN
45771	OH	45873	OH	46135	IN	46562	IN
45772	OH	45874	OH	46144	IN	46563	IN
45775	OH	45875	OH	46146	IN	46565	IN

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
46566	IN	46782	IN	46977	IN	47135	IN
46567	IN	46783	IN	46980	IN	47136	IN
46570	IN	46784	IN	46982	IN	47137	IN
46571	IN	46785	IN	46984	IN	47138	IN
46572	IN	46786	IN	46985	IN	47139	IN
46574	IN	46787	IN	46990	IN	47140	IN
46580	IN	46789	IN	46992	IN	47142	IN
46581	IN	46791	IN	46996	IN	47145	IN
46582	IN	46792	IN	47003	IN	47160	IN
46590	IN	46793	IN	47006	IN	47161	IN
46701	IN	46794	IN	47010	IN	47164	IN
46702	IN	46795	IN	47011	IN	47165	IN
46703	IN	46796	IN	47012	IN	47166	IN
46705	IN	46910	IN	47016	IN	47167	IN
46706	IN	46911	IN	47017	IN	47170	IN
46710	IN	46912	IN	47019	IN	47174	IN
46711	IN	46913	IN	47020	IN	47175	IN
46713	IN	46914	IN	47021	IN	47177	IN
46720	IN	46915	IN	47023	IN	47220	IN
46721	IN	46916	IN	47024	IN	47223	IN
46723	IN	46917	IN	47030	IN	47225	IN
46725	IN	46919	IN	47031	IN	47227	IN
46730	IN	46920	IN	47033	IN	47228	IN
46732	IN	46921	IN	47034	IN	47229	IN
46733	IN	46922	IN	47035	IN	47234	IN
46737	IN	46923	IN	47036	IN	47235	IN
46738	IN	46926	IN	47037	IN	47240	IN
46740	IN	46929	IN	47038	IN	47245	IN
46742	IN	46931	IN	47039	IN	47249	IN
46746	IN	46935	IN	47040	IN	47260	IN
46747	IN	46939	IN	47041	IN	47261	IN
46750	IN	46940	IN	47042	IN	47263	IN
46755	IN	46941	IN	47043	IN	47264	IN
46760	IN	46943	IN	47102	IN	47265	IN
46761	IN	46945	IN	47107	IN	47270	IN
46763	IN	46946	IN	47108	IN	47272	IN
46764	IN	46951	IN	47110	IN	47273	IN
46767	IN	46958	IN	47112	IN	47274	IN
46769	IN	46959	IN	47114	IN	47281	IN
46770	IN	46960	IN	47115	IN	47282	IN
46771	IN	46962	IN	47116	IN	47283	IN
46772	IN	46968	IN	47117	IN	47322	IN
46776	IN	46970	IN	47118	IN	47325	IN
46777	IN	46971	IN	47120	IN	47326	IN
46779	IN	46974	IN	47123	IN	47331	IN
46780	IN	46975	IN	47125	IN	47336	IN

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
47337	IN	47455	IN	47617	IN	47865	IN
47340	IN	47456	IN	47620	IN	47868	IN
47344	IN	47457	IN	47631	IN	47872	IN
47348	IN	47459	IN	47633	IN	47874	IN
47351	IN	47460	IN	47634	IN	47875	IN
47352	IN	47465	IN	47635	IN	47879	IN
47353	IN	47469	IN	47638	IN	47881	IN
47354	IN	47471	IN	47639	IN	47882	IN
47355	IN	47501	IN	47640	IN	47884	IN
47356	IN	47514	IN	47647	IN	47917	IN
47358	IN	47515	IN	47648	IN	47918	IN
47359	IN	47519	IN	47649	IN	47921	IN
47360	IN	47520	IN	47654	IN	47922	IN
47361	IN	47522	IN	47660	IN	47923	IN
47362	IN	47523	IN	47665	IN	47925	IN
47366	IN	47525	IN	47666	IN	47926	IN
47368	IN	47529	IN	47670	IN	47928	IN
47369	IN	47531	IN	47683	IN	47929	IN
47371	IN	47536	IN	47830	IN	47932	IN
47373	IN	47537	IN	47831	IN	47942	IN
47380	IN	47550	IN	47832	IN	47943	IN
47381	IN	47551	IN	47833	IN	47944	IN
47382	IN	47552	IN	47834	IN	47946	IN
47384	IN	47553	IN	47836	IN	47948	IN
47385	IN	47556	IN	47837	IN	47949	IN
47386	IN	47558	IN	47838	IN	47950	IN
47387	IN	47562	IN	47840	IN	47951	IN
47388	IN	47564	IN	47841	IN	47952	IN
47390	IN	47567	IN	47842	IN	47957	IN
47394	IN	47568	IN	47845	IN	47958	IN
47424	IN	47574	IN	47846	IN	47959	IN
47427	IN	47576	IN	47847	IN	47960	IN
47431	IN	47577	IN	47848	IN	47963	IN
47432	IN	47579	IN	47849	IN	47964	IN
47433	IN	47581	IN	47850	IN	47966	IN
47435	IN	47584	IN	47852	IN	47969	IN
47438	IN	47585	IN	47853	IN	47970	IN
47439	IN	47586	IN	47854	IN	47971	IN
47441	IN	47588	IN	47855	IN	47974	IN
47443	IN	47590	IN	47856	IN	47975	IN
47445	IN	47598	IN	47857	IN	47977	IN
47448	IN	47601	IN	47859	IN	47978	IN
47449	IN	47611	IN	47860	IN	47980	IN
47452	IN	47612	IN	47861	IN	47982	IN
47453	IN	47615	IN	47862	IN	47984	IN
47454	IN	47616	IN	47864	IN	47986	IN

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
47987	IN	48471	MI	48741	MI	48850	MI
47988	IN	48472	MI	48742	MI	48851	MI
47991	IN	48475	MI	48743	MI	48852	MI
47993	IN	48610	MI	48744	MI	48853	MI
47995	IN	48611	MI	48745	MI	48860	MI
47997	IN	48612	MI	48746	MI	48861	MI
48032	MI	48616	MI	48748	MI	48865	MI
48039	MI	48617	MI	48749	MI	48866	MI
48097	MI	48619	MI	48750	MI	48870	MI
48110	MI	48621	MI	48754	MI	48873	MI
48117	MI	48622	MI	48755	MI	48875	MI
48131	MI	48624	MI	48757	MI	48876	MI
48133	MI	48625	MI	48758	MI	48879	MI
48140	MI	48627	MI	48759	MI	48881	MI
48144	MI	48629	MI	48760	MI	48884	MI
48157	MI	48630	MI	48762	MI	48885	MI
48159	MI	48632	MI	48763	MI	48886	MI
48160	MI	48633	MI	48764	MI	48888	MI
48166	MI	48636	MI	48765	MI	48890	MI
48177	MI	48647	MI	48766	MI	48891	MI
48179	MI	48651	MI	48767	MI	48894	MI
48182	MI	48652	MI	48768	MI	48897	MI
48401	MI	48653	MI	48769	MI	48907	MI
48410	MI	48656	MI	48770	MI	48908	MI
48413	MI	48658	MI	48787	MI	48913	MI
48416	MI	48659	MI	48808	MI	48917	MI
48419	MI	48701	MI	48809	MI	48950	MI
48422	MI	48703	MI	48811	MI	48980	MI
48426	MI	48705	MI	48812	MI	49010	MI
48427	MI	48720	MI	48813	MI	49013	MI
48432	MI	48721	MI	48815	MI	49021	MI
48434	MI	48723	MI	48818	MI	49026	MI
48435	MI	48725	MI	48820	MI	49027	MI
48441	MI	48726	MI	48821	MI	49030	MI
48444	MI	48728	MI	48822	MI	49031	MI
48445	MI	48729	MI	48827	MI	49032	MI
48450	MI	48730	MI	48829	MI	49035	MI
48453	MI	48731	MI	48831	MI	49040	MI
48454	MI	48733	MI	48833	MI	49042	MI
48456	MI	48734	MI	48834	MI	49043	MI
48465	MI	48735	MI	48835	MI	49045	MI
48466	MI	48736	MI	48837	MI	49046	MI
48467	MI	48737	MI	48838	MI	49047	MI
48468	MI	48738	MI	48845	MI	49050	MI
48469	MI	48739	MI	48846	MI	49055	MI
48470	MI	48740	MI	48849	MI	49056	MI

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
49057	MI	49305	MI	49612	MI	49679	MI
49058	MI	49307	MI	49613	MI	49680	MI
49060	MI	49309	MI	49614	MI	49682	MI
49061	MI	49311	MI	49615	MI	49683	MI
49062	MI	49312	MI	49616	MI	49688	MI
49063	MI	49314	MI	49617	MI	49689	MI
49064	MI	49320	MI	49619	MI	49701	MI
49065	MI	49322	MI	49621	MI	49705	MI
49066	MI	49323	MI	49622	MI	49709	MI
49067	MI	49325	MI	49623	MI	49711	MI
49068	MI	49327	MI	49625	MI	49712	MI
49069	MI	49328	MI	49626	MI	49713	MI
49070	MI	49329	MI	49627	MI	49717	MI
49071	MI	49332	MI	49628	MI	49719	MI
49072	MI	49333	MI	49629	MI	49720	MI
49073	MI	49335	MI	49630	MI	49721	MI
49075	MI	49336	MI	49631	MI	49727	MI
49076	MI	49337	MI	49632	MI	49729	MI
49078	MI	49338	MI	49633	MI	49743	MI
49079	MI	49339	MI	49634	MI	49745	MI
49080	MI	49340	MI	49635	MI	49746	MI
49090	MI	49342	MI	49636	MI	49749	MI
49091	MI	49344	MI	49639	MI	49756	MI
49092	MI	49346	MI	49640	MI	49757	MI
49093	MI	49347	MI	49642	MI	49759	MI
49095	MI	49348	MI	49644	MI	49760	MI
49096	MI	49349	MI	49645	MI	49761	MI
49099	MI	49406	MI	49646	MI	49762	MI
49104	MI	49408	MI	49648	MI	49765	MI
49107	MI	49412	MI	49650	MI	49775	MI
49112	MI	49413	MI	49651	MI	49776	MI
49117	MI	49416	MI	49653	MI	49777	MI
49130	MI	49419	MI	49654	MI	49779	MI
49224	MI	49420	MI	49655	MI	49781	MI
49229	MI	49421	MI	49656	MI	49782	MI
49233	MI	49436	MI	49657	MI	49791	MI
49236	MI	49446	MI	49659	MI	49792	MI
49238	MI	49449	MI	49660	MI	49796	MI
49245	MI	49450	MI	49664	MI	49799	MI
49265	MI	49452	MI	49665	MI	49805	MI
49267	MI	49453	MI	49667	MI	49806	MI
49270	MI	49455	MI	49670	MI	49807	MI
49275	MI	49459	MI	49674	MI	49812	MI
49276	MI	49461	MI	49675	MI	49813	MI
49287	MI	49463	MI	49676	MI	49816	MI
49304	MI	49611	MI	49677	MI	49817	MI

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
49818	MI	49918	MI	50047	IA	50132	IA
49820	MI	49919	MI	50048	IA	50133	IA
49821	MI	49920	MI	50049	IA	50135	IA
49822	MI	49925	MI	50050	IA	50136	IA
49825	MI	49927	MI	50052	IA	50137	IA
49826	MI	49929	MI	50054	IA	50138	IA
49827	MI	49935	MI	50057	IA	50139	IA
49829	MI	49938	MI	50058	IA	50140	IA
49835	MI	49946	MI	50059	IA	50143	IA
49836	MI	49947	MI	50060	IA	50144	IA
49837	MI	49948	MI	50061	IA	50145	IA
49838	MI	49950	MI	50062	IA	50146	IA
49839	MI	49953	MI	50063	IA	50147	IA
49840	MI	49959	MI	50064	IA	50149	IA
49845	MI	49960	MI	50065	IA	50150	IA
49847	MI	49962	MI	50066	IA	50151	IA
49848	MI	49964	MI	50067	IA	50152	IA
49853	MI	49967	MI	50068	IA	50153	IA
49854	MI	49968	MI	50069	IA	50155	IA
49858	MI	49969	MI	50070	IA	50156	IA
49862	MI	49970	MI	50071	IA	50160	IA
49863	MI	49971	MI	50072	IA	50163	IA
49864	MI	50001	IA	50074	IA	50164	IA
49868	MI	50002	IA	50075	IA	50165	IA
49872	MI	50003	IA	50076	IA	50166	IA
49873	MI	50006	IA	50101	IA	50167	IA
49874	MI	50008	IA	50102	IA	50168	IA
49878	MI	50020	IA	50103	IA	50170	IA
49880	MI	50022	IA	50104	IA	50173	IA
49883	MI	50025	IA	50107	IA	50174	IA
49884	MI	50026	IA	50108	IA	50197	IA
49886	MI	50027	IA	50109	IA	50198	IA
49887	MI	50028	IA	50110	IA	50206	IA
49891	MI	50029	IA	50115	IA	50207	IA
49893	MI	50031	IA	50116	IA	50208	IA
49894	MI	50033	IA	50117	IA	50210	IA
49895	MI	50034	IA	50118	IA	50211	IA
49896	MI	50036	IA	50119	IA	50212	IA
49901	MI	50037	IA	50122	IA	50213	IA
49902	MI	50038	IA	50123	IA	50214	IA
49903	MI	50039	IA	50125	IA	50216	IA
49908	MI	50040	IA	50126	IA	50217	IA
49910	MI	50041	IA	50127	IA	50218	IA
49911	MI	50042	IA	50128	IA	50219	IA
49912	MI	50043	IA	50129	IA	50220	IA
49915	MI	50044	IA	50130	IA	50222	IA

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
50223	IA	50434	IA	50526	IA	50592	IA
50225	IA	50435	IA	50527	IA	50593	IA
50227	IA	50436	IA	50528	IA	50595	IA
50228	IA	50438	IA	50529	IA	50597	IA
50229	IA	50439	IA	50531	IA	50598	IA
50230	IA	50440	IA	50533	IA	50599	IA
50231	IA	50441	IA	50535	IA	50601	IA
50232	IA	50444	IA	50536	IA	50602	IA
50233	IA	50446	IA	50538	IA	50603	IA
50235	IA	50447	IA	50539	IA	50604	IA
50238	IA	50448	IA	50540	IA	50605	IA
50240	IA	50449	IA	50541	IA	50606	IA
50241	IA	50450	IA	50542	IA	50607	IA
50246	IA	50451	IA	50545	IA	50608	IA
50249	IA	50452	IA	50546	IA	50609	IA
50250	IA	50453	IA	50548	IA	50611	IA
50251	IA	50454	IA	50551	IA	50612	IA
50252	IA	50455	IA	50552	IA	50616	IA
50254	IA	50456	IA	50554	IA	50619	IA
50255	IA	50458	IA	50556	IA	50620	IA
50256	IA	50459	IA	50558	IA	50621	IA
50257	IA	50460	IA	50559	IA	50622	IA
50258	IA	50461	IA	50560	IA	50624	IA
50259	IA	50465	IA	50561	IA	50625	IA
50261	IA	50466	IA	50562	IA	50627	IA
50262	IA	50468	IA	50563	IA	50628	IA
50263	IA	50470	IA	50565	IA	50629	IA
50264	IA	50471	IA	50567	IA	50630	IA
50268	IA	50472	IA	50568	IA	50631	IA
50269	IA	50473	IA	50570	IA	50632	IA
50271	IA	50475	IA	50571	IA	50633	IA
50272	IA	50476	IA	50573	IA	50635	IA
50273	IA	50478	IA	50574	IA	50636	IA
50274	IA	50480	IA	50575	IA	50638	IA
50275	IA	50481	IA	50576	IA	50641	IA
50276	IA	50483	IA	50577	IA	50642	IA
50277	IA	50484	IA	50578	IA	50644	IA
50420	IA	50510	IA	50579	IA	50645	IA
50421	IA	50511	IA	50581	IA	50647	IA
50423	IA	50514	IA	50582	IA	50648	IA
50424	IA	50515	IA	50583	IA	50649	IA
50426	IA	50517	IA	50585	IA	50650	IA
50427	IA	50519	IA	50586	IA	50652	IA
50430	IA	50520	IA	50588	IA	50653	IA
50431	IA	50522	IA	50590	IA	50654	IA
50432	IA	50525	IA	50591	IA	50655	IA

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
50657	IA	50861	IA	51234	IA	51446	IA
50658	IA	50862	IA	51235	IA	51447	IA
50659	IA	50863	IA	51237	IA	51448	IA
50660	IA	50864	IA	51238	IA	51449	IA
50661	IA	51001	IA	51239	IA	51450	IA
50662	IA	51002	IA	51240	IA	51451	IA
50664	IA	51003	IA	51241	IA	51452	IA
50665	IA	51004	IA	51242	IA	51453	IA
50666	IA	51006	IA	51243	IA	51454	IA
50668	IA	51008	IA	51244	IA	51455	IA
50669	IA	51009	IA	51245	IA	51458	IA
50670	IA	51010	IA	51246	IA	51459	IA
50671	IA	51011	IA	51247	IA	51460	IA
50672	IA	51016	IA	51248	IA	51461	IA
50673	IA	51017	IA	51249	IA	51462	IA
50674	IA	51018	IA	51250	IA	51463	IA
50675	IA	51019	IA	51331	IA	51465	IA
50676	IA	51020	IA	51334	IA	51466	IA
50677	IA	51022	IA	51342	IA	51467	IA
50680	IA	51023	IA	51344	IA	51520	IA
50681	IA	51024	IA	51345	IA	51523	IA
50682	IA	51025	IA	51346	IA	51525	IA
50801	IA	51027	IA	51347	IA	51527	IA
50830	IA	51028	IA	51349	IA	51528	IA
50831	IA	51031	IA	51350	IA	51529	IA
50833	IA	51033	IA	51351	IA	51530	IA
50835	IA	51034	IA	51354	IA	51531	IA
50836	IA	51036	IA	51355	IA	51532	IA
50837	IA	51038	IA	51358	IA	51533	IA
50839	IA	51040	IA	51360	IA	51534	IA
50840	IA	51041	IA	51363	IA	51535	IA
50841	IA	51045	IA	51364	IA	51536	IA
50842	IA	51046	IA	51365	IA	51537	IA
50843	IA	51048	IA	51401	IA	51540	IA
50845	IA	51050	IA	51430	IA	51541	IA
50846	IA	51051	IA	51431	IA	51543	IA
50847	IA	51053	IA	51432	IA	51544	IA
50848	IA	51058	IA	51433	IA	51545	IA
50849	IA	51059	IA	51436	IA	51546	IA
50851	IA	51060	IA	51439	IA	51549	IA
50853	IA	51062	IA	51440	IA	51550	IA
50854	IA	51063	IA	51441	IA	51551	IA
50857	IA	51201	IA	51442	IA	51552	IA
50858	IA	51230	IA	51443	IA	51554	IA
50859	IA	51231	IA	51444	IA	51555	IA
50860	IA	51232	IA	51445	IA	51556	IA

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
51557	IA	52038	IA	52157	IA	52305	IA
51558	IA	52040	IA	52158	IA	52306	IA
51560	IA	52041	IA	52159	IA	52307	IA
51561	IA	52042	IA	52160	IA	52308	IA
51562	IA	52043	IA	52161	IA	52309	IA
51563	IA	52044	IA	52162	IA	52310	IA
51564	IA	52047	IA	52163	IA	52312	IA
51565	IA	52048	IA	52164	IA	52313	IA
51566	IA	52049	IA	52165	IA	52314	IA
51570	IA	52050	IA	52166	IA	52315	IA
51571	IA	52052	IA	52168	IA	52316	IA
51572	IA	52053	IA	52169	IA	52318	IA
51573	IA	52054	IA	52170	IA	52320	IA
51574	IA	52055	IA	52171	IA	52321	IA
51578	IA	52056	IA	52172	IA	52323	IA
51579	IA	52057	IA	52175	IA	52325	IA
51591	IA	52060	IA	52201	IA	52326	IA
51593	IA	52064	IA	52203	IA	52327	IA
51601	IA	52065	IA	52204	IA	52329	IA
51602	IA	52066	IA	52205	IA	52330	IA
51603	IA	52069	IA	52206	IA	52332	IA
51630	IA	52070	IA	52207	IA	52334	IA
51631	IA	52071	IA	52208	IA	52335	IA
51632	IA	52072	IA	52209	IA	52337	IA
51636	IA	52074	IA	52210	IA	52339	IA
51637	IA	52075	IA	52212	IA	52342	IA
51638	IA	52076	IA	52215	IA	52345	IA
51639	IA	52077	IA	52216	IA	52346	IA
51640	IA	52078	IA	52217	IA	52347	IA
51645	IA	52079	IA	52220	IA	52348	IA
51646	IA	52101	IA	52223	IA	52349	IA
51647	IA	52132	IA	52224	IA	52351	IA
51648	IA	52133	IA	52225	IA	52353	IA
51649	IA	52134	IA	52229	IA	52354	IA
51650	IA	52135	IA	52231	IA	52355	IA
51651	IA	52136	IA	52236	IA	52356	IA
51652	IA	52140	IA	52237	IA	52358	IA
51653	IA	52141	IA	52247	IA	52359	IA
51654	IA	52142	IA	52248	IA	52361	IA
51656	IA	52144	IA	52249	IA	52362	IA
52030	IA	52146	IA	52251	IA	52531	IA
52031	IA	52147	IA	52252	IA	52534	IA
52032	IA	52151	IA	52253	IA	52535	IA
52033	IA	52154	IA	52255	IA	52537	IA
52035	IA	52155	IA	52257	IA	52538	IA
52036	IA	52156	IA	52301	IA	52540	IA

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
52542	IA	52652	IA	53088	WI	53556	WI
52543	IA	52653	IA	53091	WI	53557	WI
52544	IA	52654	IA	53094	WI	53561	WI
52549	IA	52659	IA	53098	WI	53565	WI
52550	IA	52720	IA	53099	WI	53569	WI
52551	IA	52721	IA	53114	WI	53573	WI
52552	IA	52737	IA	53115	WI	53577	WI
52555	IA	52738	IA	53120	WI	53578	WI
52560	IA	52739	IA	53121	WI	53579	WI
52561	IA	52747	IA	53125	WI	53580	WI
52562	IA	52749	IA	53128	WI	53581	WI
52563	IA	52752	IA	53137	WI	53582	WI
52565	IA	52754	IA	53138	WI	53583	WI
52568	IA	52759	IA	53147	WI	53584	WI
52569	IA	52760	IA	53148	WI	53585	WI
52570	IA	52761	IA	53156	WI	53586	WI
52571	IA	52766	IA	53157	WI	53587	WI
52572	IA	52769	IA	53176	WI	53588	WI
52573	IA	52772	IA	53178	WI	53594	WI
52574	IA	52776	IA	53184	WI	53595	WI
52576	IA	52778	IA	53190	WI	53599	WI
52577	IA	53003	WI	53191	WI	53801	WI
52581	IA	53006	WI	53195	WI	53802	WI
52583	IA	53014	WI	53503	WI	53803	WI
52584	IA	53016	WI	53504	WI	53804	WI
52585	IA	53017	WI	53506	WI	53805	WI
52586	IA	53022	WI	53507	WI	53806	WI
52588	IA	53032	WI	53510	WI	53807	WI
52590	IA	53033	WI	53516	WI	53808	WI
52591	IA	53034	WI	53518	WI	53809	WI
52593	IA	53035	WI	53525	WI	53810	WI
52594	IA	53036	WI	53526	WI	53811	WI
52595	IA	53037	WI	53530	WI	53812	WI
52620	IA	53038	WI	53533	WI	53813	WI
52621	IA	53039	WI	53535	WI	53816	WI
52626	IA	53047	WI	53536	WI	53817	WI
52630	IA	53048	WI	53538	WI	53818	WI
52640	IA	53050	WI	53540	WI	53820	WI
52641	IA	53059	WI	53541	WI	53821	WI
52642	IA	53061	WI	53543	WI	53824	WI
52644	IA	53062	WI	53544	WI	53825	WI
52645	IA	53073	WI	53549	WI	53826	WI
52646	IA	53075	WI	53551	WI	53827	WI
52647	IA	53076	WI	53553	WI	53901	WI
52649	IA	53078	WI	53554	WI	53910	WI
52651	IA	53086	WI	53555	WI	53911	WI

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
53913	WI	54004	WI	54143	WI	54446	WI
53916	WI	54005	WI	54149	WI	54447	WI
53917	WI	54006	WI	54150	WI	54448	WI
53920	WI	54007	WI	54151	WI	54450	WI
53922	WI	54009	WI	54152	WI	54451	WI
53923	WI	54010	WI	54153	WI	54452	WI
53924	WI	54011	WI	54154	WI	54456	WI
53925	WI	54012	WI	54156	WI	54459	WI
53927	WI	54013	WI	54157	WI	54460	WI
53928	WI	54014	WI	54159	WI	54462	WI
53929	WI	54015	WI	54160	WI	54464	WI
53930	WI	54016	WI	54161	WI	54465	WI
53932	WI	54017	WI	54165	WI	54470	WI
53933	WI	54020	WI	54166	WI	54479	WI
53934	WI	54021	WI	54169	WI	54480	WI
53935	WI	54022	WI	54171	WI	54484	WI
53936	WI	54023	WI	54174	WI	54485	WI
53937	WI	54024	WI	54175	WI	54486	WI
53940	WI	54025	WI	54177	WI	54487	WI
53941	WI	54026	WI	54182	WI	54488	WI
53942	WI	54027	WI	54201	WI	54490	WI
53943	WI	54028	WI	54205	WI	54491	WI
53944	WI	54082	WI	54216	WI	54493	WI
53948	WI	54101	WI	54217	WI	54498	WI
53949	WI	54102	WI	54405	WI	54499	WI
53950	WI	54103	WI	54409	WI	54511	WI
53951	WI	54104	WI	54411	WI	54512	WI
53952	WI	54107	WI	54414	WI	54513	WI
53953	WI	54110	WI	54416	WI	54515	WI
53954	WI	54111	WI	54418	WI	54519	WI
53955	WI	54112	WI	54420	WI	54520	WI
53956	WI	54114	WI	54421	WI	54521	WI
53957	WI	54119	WI	54422	WI	54524	WI
53958	WI	54120	WI	54424	WI	54525	WI
53959	WI	54121	WI	54425	WI	54526	WI
53960	WI	54123	WI	54426	WI	54530	WI
53961	WI	54124	WI	54428	WI	54532	WI
53962	WI	54125	WI	54430	WI	54534	WI
53963	WI	54127	WI	54433	WI	54536	WI
53964	WI	54128	WI	54434	WI	54537	WI
53965	WI	54129	WI	54435	WI	54538	WI
53968	WI	54135	WI	54436	WI	54540	WI
53969	WI	54137	WI	54437	WI	54541	WI
54001	WI	54138	WI	54439	WI	54542	WI
54002	WI	54139	WI	54442	WI	54545	WI
54003	WI	54141	WI	54444	WI	54547	WI

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
54550	WI	54649	WI	54761	WI	54848	WI
54552	WI	54651	WI	54762	WI	54849	WI
54554	WI	54652	WI	54763	WI	54853	WI
54555	WI	54654	WI	54764	WI	54854	WI
54556	WI	54655	WI	54765	WI	54856	WI
54557	WI	54656	WI	54766	WI	54857	WI
54558	WI	54657	WI	54767	WI	54858	WI
54559	WI	54658	WI	54768	WI	54859	WI
54560	WI	54659	WI	54769	WI	54862	WI
54561	WI	54660	WI	54770	WI	54864	WI
54563	WI	54661	WI	54771	WI	54865	WI
54565	WI	54662	WI	54772	WI	54867	WI
54566	WI	54664	WI	54773	WI	54868	WI
54610	WI	54665	WI	54801	WI	54870	WI
54611	WI	54666	WI	54805	WI	54871	WI
54612	WI	54667	WI	54810	WI	54872	WI
54613	WI	54670	WI	54812	WI	54873	WI
54615	WI	54721	WI	54813	WI	54874	WI
54616	WI	54722	WI	54814	WI	54875	WI
54618	WI	54723	WI	54816	WI	54876	WI
54619	WI	54724	WI	54817	WI	54880	WI
54620	WI	54725	WI	54818	WI	54888	WI
54621	WI	54728	WI	54819	WI	54889	WI
54622	WI	54730	WI	54820	WI	54890	WI
54623	WI	54731	WI	54821	WI	54891	WI
54624	WI	54733	WI	54822	WI	54893	WI
54625	WI	54734	WI	54824	WI	54895	WI
54626	WI	54735	WI	54826	WI	54896	WI
54627	WI	54736	WI	54827	WI	54922	WI
54628	WI	54737	WI	54828	WI	54926	WI
54629	WI	54738	WI	54829	WI	54928	WI
54630	WI	54739	WI	54830	WI	54929	WI
54631	WI	54740	WI	54832	WI	54930	WI
54632	WI	54741	WI	54834	WI	54933	WI
54634	WI	54743	WI	54835	WI	54940	WI
54635	WI	54746	WI	54836	WI	54943	WI
54637	WI	54747	WI	54837	WI	54945	WI
54638	WI	54749	WI	54838	WI	54946	WI
54639	WI	54750	WI	54839	WI	54948	WI
54640	WI	54751	WI	54840	WI	54949	WI
54641	WI	54754	WI	54841	WI	54950	WI
54642	WI	54755	WI	54842	WI	54960	WI
54643	WI	54756	WI	54843	WI	54961	WI
54645	WI	54758	WI	54844	WI	54962	WI
54646	WI	54759	WI	54845	WI	54965	WI
54648	WI	54760	WI	54847	WI	54966	WI

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
54967	WI	55307	MN	55398	MN	55730	MN
54969	WI	55308	MN	55561	MN	55731	MN
54970	WI	55309	MN	55563	MN	55733	MN
54975	WI	55310	MN	55565	MN	55734	MN
54976	WI	55312	MN	55575	MN	55735	MN
54977	WI	55313	MN	55580	MN	55741	MN
54978	WI	55314	MN	55581	MN	55742	MN
54981	WI	55319	MN	55582	MN	55744	MN
54982	WI	55320	MN	55584	MN	55745	MN
54983	WI	55321	MN	55585	MN	55746	MN
54984	WI	55324	MN	55586	MN	55747	MN
54990	WI	55325	MN	55587	MN	55748	MN
55002	MN	55328	MN	55588	MN	55749	MN
55007	MN	55329	MN	55589	MN	55750	MN
55012	MN	55330	MN	55590	MN	55751	MN
55013	MN	55332	MN	55591	MN	55752	MN
55019	MN	55333	MN	55601	MN	55753	MN
55021	MN	55334	MN	55603	MN	55756	MN
55030	MN	55335	MN	55604	MN	55757	MN
55032	MN	55336	MN	55605	MN	55758	MN
55036	MN	55338	MN	55606	MN	55760	MN
55037	MN	55341	MN	55607	MN	55764	MN
55040	MN	55342	MN	55609	MN	55767	MN
55041	MN	55349	MN	55612	MN	55768	MN
55045	MN	55350	MN	55613	MN	55769	MN
55046	MN	55352	MN	55614	MN	55771	MN
55049	MN	55354	MN	55615	MN	55772	MN
55051	MN	55355	MN	55616	MN	55775	MN
55052	MN	55358	MN	55703	MN	55777	MN
55053	MN	55362	MN	55704	MN	55780	MN
55056	MN	55363	MN	55705	MN	55781	MN
55057	MN	55365	MN	55706	MN	55782	MN
55060	MN	55366	MN	55707	MN	55783	MN
55063	MN	55370	MN	55708	MN	55784	MN
55067	MN	55371	MN	55709	MN	55785	MN
55069	MN	55373	MN	55710	MN	55786	MN
55072	MN	55376	MN	55712	MN	55787	MN
55074	MN	55377	MN	55716	MN	55790	MN
55078	MN	55380	MN	55718	MN	55792	MN
55079	MN	55381	MN	55719	MN	55793	MN
55084	MN	55382	MN	55720	MN	55795	MN
55087	MN	55385	MN	55721	MN	55796	MN
55088	MN	55389	MN	55722	MN	55797	MN
55092	MN	55390	MN	55723	MN	55798	MN
55301	MN	55395	MN	55725	MN	55909	MN
55302	MN	55396	MN	55726	MN	55912	MN

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Specialty Physician PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
55917	MN	56007	MN	56085	MN	56157	MN
55918	MN	56009	MN	56087	MN	56158	MN
55919	MN	56011	MN	56089	MN	56159	MN
55921	MN	56013	MN	56091	MN	56160	MN
55922	MN	56014	MN	56093	MN	56161	MN
55923	MN	56016	MN	56096	MN	56164	MN
55924	MN	56017	MN	56097	MN	56165	MN
55926	MN	56019	MN	56098	MN	56166	MN
55927	MN	56020	MN	56101	MN	56167	MN
55931	MN	56022	MN	56110	MN	56168	MN
55932	MN	56023	MN	56111	MN	56169	MN
55933	MN	56025	MN	56113	MN	56170	MN
55935	MN	56026	MN	56114	MN	56172	MN
55936	MN	56027	MN	56115	MN	56173	MN
55939	MN	56028	MN	56116	MN	56174	MN
55940	MN	56029	MN	56117	MN	56175	MN
55941	MN	56030	MN	56118	MN	56177	MN
55943	MN	56032	MN	56119	MN	56178	MN
55944	MN	56033	MN	56120	MN	56180	MN
55945	MN	56035	MN	56122	MN	56183	MN
55947	MN	56036	MN	56123	MN	56185	MN
55949	MN	56041	MN	56125	MN	56186	MN
55950	MN	56042	MN	56128	MN	56187	MN
55951	MN	56043	MN	56129	MN	56207	MN
55953	MN	56044	MN	56131	MN	56208	MN
55954	MN	56045	MN	56132	MN	56210	MN
55955	MN	56046	MN	56134	MN	56211	MN
55956	MN	56047	MN	56136	MN	56212	MN
55957	MN	56048	MN	56137	MN	56214	MN
55961	MN	56050	MN	56138	MN	56215	MN
55962	MN	56051	MN	56139	MN	56218	MN
55964	MN	56052	MN	56140	MN	56219	MN
55965	MN	56056	MN	56141	MN	56220	MN
55967	MN	56057	MN	56142	MN	56221	MN
55968	MN	56058	MN	56143	MN	56222	MN
55970	MN	56060	MN	56144	MN	56223	MN
55971	MN	56062	MN	56145	MN	56224	MN
55973	MN	56068	MN	56146	MN	56225	MN
55974	MN	56069	MN	56147	MN	56226	MN
55975	MN	56071	MN	56149	MN	56227	MN
55977	MN	56072	MN	56150	MN	56228	MN
55981	MN	56073	MN	56151	MN	56229	MN
55982	MN	56076	MN	56152	MN	56230	MN
55985	MN	56081	MN	56153	MN	56231	MN
55990	MN	56083	MN	56155	MN	56232	MN
55991	MN	56084	MN	56156	MN	56235	MN

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Specialty Physician PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
56236	MN	56314	MN	56430	MN	56536	MN
56237	MN	56316	MN	56431	MN	56540	MN
56239	MN	56317	MN	56433	MN	56541	MN
56240	MN	56318	MN	56434	MN	56542	MN
56241	MN	56320	MN	56435	MN	56543	MN
56243	MN	56323	MN	56436	MN	56544	MN
56244	MN	56325	MN	56437	MN	56545	MN
56245	MN	56328	MN	56438	MN	56546	MN
56248	MN	56329	MN	56440	MN	56547	MN
56249	MN	56330	MN	56443	MN	56548	MN
56252	MN	56331	MN	56446	MN	56549	MN
56255	MN	56333	MN	56452	MN	56550	MN
56256	MN	56334	MN	56453	MN	56552	MN
56257	MN	56335	MN	56458	MN	56553	MN
56258	MN	56336	MN	56461	MN	56554	MN
56260	MN	56338	MN	56464	MN	56556	MN
56262	MN	56339	MN	56466	MN	56557	MN
56263	MN	56340	MN	56467	MN	56560	MN
56264	MN	56342	MN	56469	MN	56561	MN
56265	MN	56344	MN	56470	MN	56565	MN
56266	MN	56345	MN	56473	MN	56566	MN
56267	MN	56347	MN	56474	MN	56568	MN
56270	MN	56349	MN	56475	MN	56569	MN
56271	MN	56350	MN	56477	MN	56570	MN
56274	MN	56352	MN	56478	MN	56574	MN
56276	MN	56353	MN	56479	MN	56575	MN
56277	MN	56356	MN	56481	MN	56577	MN
56278	MN	56357	MN	56482	MN	56578	MN
56280	MN	56358	MN	56484	MN	56579	MN
56283	MN	56359	MN	56501	MN	56580	MN
56284	MN	56362	MN	56502	MN	56581	MN
56285	MN	56363	MN	56510	MN	56583	MN
56287	MN	56364	MN	56511	MN	56584	MN
56291	MN	56367	MN	56513	MN	56585	MN
56292	MN	56368	MN	56514	MN	56589	MN
56293	MN	56371	MN	56516	MN	56590	MN
56294	MN	56373	MN	56517	MN	56591	MN
56295	MN	56376	MN	56519	MN	56592	MN
56296	MN	56378	MN	56520	MN	56593	MN
56297	MN	56379	MN	56521	MN	56594	MN
56304	MN	56381	MN	56522	MN	56621	MN
56307	MN	56382	MN	56523	MN	56623	MN
56309	MN	56384	MN	56525	MN	56626	MN
56311	MN	56385	MN	56529	MN	56627	MN
56312	MN	56386	MN	56531	MN	56628	MN
56313	MN	56389	MN	56535	MN	56629	MN

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
56631	MN	56727	MN	57047	SD	57248	SD
56633	MN	56728	MN	57048	SD	57249	SD
56634	MN	56729	MN	57050	SD	57251	SD
56636	MN	56731	MN	57051	SD	57252	SD
56637	MN	56732	MN	57052	SD	57253	SD
56639	MN	56733	MN	57053	SD	57255	SD
56641	MN	56734	MN	57054	SD	57256	SD
56644	MN	56735	MN	57057	SD	57257	SD
56646	MN	56736	MN	57058	SD	57258	SD
56649	MN	56737	MN	57059	SD	57259	SD
56651	MN	56738	MN	57061	SD	57260	SD
56652	MN	56741	MN	57062	SD	57261	SD
56653	MN	56742	MN	57063	SD	57262	SD
56654	MN	56744	MN	57065	SD	57264	SD
56655	MN	56748	MN	57066	SD	57265	SD
56657	MN	56750	MN	57070	SD	57266	SD
56658	MN	56751	MN	57071	SD	57268	SD
56659	MN	56755	MN	57075	SD	57269	SD
56660	MN	56756	MN	57076	SD	57270	SD
56661	MN	56757	MN	57212	SD	57271	SD
56662	MN	56758	MN	57213	SD	57273	SD
56668	MN	56759	MN	57214	SD	57274	SD
56669	MN	56760	MN	57216	SD	57276	SD
56672	MN	56761	MN	57217	SD	57278	SD
56673	MN	56762	MN	57218	SD	57279	SD
56676	MN	56763	MN	57219	SD	57311	SD
56678	MN	57002	SD	57220	SD	57312	SD
56679	MN	57006	SD	57221	SD	57313	SD
56680	MN	57007	SD	57223	SD	57314	SD
56681	MN	57012	SD	57224	SD	57315	SD
56684	MN	57013	SD	57225	SD	57317	SD
56686	MN	57014	SD	57226	SD	57319	SD
56688	MN	57015	SD	57227	SD	57321	SD
56710	MN	57016	SD	57231	SD	57322	SD
56711	MN	57017	SD	57232	SD	57323	SD
56712	MN	57021	SD	57233	SD	57324	SD
56713	MN	57024	SD	57234	SD	57325	SD
56714	MN	57026	SD	57236	SD	57326	SD
56715	MN	57027	SD	57237	SD	57328	SD
56716	MN	57028	SD	57238	SD	57329	SD
56720	MN	57029	SD	57239	SD	57330	SD
56721	MN	57034	SD	57241	SD	57331	SD
56722	MN	57036	SD	57242	SD	57332	SD
56723	MN	57042	SD	57244	SD	57335	SD
56724	MN	57043	SD	57246	SD	57337	SD
56726	MN	57045	SD	57247	SD	57339	SD

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
57340	SD	57435	SD	57548	SD	57650	SD
57341	SD	57436	SD	57551	SD	57651	SD
57342	SD	57437	SD	57552	SD	57652	SD
57344	SD	57438	SD	57553	SD	57653	SD
57345	SD	57440	SD	57557	SD	57656	SD
57346	SD	57442	SD	57559	SD	57657	SD
57348	SD	57448	SD	57560	SD	57658	SD
57349	SD	57450	SD	57562	SD	57659	SD
57350	SD	57451	SD	57564	SD	57660	SD
57353	SD	57452	SD	57567	SD	57661	SD
57354	SD	57454	SD	57568	SD	57706	SD
57355	SD	57455	SD	57569	SD	57714	SD
57356	SD	57456	SD	57571	SD	57716	SD
57358	SD	57457	SD	57574	SD	57717	SD
57359	SD	57461	SD	57576	SD	57718	SD
57361	SD	57462	SD	57577	SD	57720	SD
57362	SD	57465	SD	57578	SD	57722	SD
57364	SD	57466	SD	57579	SD	57724	SD
57365	SD	57467	SD	57580	SD	57725	SD
57366	SD	57468	SD	57584	SD	57729	SD
57367	SD	57469	SD	57585	SD	57730	SD
57368	SD	57470	SD	57601	SD	57732	SD
57369	SD	57471	SD	57620	SD	57735	SD
57370	SD	57472	SD	57621	SD	57736	SD
57371	SD	57473	SD	57622	SD	57737	SD
57373	SD	57475	SD	57623	SD	57738	SD
57374	SD	57476	SD	57625	SD	57741	SD
57375	SD	57477	SD	57626	SD	57742	SD
57376	SD	57520	SD	57629	SD	57744	SD
57379	SD	57521	SD	57630	SD	57747	SD
57380	SD	57523	SD	57631	SD	57748	SD
57381	SD	57526	SD	57632	SD	57750	SD
57382	SD	57528	SD	57633	SD	57752	SD
57383	SD	57529	SD	57634	SD	57754	SD
57384	SD	57531	SD	57636	SD	57755	SD
57385	SD	57532	SD	57638	SD	57756	SD
57386	SD	57533	SD	57639	SD	57758	SD
57399	SD	57534	SD	57640	SD	57759	SD
57420	SD	57537	SD	57641	SD	57760	SD
57421	SD	57538	SD	57642	SD	57761	SD
57422	SD	57540	SD	57644	SD	57762	SD
57424	SD	57541	SD	57645	SD	57763	SD
57428	SD	57542	SD	57646	SD	57764	SD
57429	SD	57543	SD	57647	SD	57765	SD
57430	SD	57544	SD	57648	SD	57766	SD
57434	SD	57547	SD	57649	SD	57767	SD

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
57769	SD	58041	ND	58231	ND	58329	ND
57770	SD	58043	ND	58233	ND	58330	ND
57772	SD	58045	ND	58236	ND	58331	ND
57773	SD	58046	ND	58237	ND	58332	ND
57774	SD	58048	ND	58238	ND	58335	ND
57775	SD	58049	ND	58239	ND	58337	ND
57776	SD	58053	ND	58240	ND	58338	ND
57777	SD	58054	ND	58241	ND	58339	ND
57779	SD	58056	ND	58243	ND	58341	ND
57780	SD	58057	ND	58249	ND	58343	ND
57782	SD	58058	ND	58250	ND	58344	ND
57783	SD	58060	ND	58251	ND	58345	ND
57785	SD	58061	ND	58254	ND	58346	ND
57787	SD	58062	ND	58255	ND	58348	ND
57788	SD	58063	ND	58257	ND	58351	ND
57790	SD	58064	ND	58258	ND	58352	ND
57791	SD	58065	ND	58259	ND	58353	ND
57792	SD	58067	ND	58260	ND	58355	ND
57793	SD	58068	ND	58261	ND	58356	ND
57794	SD	58069	ND	58262	ND	58357	ND
58001	ND	58071	ND	58265	ND	58359	ND
58002	ND	58072	ND	58266	ND	58361	ND
58004	ND	58074	ND	58267	ND	58362	ND
58005	ND	58075	ND	58269	ND	58363	ND
58006	ND	58076	ND	58270	ND	58365	ND
58007	ND	58077	ND	58271	ND	58366	ND
58008	ND	58079	ND	58272	ND	58367	ND
58009	ND	58081	ND	58273	ND	58368	ND
58011	ND	58204	ND	58274	ND	58369	ND
58012	ND	58205	ND	58276	ND	58370	ND
58013	ND	58207	ND	58277	ND	58372	ND
58015	ND	58210	ND	58281	ND	58374	ND
58016	ND	58212	ND	58282	ND	58377	ND
58017	ND	58213	ND	58301	ND	58379	ND
58018	ND	58214	ND	58310	ND	58380	ND
58027	ND	58216	ND	58311	ND	58381	ND
58029	ND	58218	ND	58313	ND	58382	ND
58030	ND	58219	ND	58316	ND	58384	ND
58031	ND	58220	ND	58317	ND	58385	ND
58032	ND	58222	ND	58318	ND	58386	ND
58033	ND	58223	ND	58319	ND	58413	ND
58035	ND	58224	ND	58321	ND	58415	ND
58036	ND	58225	ND	58323	ND	58416	ND
58038	ND	58227	ND	58324	ND	58418	ND
58039	ND	58229	ND	58325	ND	58421	ND
58040	ND	58230	ND	58327	ND	58422	ND

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
58423	ND	58523	ND	58640	ND	58778	ND
58425	ND	58524	ND	58642	ND	58782	ND
58428	ND	58528	ND	58643	ND	58783	ND
58429	ND	58529	ND	58644	ND	58784	ND
58430	ND	58530	ND	58645	ND	58787	ND
58431	ND	58531	ND	58646	ND	58788	ND
58433	ND	58533	ND	58647	ND	58789	ND
58436	ND	58535	ND	58650	ND	58790	ND
58438	ND	58538	ND	58651	ND	58792	ND
58439	ND	58540	ND	58653	ND	58793	ND
58440	ND	58541	ND	58654	ND	58794	ND
58441	ND	58542	ND	58710	ND	58831	ND
58442	ND	58544	ND	58711	ND	58833	ND
58443	ND	58545	ND	58712	ND	58835	ND
58444	ND	58549	ND	58713	ND	58838	ND
58445	ND	58552	ND	58716	ND	58844	ND
58448	ND	58554	ND	58721	ND	58847	ND
58451	ND	58559	ND	58723	ND	58854	ND
58452	ND	58561	ND	58727	ND	59001	MT
58454	ND	58562	ND	58730	ND	59003	MT
58456	ND	58563	ND	58731	ND	59004	MT
58458	ND	58564	ND	58736	ND	59007	MT
58460	ND	58565	ND	58737	ND	59008	MT
58461	ND	58566	ND	58740	ND	59010	MT
58463	ND	58568	ND	58741	ND	59011	MT
58464	ND	58569	ND	58744	ND	59012	MT
58466	ND	58570	ND	58747	ND	59013	MT
58474	ND	58571	ND	58748	ND	59014	MT
58475	ND	58573	ND	58750	ND	59016	MT
58477	ND	58575	ND	58752	ND	59018	MT
58478	ND	58576	ND	58757	ND	59019	MT
58479	ND	58577	ND	58758	ND	59020	MT
58480	ND	58579	ND	58759	ND	59022	MT
58481	ND	58580	ND	58760	ND	59025	MT
58482	ND	58581	ND	58761	ND	59026	MT
58484	ND	58620	ND	58762	ND	59027	MT
58486	ND	58621	ND	58763	ND	59028	MT
58487	ND	58623	ND	58765	ND	59029	MT
58488	ND	58625	ND	58768	ND	59030	MT
58489	ND	58626	ND	58769	ND	59031	MT
58490	ND	58627	ND	58770	ND	59032	MT
58492	ND	58631	ND	58771	ND	59033	MT
58494	ND	58632	ND	58772	ND	59034	MT
58495	ND	58634	ND	58773	ND	59035	MT
58520	ND	58636	ND	58775	ND	59036	MT
58521	ND	58638	ND	58776	ND	59038	MT

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
59039	MT	59221	MT	59348	MT	59482	MT
59041	MT	59222	MT	59349	MT	59484	MT
59043	MT	59226	MT	59353	MT	59486	MT
59046	MT	59242	MT	59354	MT	59489	MT
59047	MT	59243	MT	59411	MT	59501	MT
59050	MT	59245	MT	59416	MT	59520	MT
59052	MT	59247	MT	59417	MT	59521	MT
59053	MT	59252	MT	59418	MT	59523	MT
59054	MT	59253	MT	59419	MT	59524	MT
59055	MT	59254	MT	59420	MT	59525	MT
59058	MT	59255	MT	59422	MT	59526	MT
59059	MT	59256	MT	59424	MT	59527	MT
59061	MT	59257	MT	59425	MT	59528	MT
59062	MT	59258	MT	59427	MT	59529	MT
59063	MT	59259	MT	59430	MT	59530	MT
59065	MT	59261	MT	59432	MT	59532	MT
59066	MT	59262	MT	59433	MT	59535	MT
59067	MT	59263	MT	59434	MT	59537	MT
59068	MT	59270	MT	59435	MT	59538	MT
59069	MT	59274	MT	59436	MT	59540	MT
59070	MT	59275	MT	59440	MT	59542	MT
59071	MT	59276	MT	59441	MT	59544	MT
59072	MT	59311	MT	59442	MT	59546	MT
59073	MT	59312	MT	59444	MT	59547	MT
59074	MT	59313	MT	59445	MT	59631	MT
59075	MT	59314	MT	59446	MT	59632	MT
59076	MT	59315	MT	59447	MT	59634	MT
59077	MT	59316	MT	59448	MT	59638	MT
59078	MT	59317	MT	59450	MT	59641	MT
59081	MT	59318	MT	59451	MT	59642	MT
59082	MT	59319	SD	59452	MT	59643	MT
59083	MT	59322	MT	59453	MT	59644	MT
59084	MT	59323	MT	59454	MT	59645	MT
59085	MT	59324	MT	59456	MT	59647	MT
59086	MT	59326	MT	59457	MT	59710	MT
59087	MT	59327	MT	59460	MT	59713	MT
59089	MT	59330	MT	59462	MT	59720	MT
59201	MT	59332	MT	59464	MT	59721	MT
59211	MT	59333	MT	59466	MT	59722	MT
59212	MT	59337	MT	59467	MT	59724	MT
59213	MT	59339	MT	59468	MT	59725	MT
59214	MT	59341	MT	59469	MT	59728	MT
59215	MT	59343	MT	59471	MT	59729	MT
59217	MT	59344	MT	59473	MT	59731	MT
59218	MT	59345	MT	59474	MT	59732	MT
59219	MT	59347	MT	59479	MT	59733	MT

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
59735	MT	59871	MT	60928	IL	61049	IL
59736	MT	59872	MT	60929	IL	61051	IL
59739	MT	59873	MT	60930	IL	61052	IL
59740	MT	59874	MT	60931	IL	61053	IL
59745	MT	59875	MT	60933	IL	61054	IL
59746	MT	59910	MT	60934	IL	61059	IL
59747	MT	59914	MT	60936	IL	61061	IL
59749	MT	59915	MT	60938	IL	61064	IL
59751	MT	59917	MT	60939	IL	61065	IL
59754	MT	59918	MT	60945	IL	61068	IL
59755	MT	59923	MT	60946	IL	61071	IL
59759	MT	59929	MT	60948	IL	61074	IL
59761	MT	59930	MT	60951	IL	61075	IL
59762	MT	59931	MT	60952	IL	61078	IL
59820	MT	59933	MT	60953	IL	61081	IL
59821	MT	59934	MT	60954	IL	61084	IL
59824	MT	59935	MT	60955	IL	61085	IL
59827	MT	60113	IL	60956	IL	61087	IL
59828	MT	60416	IL	60957	IL	61091	IL
59829	MT	60420	IL	60959	IL	61230	IL
59830	MT	60447	IL	60962	IL	61231	IL
59831	MT	60460	IL	60966	IL	61233	IL
59832	MT	60470	IL	60967	IL	61234	IL
59833	MT	60512	IL	60968	IL	61235	IL
59835	MT	60518	IL	60970	IL	61238	IL
59837	MT	60531	IL	60973	IL	61241	IL
59840	MT	60536	IL	60974	IL	61243	IL
59841	MT	60537	IL	61001	IL	61250	IL
59842	MT	60538	IL	61007	IL	61251	IL
59843	MT	60541	IL	61008	IL	61252	IL
59844	MT	60543	IL	61010	IL	61254	IL
59845	MT	60545	IL	61011	IL	61258	IL
59848	MT	60549	IL	61012	IL	61260	IL
59853	MT	60551	IL	61014	IL	61261	IL
59854	MT	60557	IL	61015	IL	61262	IL
59855	MT	60560	IL	61020	IL	61263	IL
59856	MT	60911	IL	61025	IL	61270	IL
59858	MT	60912	IL	61028	IL	61272	IL
59859	MT	60918	IL	61030	IL	61273	IL
59860	MT	60919	IL	61036	IL	61274	IL
59863	MT	60920	IL	61037	IL	61276	IL
59864	MT	60921	IL	61038	IL	61277	IL
59865	MT	60922	IL	61041	IL	61281	IL
59866	MT	60924	IL	61043	IL	61283	IL
59867	MT	60926	IL	61046	IL	61285	IL
59870	MT	60927	IL	61047	IL	61301	IL

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
61311	IL	61371	IL	61478	IL	61727	IL
61312	IL	61372	IL	61479	IL	61729	IL
61313	IL	61373	IL	61480	IL	61733	IL
61314	IL	61374	IL	61482	IL	61734	IL
61315	IL	61375	IL	61483	IL	61735	IL
61316	IL	61376	IL	61484	IL	61738	IL
61317	IL	61377	IL	61486	IL	61739	IL
61319	IL	61379	IL	61490	IL	61740	IL
61320	IL	61412	IL	61491	IL	61741	IL
61321	IL	61413	IL	61501	IL	61742	IL
61322	IL	61415	IL	61516	IL	61743	IL
61323	IL	61417	IL	61519	IL	61747	IL
61325	IL	61418	IL	61520	IL	61749	IL
61326	IL	61419	IL	61524	IL	61750	IL
61327	IL	61421	IL	61530	IL	61751	IL
61328	IL	61423	IL	61531	IL	61755	IL
61329	IL	61424	IL	61532	IL	61759	IL
61330	IL	61425	IL	61534	IL	61760	IL
61332	IL	61426	IL	61535	IL	61764	IL
61333	IL	61427	IL	61537	IL	61769	IL
61334	IL	61431	IL	61540	IL	61771	IL
61335	IL	61432	IL	61541	IL	61773	IL
61336	IL	61433	IL	61542	IL	61775	IL
61337	IL	61434	IL	61543	IL	61777	IL
61338	IL	61435	IL	61544	IL	61778	IL
61340	IL	61437	IL	61545	IL	61813	IL
61341	IL	61441	IL	61546	IL	61818	IL
61342	IL	61442	IL	61548	IL	61830	IL
61344	IL	61443	IL	61550	IL	61839	IL
61345	IL	61447	IL	61553	IL	61842	IL
61346	IL	61449	IL	61554	IL	61854	IL
61348	IL	61450	IL	61555	IL	61855	IL
61349	IL	61452	IL	61558	IL	61856	IL
61350	IL	61453	IL	61560	IL	61866	IL
61354	IL	61454	IL	61561	IL	61882	IL
61356	IL	61459	IL	61563	IL	61884	IL
61358	IL	61460	IL	61564	IL	61910	IL
61359	IL	61462	IL	61565	IL	61911	IL
61360	IL	61465	IL	61567	IL	61913	IL
61361	IL	61466	IL	61568	IL	61914	IL
61362	IL	61468	IL	61570	IL	61917	IL
61363	IL	61469	IL	61571	IL	61919	IL
61364	IL	61471	IL	61610	IL	61924	IL
61368	IL	61473	IL	61611	IL	61925	IL
61369	IL	61476	IL	61721	IL	61928	IL
61370	IL	61477	IL	61723	IL	61929	IL

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
61930	IL	62065	IL	62261	IL	62355	IL
61932	IL	62069	IL	62262	IL	62356	IL
61933	IL	62070	IL	62263	IL	62357	IL
61936	IL	62075	IL	62265	IL	62358	IL
61937	IL	62076	IL	62266	IL	62361	IL
61940	IL	62077	IL	62268	IL	62362	IL
61941	IL	62078	IL	62271	IL	62363	IL
61942	IL	62079	IL	62272	IL	62366	IL
61944	IL	62080	IL	62273	IL	62367	IL
61949	IL	62081	IL	62274	IL	62370	IL
61951	IL	62082	IL	62275	IL	62373	IL
61953	IL	62083	IL	62277	IL	62375	IL
61955	IL	62085	IL	62278	IL	62378	IL
61956	IL	62086	IL	62279	IL	62379	IL
61957	IL	62088	IL	62280	IL	62380	IL
62006	IL	62089	IL	62283	IL	62410	IL
62009	IL	62091	IL	62284	IL	62413	IL
62011	IL	62092	IL	62286	IL	62415	IL
62012	IL	62093	IL	62288	IL	62417	IL
62013	IL	62094	IL	62292	IL	62418	IL
62014	IL	62098	IL	62293	IL	62420	IL
62015	IL	62214	IL	62295	IL	62422	IL
62016	IL	62215	IL	62297	IL	62423	IL
62017	IL	62216	IL	62298	IL	62427	IL
62019	IL	62217	IL	62310	IL	62428	IL
62022	IL	62218	IL	62311	IL	62431	IL
62023	IL	62219	IL	62312	IL	62432	IL
62027	IL	62230	IL	62313	IL	62433	IL
62028	IL	62231	IL	62314	IL	62434	IL
62030	IL	62233	IL	62316	IL	62435	IL
62031	IL	62236	IL	62318	IL	62436	IL
62032	IL	62237	IL	62319	IL	62438	IL
62033	IL	62238	IL	62321	IL	62439	IL
62036	IL	62241	IL	62323	IL	62441	IL
62037	IL	62242	IL	62329	IL	62442	IL
62044	IL	62244	IL	62330	IL	62444	IL
62045	IL	62245	IL	62334	IL	62446	IL
62047	IL	62246	IL	62336	IL	62447	IL
62049	IL	62247	IL	62340	IL	62448	IL
62050	IL	62248	IL	62341	IL	62449	IL
62051	IL	62249	IL	62343	IL	62451	IL
62052	IL	62250	IL	62344	IL	62454	IL
62053	IL	62252	IL	62345	IL	62458	IL
62054	IL	62253	IL	62352	IL	62459	IL
62056	IL	62256	IL	62353	IL	62460	IL
62063	IL	62259	IL	62354	IL	62462	IL

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
62463	IL	62617	IL	62815	IL	62877	IL
62464	IL	62618	IL	62817	IL	62878	IL
62465	IL	62621	IL	62818	IL	62879	IL
62466	IL	62622	IL	62819	IL	62880	IL
62468	IL	62624	IL	62820	IL	62884	IL
62471	IL	62626	IL	62821	IL	62885	IL
62474	IL	62627	IL	62822	IL	62886	IL
62475	IL	62630	IL	62823	IL	62887	IL
62476	IL	62633	IL	62824	IL	62888	IL
62477	IL	62634	IL	62825	IL	62890	IL
62478	IL	62635	IL	62827	IL	62891	IL
62479	IL	62639	IL	62828	IL	62895	IL
62480	IL	62640	IL	62829	IL	62896	IL
62481	IL	62642	IL	62831	IL	62897	IL
62510	IL	62643	IL	62832	IL	62899	IL
62511	IL	62644	IL	62833	IL	62905	IL
62512	IL	62649	IL	62834	IL	62906	IL
62517	IL	62655	IL	62835	IL	62908	IL
62518	IL	62656	IL	62836	IL	62909	IL
62519	IL	62659	IL	62837	IL	62910	IL
62531	IL	62662	IL	62838	IL	62912	IL
62533	IL	62663	IL	62839	IL	62913	IL
62534	IL	62664	IL	62840	IL	62914	IL
62538	IL	62666	IL	62842	IL	62917	IL
62540	IL	62667	IL	62843	IL	62919	IL
62541	IL	62671	IL	62844	IL	62920	IL
62543	IL	62672	IL	62847	IL	62923	IL
62546	IL	62673	IL	62848	IL	62926	IL
62547	IL	62674	IL	62850	IL	62928	IL
62548	IL	62675	IL	62851	IL	62930	IL
62550	IL	62681	IL	62852	IL	62931	IL
62553	IL	62682	IL	62855	IL	62934	IL
62555	IL	62683	IL	62856	IL	62935	IL
62556	IL	62685	IL	62857	IL	62938	IL
62557	IL	62686	IL	62858	IL	62939	IL
62560	IL	62688	IL	62859	IL	62941	IL
62565	IL	62690	IL	62860	IL	62943	IL
62567	IL	62691	IL	62861	IL	62944	IL
62568	IL	62694	IL	62862	IL	62946	IL
62570	IL	62803	IL	62863	IL	62947	IL
62571	IL	62805	IL	62865	IL	62952	IL
62572	IL	62806	IL	62867	IL	62953	IL
62610	IL	62808	IL	62869	IL	62954	IL
62611	IL	62809	IL	62871	IL	62955	IL
62612	IL	62811	IL	62874	IL	62956	IL
62613	IL	62812	IL	62876	IL	62957	IL

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
62960	IL	63052	MO	63431	MO	63543	MO
62961	IL	63053	MO	63432	MO	63544	MO
62962	IL	63056	MO	63433	MO	63545	MO
62963	IL	63057	MO	63434	MO	63547	MO
62964	IL	63060	MO	63435	MO	63548	MO
62965	IL	63061	MO	63436	MO	63549	MO
62967	IL	63065	MO	63437	MO	63551	MO
62969	IL	63066	MO	63438	MO	63552	MO
62970	IL	63069	MO	63439	MO	63555	MO
62972	IL	63070	MO	63440	MO	63556	MO
62973	IL	63071	MO	63441	MO	63557	MO
62976	IL	63072	MO	63442	MO	63558	MO
62977	IL	63079	MO	63443	MO	63560	MO
62979	IL	63087	MO	63445	MO	63561	MO
62982	IL	63091	MO	63446	MO	63563	MO
62983	IL	63330	MO	63447	MO	63565	MO
62984	IL	63333	MO	63448	MO	63566	MO
62985	IL	63334	MO	63450	MO	63567	MO
62987	IL	63336	MO	63451	MO	63601	MO
62988	IL	63339	MO	63452	MO	63620	MO
62990	IL	63342	MO	63453	MO	63621	MO
62991	IL	63343	MO	63456	MO	63622	MO
62992	IL	63344	MO	63457	MO	63623	MO
62993	IL	63347	MO	63458	MO	63624	MO
62995	IL	63349	MO	63459	MO	63625	MO
62996	IL	63350	MO	63460	MO	63626	MO
62997	IL	63351	MO	63462	MO	63627	MO
62998	IL	63353	MO	63464	MO	63628	MO
62999	IL	63357	MO	63465	MO	63629	MO
63010	MO	63359	MO	63466	MO	63630	MO
63012	MO	63361	MO	63467	MO	63631	MO
63015	MO	63362	MO	63468	MO	63632	MO
63016	MO	63363	MO	63469	MO	63633	MO
63019	MO	63369	MO	63472	MO	63636	MO
63020	MO	63370	MO	63473	MO	63637	MO
63023	MO	63377	MO	63474	MO	63638	MO
63028	MO	63378	MO	63530	MO	63640	MO
63030	MO	63379	MO	63531	MO	63645	MO
63036	MO	63381	MO	63532	MO	63646	MO
63037	MO	63383	MO	63534	MO	63648	MO
63041	MO	63384	MO	63535	MO	63650	MO
63047	MO	63387	MO	63536	MO	63651	MO
63048	MO	63388	MO	63537	MO	63653	MO
63049	MO	63389	MO	63538	MO	63654	MO
63050	MO	63390	MO	63539	MO	63655	MO
63051	MO	63430	MO	63541	MO	63656	MO

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
63660	MO	63841	MO	63953	MO	64430	MO
63661	MO	63845	MO	63955	MO	64431	MO
63662	MO	63846	MO	63956	MO	64432	MO
63663	MO	63847	MO	63957	MO	64433	MO
63664	MO	63848	MO	63960	MO	64434	MO
63665	MO	63849	MO	63963	MO	64436	MO
63666	MO	63850	MO	63964	MO	64437	MO
63670	MO	63851	MO	63965	MO	64438	MO
63673	MO	63852	MO	63966	MO	64441	MO
63674	MO	63853	MO	63967	MO	64442	MO
63675	MO	63855	MO	64001	MO	64445	MO
63730	MO	63857	MO	64011	MO	64446	MO
63735	MO	63860	MO	64012	MO	64447	MO
63737	MO	63862	MO	64017	MO	64449	MO
63738	MO	63863	MO	64020	MO	64451	MO
63746	MO	63866	MO	64021	MO	64453	MO
63748	MO	63867	MO	64022	MO	64454	MO
63750	MO	63868	MO	64035	MO	64455	MO
63751	MO	63869	MO	64036	MO	64456	MO
63753	MO	63870	MO	64037	MO	64457	MO
63760	MO	63871	MO	64062	MO	64458	MO
63763	MO	63873	MO	64067	MO	64459	MO
63764	MO	63874	MO	64071	MO	64461	MO
63772	MO	63875	MO	64074	MO	64463	MO
63775	MO	63876	MO	64076	MO	64465	MO
63776	MO	63877	MO	64077	MO	64466	MO
63781	MO	63878	MO	64078	MO	64467	MO
63782	MO	63879	MO	64079	MO	64468	MO
63783	MO	63880	MO	64080	MO	64469	MO
63787	MO	63881	MO	64083	MO	64470	MO
63820	MO	63882	MO	64084	MO	64471	MO
63821	MO	63931	MO	64085	MO	64473	MO
63822	MO	63933	MO	64090	MO	64474	MO
63823	MO	63934	MO	64096	MO	64475	MO
63825	MO	63935	MO	64097	MO	64476	MO
63826	MO	63936	MO	64098	MO	64477	MO
63827	MO	63937	MO	64402	MO	64478	MO
63828	MO	63939	MO	64420	MO	64479	MO
63829	MO	63941	MO	64421	MO	64480	MO
63830	MO	63942	MO	64422	MO	64481	MO
63833	MO	63943	MO	64423	MO	64482	MO
63834	MO	63944	MO	64424	MO	64483	MO
63837	MO	63947	MO	64426	MO	64485	MO
63838	MO	63950	MO	64427	MO	64486	MO
63839	MO	63951	MO	64428	MO	64487	MO
63840	MO	63952	MO	64429	MO	64489	MO

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
64490	MO	64661	MO	64770	MO	65034	MO
64491	MO	64664	MO	64776	MO	65035	MO
64492	MO	64667	MO	64777	MO	65036	MO
64493	MO	64668	MO	64779	MO	65037	MO
64494	MO	64670	MO	64780	MO	65038	MO
64496	MO	64671	MO	64781	MO	65041	MO
64497	MO	64672	MO	64788	MO	65042	MO
64498	MO	64673	MO	64789	MO	65043	MO
64499	MO	64674	MO	64831	MO	65046	MO
64601	MO	64676	MO	64832	MO	65047	MO
64620	MO	64679	MO	64833	MO	65048	MO
64622	MO	64680	MO	64836	MO	65050	MO
64623	MO	64681	MO	64840	MO	65051	MO
64624	MO	64682	MO	64842	MO	65054	MO
64625	MO	64683	MO	64843	MO	65055	MO
64628	MO	64686	MO	64844	MO	65058	MO
64630	MO	64687	MO	64847	MO	65059	MO
64631	MO	64688	MO	64848	MO	65061	MO
64632	MO	64689	MO	64850	MO	65062	MO
64633	MO	64701	MO	64853	MO	65063	MO
64635	MO	64720	MO	64854	MO	65064	MO
64636	MO	64722	MO	64856	MO	65066	MO
64637	MO	64723	MO	64858	MO	65067	MO
64638	MO	64724	MO	64859	MO	65068	MO
64639	MO	64725	MO	64861	MO	65069	MO
64640	MO	64726	MO	64862	MO	65072	MO
64641	MO	64730	MO	64863	MO	65075	MO
64642	MO	64734	MO	64864	MO	65077	MO
64643	MO	64735	MO	64865	MO	65078	MO
64644	MO	64738	MO	64866	MO	65080	MO
64645	MO	64739	MO	64867	MO	65081	MO
64646	MO	64740	MO	64868	MO	65082	MO
64647	MO	64742	MO	64873	MO	65083	MO
64648	MO	64743	MO	64874	MO	65084	MO
64649	MO	64744	MO	65001	MO	65085	MO
64650	MO	64745	MO	65011	MO	65230	MO
64651	MO	64746	MO	65013	MO	65231	MO
64652	MO	64747	MO	65014	MO	65233	MO
64653	MO	64748	MO	65016	MO	65236	MO
64654	MO	64752	MO	65017	MO	65237	MO
64655	MO	64756	MO	65018	MO	65239	MO
64656	MO	64759	MO	65022	MO	65240	MO
64657	MO	64762	MO	65024	MO	65243	MO
64658	MO	64763	MO	65025	MO	65244	MO
64659	MO	64766	MO	65026	MO	65246	MO
64660	MO	64769	MO	65031	MO	65247	MO

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
65248	MO	65441	MO	65584	MO	65659	MO
65250	MO	65443	MO	65586	MO	65660	MO
65251	MO	65444	MO	65588	MO	65661	MO
65254	MO	65446	MO	65589	MO	65662	MO
65257	MO	65449	MO	65590	MO	65663	MO
65258	MO	65452	MO	65601	MO	65664	MO
65259	MO	65453	MO	65603	MO	65666	MO
65260	MO	65456	MO	65605	MO	65667	MO
65261	MO	65457	MO	65606	MO	65668	MO
65262	MO	65459	MO	65608	MO	65669	MO
65263	MO	65463	MO	65609	MO	65674	MO
65270	MO	65464	MO	65610	MO	65675	MO
65274	MO	65466	MO	65611	MO	65676	MO
65275	MO	65468	MO	65613	MO	65681	MO
65276	MO	65470	MO	65617	MO	65682	MO
65278	MO	65473	MO	65618	MO	65685	MO
65281	MO	65479	MO	65620	MO	65686	MO
65282	MO	65483	MO	65622	MO	65688	MO
65283	MO	65484	MO	65623	MO	65689	MO
65286	MO	65486	MO	65624	MO	65690	MO
65287	MO	65501	MO	65625	MO	65692	MO
65320	MO	65532	MO	65626	MO	65701	MO
65321	MO	65534	MO	65629	MO	65702	MO
65322	MO	65535	MO	65630	MO	65704	MO
65323	MO	65536	MO	65631	MO	65705	MO
65325	MO	65540	MO	65632	MO	65706	MO
65326	MO	65541	MO	65633	MO	65707	MO
65327	MO	65542	MO	65634	MO	65708	MO
65329	MO	65543	MO	65635	MO	65710	MO
65330	MO	65546	MO	65636	MO	65711	MO
65335	MO	65548	MO	65637	MO	65712	MO
65338	MO	65552	MO	65638	MO	65714	MO
65339	MO	65555	MO	65640	MO	65715	MO
65340	MO	65556	MO	65641	MO	65717	MO
65344	MO	65557	MO	65644	MO	65720	MO
65347	MO	65560	MO	65645	MO	65721	MO
65348	MO	65564	MO	65646	MO	65722	MO
65349	MO	65565	MO	65647	MO	65723	MO
65351	MO	65566	MO	65649	MO	65724	MO
65354	MO	65567	MO	65650	MO	65725	MO
65355	MO	65570	MO	65652	MO	65727	MO
65360	MO	65571	MO	65654	MO	65728	MO
65433	MO	65572	MO	65655	MO	65729	MO
65438	MO	65580	MO	65656	MO	65730	MO
65439	MO	65582	MO	65657	MO	65732	MO
65440	MO	65583	MO	65658	MO	65734	MO

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
65735	MO	66026	KS	66413	KS	66538	KS
65737	MO	66032	KS	66414	KS	66540	KS
65741	MO	66033	KS	66415	KS	66541	KS
65745	MO	66035	KS	66416	KS	66543	KS
65746	MO	66036	KS	66417	KS	66544	KS
65747	MO	66039	KS	66418	KS	66547	KS
65752	MO	66040	KS	66419	KS	66548	KS
65753	MO	66041	KS	66422	KS	66549	KS
65754	MO	66042	KS	66423	KS	66550	KS
65755	MO	66052	KS	66424	KS	66551	KS
65756	MO	66053	KS	66425	KS	66552	KS
65760	MO	66054	KS	66426	KS	66555	KS
65761	MO	66056	KS	66427	KS	66701	KS
65762	MO	66058	KS	66428	KS	66710	KS
65764	MO	66060	KS	66429	KS	66711	KS
65766	MO	66064	KS	66431	KS	66712	KS
65767	MO	66066	KS	66432	KS	66713	KS
65768	MO	66067	KS	66434	KS	66714	KS
65769	MO	66070	KS	66436	KS	66716	KS
65772	MO	66071	KS	66438	KS	66717	KS
65773	MO	66072	KS	66439	KS	66720	KS
65774	MO	66073	KS	66440	KS	66724	KS
65775	MO	66075	KS	66450	KS	66725	KS
65776	MO	66076	KS	66451	KS	66727	KS
65777	MO	66077	KS	66501	KS	66728	KS
65778	MO	66078	KS	66507	KS	66732	KS
65779	MO	66079	KS	66508	KS	66733	KS
65783	MO	66080	KS	66509	KS	66734	KS
65784	MO	66086	KS	66510	KS	66735	KS
65785	MO	66087	KS	66512	KS	66736	KS
65788	MO	66088	KS	66515	KS	66738	KS
65789	MO	66090	KS	66516	KS	66739	KS
65790	MO	66091	KS	66518	KS	66740	KS
65791	MO	66092	KS	66520	KS	66741	KS
65793	MO	66093	KS	66521	KS	66742	KS
66002	KS	66094	KS	66522	KS	66743	KS
66007	KS	66095	KS	66523	KS	66746	KS
66008	KS	66097	KS	66524	KS	66748	KS
66010	KS	66401	KS	66526	KS	66749	KS
66013	KS	66403	KS	66527	KS	66751	KS
66014	KS	66404	KS	66528	KS	66753	KS
66015	KS	66406	KS	66532	KS	66754	KS
66016	KS	66407	KS	66534	KS	66755	KS
66017	KS	66408	KS	66535	KS	66756	KS
66023	KS	66411	KS	66536	KS	66757	KS
66024	KS	66412	KS	66537	KS	66758	KS

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
66759	KS	66872	KS	67018	KS	67131	KS
66760	KS	66873	KS	67019	KS	67132	KS
66761	KS	66901	KS	67022	KS	67133	KS
66762	KS	66930	KS	67023	KS	67137	KS
66763	KS	66932	KS	67024	KS	67138	KS
66767	KS	66933	KS	67029	KS	67140	KS
66769	KS	66935	KS	67031	KS	67142	KS
66770	KS	66936	KS	67035	KS	67143	KS
66771	KS	66937	KS	67036	KS	67144	KS
66772	KS	66938	KS	67038	KS	67146	KS
66773	KS	66939	KS	67039	KS	67150	KS
66775	KS	66940	KS	67041	KS	67152	KS
66776	KS	66941	KS	67042	KS	67154	KS
66777	KS	66942	KS	67045	KS	67155	KS
66778	KS	66943	KS	67047	KS	67156	KS
66779	KS	66944	KS	67049	KS	67159	KS
66780	KS	66945	KS	67051	KS	67301	KS
66781	KS	66946	KS	67053	KS	67333	KS
66782	KS	66948	KS	67054	KS	67334	KS
66783	KS	66949	KS	67057	KS	67335	KS
66834	KS	66951	KS	67058	KS	67337	KS
66838	KS	66952	KS	67059	KS	67340	KS
66839	KS	66953	KS	67061	KS	67344	KS
66840	KS	66955	KS	67063	KS	67345	KS
66842	KS	66956	KS	67065	KS	67346	KS
66843	KS	66958	KS	67068	KS	67347	KS
66845	KS	66959	KS	67070	KS	67349	KS
66846	KS	66960	KS	67071	KS	67351	KS
66849	KS	66961	KS	67072	KS	67352	KS
66850	KS	66962	KS	67073	KS	67353	KS
66851	KS	66963	KS	67074	KS	67355	KS
66852	KS	66964	KS	67102	KS	67360	KS
66853	KS	66966	KS	67103	KS	67361	KS
66855	KS	66967	KS	67104	KS	67363	KS
66856	KS	66968	KS	67105	KS	67364	KS
66857	KS	66970	KS	67106	KS	67410	KS
66858	KS	67002	KS	67107	KS	67417	KS
66859	KS	67003	KS	67109	KS	67418	KS
66860	KS	67004	KS	67111	KS	67420	KS
66861	KS	67005	KS	67112	KS	67422	KS
66862	KS	67008	KS	67118	KS	67423	KS
66863	KS	67009	KS	67119	KS	67427	KS
66866	KS	67010	KS	67120	KS	67428	KS
66869	KS	67012	KS	67122	KS	67430	KS
66870	KS	67013	KS	67123	KS	67431	KS
66871	KS	67017	KS	67127	KS	67432	KS

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
67436	KS	67520	KS	67651	KS	67837	KS
67437	KS	67521	KS	67653	KS	67838	KS
67438	KS	67524	KS	67654	KS	67839	KS
67439	KS	67545	KS	67656	KS	67840	KS
67441	KS	67546	KS	67657	KS	67841	KS
67443	KS	67547	KS	67658	KS	67844	KS
67444	KS	67548	KS	67659	KS	67849	KS
67445	KS	67552	KS	67661	KS	67850	KS
67446	KS	67553	KS	67663	KS	67853	KS
67447	KS	67554	KS	67664	KS	67854	KS
67449	KS	67556	KS	67665	KS	67855	KS
67450	KS	67557	KS	67669	KS	67857	KS
67451	KS	67559	KS	67672	KS	67860	KS
67452	KS	67560	KS	67673	KS	67861	KS
67454	KS	67563	KS	67675	KS	67862	KS
67455	KS	67565	KS	67701	KS	67863	KS
67456	KS	67572	KS	67730	KS	67864	KS
67457	KS	67573	KS	67731	KS	67865	KS
67458	KS	67575	KS	67732	KS	67867	KS
67459	KS	67576	KS	67733	KS	67869	KS
67460	KS	67578	KS	67734	KS	67870	KS
67464	KS	67579	KS	67735	KS	67871	KS
67466	KS	67584	KS	67736	KS	67877	KS
67467	KS	67621	KS	67737	KS	67878	KS
67468	KS	67622	KS	67738	KS	67879	KS
67473	KS	67623	KS	67739	KS	67880	KS
67474	KS	67625	KS	67740	KS	67951	KS
67475	KS	67626	KS	67741	KS	67952	KS
67476	KS	67628	KS	67743	KS	68001	NE
67478	KS	67629	KS	67744	KS	68002	NE
67480	KS	67631	KS	67745	KS	68003	NE
67481	KS	67632	KS	67747	KS	68004	NE
67482	KS	67634	KS	67748	KS	68008	NE
67483	KS	67635	KS	67749	KS	68009	NE
67484	KS	67638	KS	67751	KS	68014	NE
67485	KS	67639	KS	67752	KS	68015	NE
67487	KS	67640	KS	67753	KS	68016	NE
67490	KS	67642	KS	67756	KS	68017	NE
67491	KS	67643	KS	67757	KS	68018	NE
67492	KS	67644	KS	67758	KS	68019	NE
67512	KS	67645	KS	67761	KS	68020	NE
67513	KS	67646	KS	67762	KS	68023	NE
67515	KS	67647	KS	67764	KS	68029	NE
67516	KS	67648	KS	67831	KS	68030	NE
67518	KS	67649	KS	67835	KS	68033	NE
67519	KS	67650	KS	67836	KS	68034	NE

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
68036	NE	68331	NE	68410	NE	68623	NE
68037	NE	68332	NE	68413	NE	68624	NE
68038	NE	68333	NE	68414	NE	68626	NE
68039	NE	68335	NE	68415	NE	68627	NE
68040	NE	68337	NE	68416	NE	68628	NE
68041	NE	68338	NE	68417	NE	68629	NE
68042	NE	68340	NE	68418	NE	68631	NE
68045	NE	68341	NE	68420	NE	68632	NE
68047	NE	68342	NE	68421	NE	68634	NE
68048	NE	68343	NE	68422	NE	68635	NE
68050	NE	68344	NE	68423	NE	68636	NE
68055	NE	68345	NE	68424	NE	68637	NE
68058	NE	68346	NE	68429	NE	68638	NE
68061	NE	68347	NE	68431	NE	68640	NE
68062	NE	68348	NE	68433	NE	68641	NE
68065	NE	68349	NE	68434	NE	68642	NE
68066	NE	68350	NE	68436	NE	68643	NE
68067	NE	68351	NE	68437	NE	68644	NE
68068	NE	68352	NE	68439	NE	68647	NE
68070	NE	68354	NE	68440	NE	68648	NE
68071	NE	68355	NE	68441	NE	68651	NE
68073	NE	68357	NE	68442	NE	68652	NE
68301	NE	68359	NE	68443	NE	68653	NE
68303	NE	68360	NE	68444	NE	68654	NE
68304	NE	68361	NE	68445	NE	68655	NE
68305	NE	68362	NE	68446	NE	68658	NE
68307	NE	68364	NE	68447	NE	68659	NE
68309	NE	68365	NE	68448	NE	68660	NE
68310	NE	68366	NE	68450	NE	68661	NE
68313	NE	68367	NE	68452	NE	68662	NE
68314	NE	68370	NE	68453	NE	68663	NE
68315	NE	68371	NE	68454	NE	68665	NE
68316	NE	68374	NE	68455	NE	68666	NE
68318	NE	68375	NE	68456	NE	68667	NE
68319	NE	68376	NE	68457	NE	68669	NE
68320	NE	68377	NE	68458	NE	68710	NE
68321	NE	68378	NE	68460	NE	68711	NE
68322	NE	68380	NE	68463	NE	68713	NE
68323	NE	68381	NE	68464	NE	68714	NE
68324	NE	68382	NE	68465	NE	68716	NE
68325	NE	68401	NE	68466	NE	68717	NE
68326	NE	68403	NE	68467	NE	68718	NE
68327	NE	68405	NE	68601	NE	68719	NE
68328	NE	68406	NE	68602	NE	68720	NE
68329	NE	68407	NE	68620	NE	68722	NE
68330	NE	68409	NE	68622	NE	68723	NE

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
68724	NE	68778	NE	68860	NE	68959	NE
68725	NE	68779	NE	68862	NE	68960	NE
68726	NE	68780	NE	68863	NE	68961	NE
68727	NE	68783	NE	68864	NE	68963	NE
68728	NE	68784	NE	68865	NE	68964	NE
68729	NE	68785	NE	68871	NE	68966	NE
68730	NE	68786	NE	68872	NE	68967	NE
68731	NE	68787	NE	68873	NE	68969	NE
68732	NE	68788	NE	68874	NE	68970	NE
68733	NE	68789	NE	68875	NE	68971	NE
68734	NE	68790	NE	68878	NE	68972	NE
68735	NE	68791	NE	68879	NE	68974	NE
68736	NE	68792	NE	68880	NE	68975	NE
68737	NE	68813	NE	68881	NE	68976	NE
68738	NE	68814	NE	68882	NE	68977	NE
68739	NE	68815	NE	68920	NE	68978	NE
68740	NE	68816	NE	68922	NE	68979	NE
68741	NE	68817	NE	68923	NE	68980	NE
68742	NE	68818	NE	68924	NE	68981	NE
68743	NE	68819	NE	68926	NE	68982	NE
68745	NE	68820	NE	68927	NE	69001	NE
68746	NE	68821	NE	68928	NE	69020	NE
68747	NE	68822	NE	68929	NE	69022	NE
68749	NE	68823	NE	68930	NE	69023	NE
68751	NE	68825	NE	68932	NE	69024	NE
68753	NE	68826	NE	68933	NE	69025	NE
68755	NE	68827	NE	68934	NE	69026	NE
68756	NE	68828	NE	68935	NE	69027	NE
68757	NE	68831	NE	68936	NE	69028	NE
68759	NE	68833	NE	68937	NE	69029	NE
68760	NE	68834	NE	68938	NE	69031	NE
68761	NE	68835	NE	68939	NE	69032	NE
68763	NE	68837	NE	68940	NE	69033	NE
68764	NE	68838	NE	68941	NE	69034	NE
68765	NE	68841	NE	68942	NE	69036	NE
68766	NE	68842	NE	68943	NE	69038	NE
68767	NE	68843	NE	68944	NE	69039	NE
68768	NE	68844	NE	68945	NE	69040	NE
68769	NE	68846	NE	68946	NE	69042	NE
68770	NE	68850	NE	68947	NE	69043	NE
68771	NE	68852	NE	68948	NE	69044	NE
68772	NE	68853	NE	68949	NE	69045	NE
68773	NE	68854	NE	68952	NE	69046	NE
68774	NE	68855	NE	68954	NE	69120	NE
68776	NE	68856	NE	68957	NE	69121	NE
68777	NE	68859	NE	68958	NE	69122	NE

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
69125	NE	69301	NE	70086	LA	70538	LA
69127	NE	69331	NE	70087	LA	70540	LA
69128	NE	69333	NE	70090	LA	70542	LA
69129	NE	69334	NE	70091	LA	70543	LA
69130	NE	69335	NE	70339	LA	70546	LA
69131	NE	69336	NE	70340	LA	70548	LA
69133	NE	69337	NE	70341	LA	70549	LA
69134	NE	69339	NE	70342	LA	70554	LA
69135	NE	69340	NE	70372	LA	70555	LA
69138	NE	69343	NE	70380	LA	70556	LA
69140	NE	69345	NE	70381	LA	70559	LA
69141	NE	69346	NE	70390	LA	70575	LA
69142	NE	69347	NE	70391	LA	70576	LA
69144	NE	69348	NE	70392	LA	70578	LA
69145	NE	69350	NE	70393	LA	70580	LA
69146	NE	69351	NE	70426	LA	70581	LA
69147	NE	69354	NE	70427	LA	70582	LA
69148	NE	69360	NE	70429	LA	70584	LA
69149	NE	69365	NE	70438	LA	70585	LA
69150	NE	69366	NE	70441	LA	70586	LA
69152	NE	69367	NE	70449	LA	70591	LA
69153	NE	70030	LA	70450	LA	70631	LA
69154	NE	70031	LA	70453	LA	70632	LA
69155	NE	70037	LA	70462	LA	70634	LA
69156	NE	70038	LA	70467	LA	70637	LA
69157	NE	70039	LA	70510	LA	70638	LA
69160	NE	70040	LA	70511	LA	70640	LA
69161	NE	70041	LA	70512	LA	70643	LA
69162	NE	70042	LA	70514	LA	70644	LA
69163	NE	70046	LA	70515	LA	70645	LA
69166	NE	70047	LA	70516	LA	70648	LA
69167	NE	70050	LA	70517	LA	70650	LA
69168	NE	70051	LA	70519	LA	70651	LA
69171	NE	70052	LA	70521	LA	70652	LA
69190	NE	70057	LA	70522	LA	70653	LA
69201	NE	70066	LA	70523	LA	70654	LA
69210	NE	70070	LA	70524	LA	70655	LA
69211	NE	70071	LA	70525	LA	70657	LA
69212	NE	70076	LA	70526	LA	70658	LA
69214	NE	70078	LA	70527	LA	70660	LA
69216	NE	70079	LA	70528	LA	70662	LA
69217	NE	70080	LA	70531	LA	70706	LA
69218	NE	70081	LA	70532	LA	70710	LA
69219	NE	70082	LA	70533	LA	70711	LA
69220	NE	70083	LA	70534	LA	70712	LA
69221	NE	70084	LA	70537	LA	70715	LA

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
70716	LA	70785	LA	71082	LA	71329	LA
70717	LA	70786	LA	71218	LA	71330	LA
70719	LA	70787	LA	71219	LA	71331	LA
70720	LA	70788	LA	71220	LA	71333	LA
70721	LA	70789	LA	71221	LA	71334	LA
70722	LA	71001	LA	71222	LA	71336	LA
70723	LA	71002	LA	71223	LA	71339	LA
70726	LA	71003	LA	71226	LA	71340	LA
70727	LA	71008	LA	71229	LA	71341	LA
70728	LA	71016	LA	71230	LA	71342	LA
70729	LA	71018	LA	71232	LA	71343	LA
70730	LA	71019	LA	71233	LA	71350	LA
70732	LA	71021	LA	71234	LA	71351	LA
70733	LA	71023	LA	71237	LA	71354	LA
70736	LA	71024	LA	71241	LA	71355	LA
70740	LA	71025	LA	71242	LA	71357	LA
70743	LA	71027	LA	71243	LA	71362	LA
70744	LA	71028	LA	71247	LA	71363	LA
70747	LA	71030	LA	71249	LA	71366	LA
70748	LA	71031	LA	71250	LA	71367	LA
70749	LA	71032	LA	71251	LA	71368	LA
70752	LA	71034	LA	71253	LA	71369	LA
70753	LA	71036	LA	71254	LA	71371	LA
70754	LA	71038	LA	71256	LA	71373	LA
70755	LA	71039	LA	71259	LA	71375	LA
70756	LA	71040	LA	71260	LA	71377	LA
70757	LA	71045	LA	71261	LA	71378	LA
70759	LA	71046	LA	71263	LA	71401	LA
70760	LA	71048	LA	71264	LA	71404	LA
70761	LA	71049	LA	71266	LA	71406	LA
70762	LA	71050	LA	71268	LA	71407	LA
70763	LA	71052	LA	71269	LA	71410	LA
70764	LA	71055	LA	71276	LA	71411	LA
70765	LA	71058	LA	71277	LA	71414	LA
70767	LA	71063	LA	71279	LA	71415	LA
70769	LA	71065	LA	71282	LA	71416	LA
70772	LA	71066	LA	71284	LA	71417	LA
70773	LA	71068	LA	71286	LA	71418	LA
70775	LA	71070	LA	71295	LA	71419	LA
70776	LA	71071	LA	71316	LA	71422	LA
70777	LA	71072	LA	71320	LA	71423	LA
70780	LA	71073	LA	71322	LA	71425	LA
70781	LA	71075	LA	71323	LA	71426	LA
70782	LA	71078	LA	71324	LA	71428	LA
70783	LA	71079	LA	71326	LA	71429	LA
70784	LA	71080	LA	71327	LA	71432	LA

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71434	LA	71661	AR	71832	AR	71953	AR
71435	LA	71662	AR	71833	AR	71957	AR
71440	LA	71663	AR	71834	AR	71958	AR
71441	LA	71665	AR	71835	AR	71959	AR
71449	LA	71666	AR	71836	AR	71960	AR
71450	LA	71667	AR	71837	AR	71961	AR
71452	LA	71670	AR	71838	AR	71962	AR
71454	LA	71671	AR	71839	AR	71965	AR
71456	LA	71674	AR	71840	AR	71966	AR
71457	LA	71675	AR	71841	AR	71969	AR
71458	LA	71676	AR	71842	AR	71970	AR
71460	LA	71677	AR	71844	AR	71971	AR
71462	LA	71678	AR	71845	AR	71972	AR
71463	LA	71701	AR	71846	AR	71973	AR
71465	LA	71711	AR	71847	AR	71998	AR
71467	LA	71720	AR	71851	AR	72001	AR
71468	LA	71721	AR	71852	AR	72002	AR
71469	LA	71722	AR	71853	AR	72003	AR
71471	LA	71725	AR	71854	AR	72006	AR
71473	LA	71726	AR	71855	AR	72007	AR
71479	LA	71728	AR	71857	AR	72011	AR
71480	LA	71740	AR	71858	AR	72013	AR
71483	LA	71742	AR	71859	AR	72015	AR
71486	LA	71743	AR	71860	AR	72016	AR
71497	LA	71744	AR	71861	AR	72017	AR
71630	AR	71745	AR	71862	AR	72018	AR
71631	AR	71748	AR	71864	AR	72021	AR
71635	AR	71751	AR	71865	AR	72022	AR
71638	AR	71752	AR	71866	AR	72023	AR
71639	AR	71753	AR	71920	AR	72024	AR
71640	AR	71754	AR	71921	AR	72025	AR
71642	AR	71763	AR	71922	AR	72026	AR
71643	AR	71764	AR	71923	AR	72027	AR
71644	AR	71766	AR	71929	AR	72028	AR
71646	AR	71770	AR	71932	AR	72029	AR
71647	AR	71772	AR	71933	AR	72030	AR
71651	AR	71801	AR	71935	AR	72031	AR
71652	AR	71802	AR	71937	AR	72036	AR
71653	AR	71820	AR	71940	AR	72037	AR
71654	AR	71822	AR	71941	AR	72038	AR
71655	AR	71823	AR	71942	AR	72040	AR
71656	AR	71825	AR	71943	AR	72041	AR
71657	AR	71826	AR	71944	AR	72042	AR
71658	AR	71827	AR	71945	AR	72044	AR
71659	AR	71828	AR	71950	AR	72046	AR
71660	AR	71831	AR	71952	AR	72048	AR

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
72051	AR	72160	AR	72368	AR	72453	AR
72055	AR	72166	AR	72369	AR	72454	AR
72057	AR	72167	AR	72370	AR	72455	AR
72059	AR	72168	AR	72372	AR	72456	AR
72063	AR	72170	AR	72373	AR	72457	AR
72064	AR	72176	AR	72374	AR	72458	AR
72065	AR	72179	AR	72377	AR	72459	AR
72066	AR	72189	AR	72379	AR	72460	AR
72067	AR	72310	AR	72383	AR	72461	AR
72069	AR	72311	AR	72385	AR	72462	AR
72070	AR	72312	AR	72386	AR	72464	AR
72071	AR	72313	AR	72387	AR	72465	AR
72072	AR	72315	AR	72389	AR	72466	AR
72073	AR	72316	AR	72390	AR	72469	AR
72074	AR	72319	AR	72391	AR	72470	AR
72080	AR	72320	AR	72392	AR	72472	AR
72083	AR	72321	AR	72394	AR	72474	AR
72084	AR	72322	AR	72395	AR	72475	AR
72086	AR	72324	AR	72396	AR	72476	AR
72088	AR	72326	AR	72410	AR	72478	AR
72089	AR	72328	AR	72412	AR	72479	AR
72101	AR	72329	AR	72413	AR	72482	AR
72103	AR	72330	AR	72415	AR	72512	AR
72104	AR	72331	AR	72422	AR	72513	AR
72105	AR	72333	AR	72424	AR	72515	AR
72107	AR	72335	AR	72425	AR	72517	AR
72108	AR	72336	AR	72426	AR	72519	AR
72110	AR	72338	AR	72428	AR	72520	AR
72122	AR	72340	AR	72429	AR	72521	AR
72123	AR	72341	AR	72430	AR	72523	AR
72125	AR	72342	AR	72432	AR	72525	AR
72126	AR	72346	AR	72433	AR	72528	AR
72127	AR	72347	AR	72434	AR	72529	AR
72128	AR	72348	AR	72435	AR	72530	AR
72129	AR	72350	AR	72436	AR	72531	AR
72130	AR	72351	AR	72438	AR	72532	AR
72131	AR	72352	AR	72439	AR	72533	AR
72133	AR	72353	AR	72440	AR	72536	AR
72134	AR	72354	AR	72441	AR	72538	AR
72140	AR	72355	AR	72442	AR	72539	AR
72141	AR	72358	AR	72443	AR	72540	AR
72150	AR	72359	AR	72444	AR	72542	AR
72153	AR	72360	AR	72445	AR	72543	AR
72156	AR	72365	AR	72449	AR	72545	AR
72157	AR	72366	AR	72450	AR	72546	AR
72158	AR	72367	AR	72451	AR	72554	AR

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
72555	AR	72675	AR	72834	AR	73006	OK
72556	AR	72677	AR	72835	AR	73009	OK
72560	AR	72680	AR	72838	AR	73010	OK
72561	AR	72683	AR	72839	AR	73011	OK
72565	AR	72685	AR	72840	AR	73012	OK
72566	AR	72686	AR	72841	AR	73014	OK
72567	AR	72687	AR	72842	AR	73015	OK
72569	AR	72711	AR	72845	AR	73016	OK
72572	AR	72712	AR	72846	AR	73017	OK
72573	AR	72714	AR	72851	AR	73018	OK
72576	AR	72715	AR	72852	AR	73021	OK
72577	AR	72716	AR	72853	AR	73022	OK
72578	AR	72718	AR	72854	AR	73023	OK
72581	AR	72719	AR	72855	AR	73024	OK
72583	AR	72721	AR	72856	AR	73027	OK
72584	AR	72722	AR	72857	AR	73028	OK
72585	AR	72732	AR	72860	AR	73029	OK
72587	AR	72733	AR	72863	AR	73030	OK
72610	AR	72734	AR	72865	AR	73031	OK
72613	AR	72736	AR	72921	AR	73032	OK
72616	AR	72738	AR	72924	AR	73033	OK
72619	AR	72739	AR	72926	AR	73036	OK
72624	AR	72740	AR	72927	AR	73038	OK
72628	AR	72742	AR	72928	AR	73040	OK
72629	AR	72745	AR	72930	AR	73041	OK
72631	AR	72747	AR	72932	AR	73042	OK
72632	AR	72751	AR	72933	AR	73043	OK
72634	AR	72752	AR	72934	AR	73044	OK
72636	AR	72756	AR	72935	AR	73047	OK
72638	AR	72757	AR	72943	AR	73048	OK
72639	AR	72758	AR	72944	AR	73050	OK
72640	AR	72760	AR	72946	AR	73052	OK
72641	AR	72761	AR	72947	AR	73053	OK
72645	AR	72768	AR	72948	AR	73055	OK
72648	AR	72773	AR	72949	AR	73056	OK
72650	AR	72776	AR	72950	AR	73057	OK
72655	AR	72820	AR	72951	AR	73058	OK
72657	AR	72821	AR	72952	AR	73059	OK
72660	AR	72824	AR	72955	AR	73061	OK
72661	AR	72826	AR	72956	AR	73062	OK
72663	AR	72827	AR	72957	AR	73063	OK
72666	AR	72828	AR	72958	AR	73064	OK
72668	AR	72829	AR	73001	OK	73065	OK
72669	AR	72830	AR	73002	OK	73067	OK
72670	AR	72832	AR	73004	OK	73073	OK
72672	AR	72833	AR	73005	OK	73074	OK

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
73075	OK	73542	OK	73664	OK	73840	OK
73077	OK	73544	OK	73666	OK	73841	OK
73078	OK	73546	OK	73667	OK	73842	OK
73079	OK	73547	OK	73669	OK	73843	OK
73080	OK	73548	OK	73673	OK	73844	OK
73082	OK	73550	OK	73716	OK	73847	OK
73085	OK	73551	OK	73717	OK	73848	OK
73086	OK	73553	OK	73718	OK	73851	OK
73089	OK	73554	OK	73719	OK	73852	OK
73090	OK	73555	OK	73722	OK	73853	OK
73092	OK	73559	OK	73724	OK	73855	OK
73093	OK	73561	OK	73726	OK	73857	OK
73094	OK	73562	OK	73728	OK	73858	OK
73095	OK	73564	OK	73729	OK	73859	OK
73096	OK	73565	OK	73731	OK	73860	OK
73098	OK	73566	OK	73734	OK	73901	OK
73099	OK	73568	OK	73737	OK	73931	OK
73425	OK	73569	OK	73739	OK	73932	OK
73430	OK	73570	OK	73741	OK	73933	OK
73432	OK	73571	OK	73742	OK	73937	OK
73433	OK	73572	OK	73744	OK	73938	OK
73434	OK	73573	OK	73746	OK	73939	OK
73439	OK	73575	OK	73747	OK	73942	OK
73440	OK	73601	OK	73749	OK	73944	OK
73441	OK	73620	OK	73750	OK	73945	OK
73442	OK	73622	OK	73755	OK	73946	OK
73446	OK	73624	OK	73756	OK	73947	OK
73447	OK	73625	OK	73757	OK	73949	OK
73448	OK	73626	OK	73758	OK	73950	OK
73449	OK	73628	OK	73759	OK	73951	OK
73450	OK	73632	OK	73760	OK	74001	OK
73453	OK	73638	OK	73761	OK	74002	OK
73455	OK	73639	OK	73762	OK	74009	OK
73456	OK	73641	OK	73763	OK	74010	OK
73459	OK	73642	OK	73764	OK	74014	OK
73460	OK	73646	OK	73766	OK	74015	OK
73461	OK	73647	OK	73768	OK	74020	OK
73476	OK	73650	OK	73770	OK	74026	OK
73491	OK	73651	OK	73771	OK	74027	OK
73520	OK	73654	OK	73772	OK	74028	OK
73529	OK	73655	OK	73801	OK	74030	OK
73530	OK	73658	OK	73802	OK	74034	OK
73531	OK	73659	OK	73832	OK	74035	OK
73533	OK	73660	OK	73834	OK	74036	OK
73534	OK	73661	OK	73835	OK	74038	OK
73536	OK	73663	OK	73838	OK	74039	OK

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74041	OK	74359	OK	74540	OK	74724	OK
74042	OK	74360	OK	74542	OK	74726	OK
74044	OK	74361	OK	74543	OK	74727	OK
74045	OK	74362	OK	74545	OK	74728	OK
74046	OK	74363	OK	74549	OK	74729	OK
74047	OK	74364	OK	74552	OK	74730	OK
74048	OK	74365	OK	74555	OK	74731	OK
74052	OK	74366	OK	74556	OK	74733	OK
74053	OK	74367	OK	74557	OK	74734	OK
74054	OK	74368	OK	74558	OK	74735	OK
74056	OK	74369	OK	74559	OK	74736	OK
74058	OK	74370	OK	74562	OK	74737	OK
74060	OK	74421	OK	74563	OK	74738	OK
74066	OK	74426	OK	74567	OK	74740	OK
74067	OK	74429	OK	74569	OK	74741	OK
74068	OK	74431	OK	74570	OK	74743	OK
74071	OK	74432	OK	74571	OK	74745	OK
74072	OK	74435	OK	74572	OK	74747	OK
74079	OK	74437	OK	74574	OK	74748	OK
74080	OK	74438	OK	74577	OK	74750	OK
74081	OK	74440	OK	74578	OK	74752	OK
74083	OK	74445	OK	74601	OK	74753	OK
74084	OK	74446	OK	74602	OK	74754	OK
74131	OK	74447	OK	74603	OK	74755	OK
74301	OK	74454	OK	74604	OK	74756	OK
74330	OK	74456	OK	74630	OK	74759	OK
74331	OK	74457	OK	74631	OK	74760	OK
74332	OK	74458	OK	74632	OK	74761	OK
74333	OK	74459	OK	74633	OK	74764	OK
74335	OK	74460	OK	74636	OK	74766	OK
74337	OK	74461	OK	74637	OK	74818	OK
74338	OK	74462	OK	74641	OK	74824	OK
74339	OK	74466	OK	74643	OK	74826	OK
74340	OK	74467	OK	74644	OK	74827	OK
74342	OK	74472	OK	74646	OK	74829	OK
74343	OK	74477	OK	74647	OK	74830	OK
74344	OK	74521	OK	74650	OK	74831	OK
74345	OK	74523	OK	74651	OK	74832	OK
74346	OK	74525	OK	74652	OK	74833	OK
74347	OK	74530	OK	74653	OK	74834	OK
74349	OK	74531	OK	74701	OK	74836	OK
74350	OK	74533	OK	74702	OK	74837	OK
74352	OK	74534	OK	74720	OK	74839	OK
74354	OK	74535	OK	74721	OK	74845	OK
74355	OK	74536	OK	74722	OK	74848	OK
74358	OK	74538	OK	74723	OK	74849	OK

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74850	OK	74965	OK	75440	TX	75571	TX
74855	OK	74966	OK	75441	TX	75572	TX
74856	OK	75102	TX	75443	TX	75574	TX
74859	OK	75103	TX	75444	TX	75630	TX
74860	OK	75105	TX	75446	TX	75631	TX
74864	OK	75109	TX	75447	TX	75633	TX
74867	OK	75110	TX	75448	TX	75636	TX
74868	OK	75114	TX	75449	TX	75637	TX
74869	OK	75117	TX	75450	TX	75638	TX
74872	OK	75118	TX	75451	TX	75639	TX
74875	OK	75124	TX	75452	TX	75640	TX
74878	OK	75125	TX	75457	TX	75643	TX
74880	OK	75126	TX	75469	TX	75644	TX
74881	OK	75127	TX	75471	TX	75645	TX
74883	OK	75140	TX	75472	TX	75650	TX
74884	OK	75142	TX	75474	TX	75652	TX
74901	OK	75143	TX	75475	TX	75653	TX
74902	OK	75144	TX	75476	TX	75654	TX
74930	OK	75147	TX	75478	TX	75656	TX
74931	OK	75151	TX	75479	TX	75657	TX
74932	OK	75152	TX	75480	TX	75658	TX
74935	OK	75153	TX	75481	TX	75659	TX
74936	OK	75154	TX	75482	TX	75661	TX
74937	OK	75155	TX	75483	TX	75662	TX
74939	OK	75156	TX	75487	TX	75663	TX
74940	OK	75157	TX	75488	TX	75666	TX
74941	OK	75158	TX	75490	TX	75667	TX
74942	OK	75161	TX	75492	TX	75668	TX
74943	OK	75163	TX	75494	TX	75669	TX
74944	OK	75167	TX	75497	TX	75680	TX
74945	OK	75169	TX	75550	TX	75681	TX
74946	OK	75410	TX	75551	TX	75682	TX
74947	OK	75412	TX	75554	TX	75683	TX
74948	OK	75413	TX	75555	TX	75684	TX
74949	OK	75415	TX	75556	TX	75685	TX
74951	OK	75417	TX	75559	TX	75686	TX
74953	OK	75418	TX	75560	TX	75687	TX
74954	OK	75420	TX	75561	TX	75689	TX
74955	OK	75426	TX	75562	TX	75691	TX
74956	OK	75431	TX	75563	TX	75692	TX
74957	OK	75432	TX	75564	TX	75754	TX
74959	OK	75433	TX	75565	TX	75755	TX
74960	OK	75436	TX	75566	TX	75756	TX
74962	OK	75437	TX	75567	TX	75758	TX
74963	OK	75438	TX	75568	TX	75765	TX
74964	OK	75439	TX	75570	TX	75770	TX

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
75773	TX	75959	TX	76227	TX	76435	TX
75778	TX	75960	TX	76228	TX	76436	TX
75782	TX	75966	TX	76230	TX	76437	TX
75783	TX	75968	TX	76234	TX	76439	TX
75790	TX	75972	TX	76238	TX	76442	TX
75797	TX	75973	TX	76239	TX	76443	TX
75831	TX	75974	TX	76240	TX	76444	TX
75833	TX	75975	TX	76241	TX	76445	TX
75834	TX	75977	TX	76246	TX	76448	TX
75835	TX	75979	TX	76250	TX	76449	TX
75838	TX	75990	TX	76251	TX	76450	TX
75840	TX	76008	TX	76252	TX	76452	TX
75844	TX	76009	TX	76253	TX	76453	TX
75845	TX	76023	TX	76255	TX	76454	TX
75846	TX	76028	TX	76258	TX	76455	TX
75847	TX	76031	TX	76261	TX	76457	TX
75848	TX	76033	TX	76263	TX	76458	TX
75849	TX	76035	TX	76265	TX	76459	TX
75850	TX	76043	TX	76267	TX	76460	TX
75851	TX	76044	TX	76270	TX	76462	TX
75852	TX	76048	TX	76272	TX	76463	TX
75855	TX	76049	TX	76351	TX	76464	TX
75856	TX	76050	TX	76352	TX	76466	TX
75858	TX	76055	TX	76357	TX	76467	TX
75859	TX	76058	TX	76363	TX	76468	TX
75860	TX	76059	TX	76364	TX	76469	TX
75862	TX	76061	TX	76365	TX	76470	TX
75865	TX	76064	TX	76366	TX	76471	TX
75926	TX	76065	TX	76370	TX	76472	TX
75928	TX	76066	TX	76371	TX	76474	TX
75929	TX	76067	TX	76372	TX	76475	TX
75930	TX	76068	TX	76373	TX	76476	TX
75931	TX	76070	TX	76374	TX	76481	TX
75932	TX	76071	TX	76377	TX	76483	TX
75933	TX	76073	TX	76379	TX	76484	TX
75934	TX	76077	TX	76380	TX	76485	TX
75935	TX	76078	TX	76384	TX	76486	TX
75936	TX	76082	TX	76385	TX	76487	TX
75938	TX	76084	TX	76388	TX	76490	TX
75939	TX	76085	TX	76389	TX	76491	TX
75942	TX	76087	TX	76424	TX	76518	TX
75947	TX	76088	TX	76426	TX	76519	TX
75948	TX	76093	TX	76427	TX	76520	TX
75951	TX	76097	TX	76429	TX	76522	TX
75954	TX	76098	TX	76430	TX	76523	TX
75956	TX	76225	TX	76431	TX	76525	TX

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
76526	TX	76666	TX	76866	TX	77351	TX
76528	TX	76667	TX	76867	TX	77358	TX
76531	TX	76671	TX	76869	TX	77359	TX
76538	TX	76673	TX	76870	TX	77360	TX
76539	TX	76675	TX	76871	TX	77363	TX
76550	TX	76676	TX	76872	TX	77364	TX
76555	TX	76677	TX	76873	TX	77367	TX
76556	TX	76678	TX	76874	TX	77368	TX
76558	TX	76679	TX	76875	TX	77369	TX
76561	TX	76680	TX	76877	TX	77371	TX
76565	TX	76681	TX	76878	TX	77374	TX
76566	TX	76685	TX	76880	TX	77376	TX
76567	TX	76686	TX	76882	TX	77399	TX
76570	TX	76687	TX	76883	TX	77404	TX
76577	TX	76689	TX	76884	TX	77412	TX
76596	TX	76690	TX	76885	TX	77414	TX
76597	TX	76691	TX	76887	TX	77415	TX
76598	TX	76692	TX	76888	TX	77418	TX
76599	TX	76693	TX	76930	TX	77419	TX
76621	TX	76820	TX	76932	TX	77423	TX
76622	TX	76821	TX	76933	TX	77426	TX
76626	TX	76824	TX	76936	TX	77428	TX
76627	TX	76825	TX	76937	TX	77434	TX
76628	TX	76828	TX	76941	TX	77440	TX
76629	TX	76831	TX	76943	TX	77442	TX
76631	TX	76832	TX	76945	TX	77445	TX
76632	TX	76834	TX	76949	TX	77446	TX
76634	TX	76836	TX	76950	TX	77452	TX
76635	TX	76837	TX	76951	TX	77456	TX
76636	TX	76841	TX	76953	TX	77457	TX
76637	TX	76842	TX	77320	TX	77458	TX
76639	TX	76844	TX	77326	TX	77460	TX
76641	TX	76845	TX	77327	TX	77465	TX
76642	TX	76848	TX	77328	TX	77466	TX
76644	TX	76849	TX	77331	TX	77468	TX
76645	TX	76852	TX	77332	TX	77470	TX
76648	TX	76853	TX	77334	TX	77473	TX
76649	TX	76854	TX	77335	TX	77474	TX
76650	TX	76855	TX	77340	TX	77475	TX
76652	TX	76856	TX	77341	TX	77482	TX
76653	TX	76858	TX	77342	TX	77483	TX
76656	TX	76859	TX	77343	TX	77484	TX
76657	TX	76861	TX	77344	TX	77485	TX
76660	TX	76862	TX	77348	TX	77514	TX
76661	TX	76864	TX	77349	TX	77519	TX
76665	TX	76865	TX	77350	TX	77533	TX

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
77535	TX	77857	TX	77995	TX	78117	TX
77538	TX	77859	TX	78001	TX	78118	TX
77560	TX	77861	TX	78003	TX	78119	TX
77561	TX	77863	TX	78005	TX	78121	TX
77564	TX	77864	TX	78007	TX	78122	TX
77575	TX	77865	TX	78008	TX	78123	TX
77580	TX	77867	TX	78009	TX	78124	TX
77582	TX	77868	TX	78011	TX	78125	TX
77585	TX	77869	TX	78012	TX	78133	TX
77597	TX	77870	TX	78014	TX	78140	TX
77611	TX	77871	TX	78016	TX	78141	TX
77612	TX	77872	TX	78017	TX	78142	TX
77614	TX	77873	TX	78019	TX	78143	TX
77615	TX	77875	TX	78021	TX	78144	TX
77616	TX	77876	TX	78022	TX	78145	TX
77624	TX	77878	TX	78026	TX	78146	TX
77625	TX	77879	TX	78039	TX	78147	TX
77626	TX	77880	TX	78050	TX	78151	TX
77630	TX	77882	TX	78052	TX	78154	TX
77631	TX	77950	TX	78053	TX	78155	TX
77632	TX	77954	TX	78055	TX	78156	TX
77639	TX	77957	TX	78056	TX	78159	TX
77656	TX	77960	TX	78057	TX	78160	TX
77657	TX	77961	TX	78059	TX	78161	TX
77659	TX	77962	TX	78060	TX	78162	TX
77660	TX	77963	TX	78061	TX	78163	TX
77661	TX	77964	TX	78062	TX	78164	TX
77662	TX	77967	TX	78063	TX	78266	TX
77663	TX	77969	TX	78064	TX	78332	TX
77664	TX	77970	TX	78065	TX	78333	TX
77665	TX	77971	TX	78066	TX	78335	TX
77670	TX	77972	TX	78067	TX	78336	TX
77830	TX	77974	TX	78070	TX	78338	TX
77831	TX	77975	TX	78071	TX	78340	TX
77833	TX	77978	TX	78072	TX	78341	TX
77834	TX	77979	TX	78075	TX	78342	TX
77835	TX	77982	TX	78076	TX	78343	TX
77836	TX	77983	TX	78102	TX	78349	TX
77837	TX	77984	TX	78104	TX	78350	TX
77838	TX	77986	TX	78107	TX	78352	TX
77839	TX	77987	TX	78108	TX	78353	TX
77850	TX	77989	TX	78111	TX	78355	TX
77852	TX	77990	TX	78113	TX	78357	TX
77853	TX	77991	TX	78114	TX	78358	TX
77855	TX	77993	TX	78115	TX	78359	TX
77856	TX	77994	TX	78116	TX	78360	TX

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
78361	TX	78607	TX	78837	TX	78954	TX
78362	TX	78608	TX	78838	TX	78956	TX
78363	TX	78609	TX	78839	TX	78957	TX
78364	TX	78610	TX	78840	TX	78959	TX
78368	TX	78611	TX	78841	TX	78960	TX
78370	TX	78612	TX	78842	TX	78961	TX
78372	TX	78614	TX	78843	TX	78962	TX
78373	TX	78616	TX	78847	TX	78963	TX
78374	TX	78620	TX	78850	TX	79001	TX
78375	TX	78621	TX	78851	TX	79002	TX
78376	TX	78622	TX	78852	TX	79003	TX
78377	TX	78623	TX	78853	TX	79005	TX
78379	TX	78629	TX	78860	TX	79007	TX
78381	TX	78632	TX	78861	TX	79008	TX
78382	TX	78635	TX	78870	TX	79009	TX
78383	TX	78636	TX	78871	TX	79010	TX
78384	TX	78638	TX	78872	TX	79011	TX
78385	TX	78639	TX	78873	TX	79014	TX
78387	TX	78640	TX	78877	TX	79015	TX
78389	TX	78643	TX	78879	TX	79016	TX
78390	TX	78644	TX	78880	TX	79018	TX
78391	TX	78648	TX	78881	TX	79019	TX
78393	TX	78650	TX	78883	TX	79021	TX
78536	TX	78654	TX	78884	TX	79022	TX
78545	TX	78655	TX	78885	TX	79024	TX
78547	TX	78656	TX	78886	TX	79025	TX
78548	TX	78657	TX	78931	TX	79027	TX
78561	TX	78658	TX	78932	TX	79031	TX
78564	TX	78659	TX	78933	TX	79032	TX
78569	TX	78661	TX	78934	TX	79033	TX
78578	TX	78662	TX	78935	TX	79034	TX
78580	TX	78663	TX	78938	TX	79035	TX
78582	TX	78670	TX	78940	TX	79036	TX
78584	TX	78672	TX	78941	TX	79039	TX
78585	TX	78677	TX	78942	TX	79040	TX
78588	TX	78737	TX	78943	TX	79041	TX
78590	TX	78801	TX	78944	TX	79042	TX
78591	TX	78802	TX	78945	TX	79043	TX
78594	TX	78827	TX	78946	TX	79044	TX
78597	TX	78828	TX	78947	TX	79045	TX
78598	TX	78829	TX	78948	TX	79046	TX
78602	TX	78830	TX	78949	TX	79051	TX
78603	TX	78832	TX	78950	TX	79052	TX
78604	TX	78833	TX	78951	TX	79053	TX
78605	TX	78834	TX	78952	TX	79054	TX
78606	TX	78836	TX	78953	TX	79056	TX

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
79057	TX	79237	TX	79359	TX	79547	TX
79059	TX	79239	TX	79360	TX	79548	TX
79061	TX	79240	TX	79367	TX	79549	TX
79062	TX	79241	TX	79369	TX	79550	TX
79063	TX	79243	TX	79370	TX	79553	TX
79064	TX	79244	TX	79371	TX	79556	TX
79065	TX	79245	TX	79372	TX	79560	TX
79066	TX	79247	TX	79373	TX	79565	TX
79068	TX	79248	TX	79376	TX	79566	TX
79070	TX	79250	TX	79377	TX	79567	TX
79072	TX	79251	TX	79378	TX	79713	TX
79073	TX	79252	TX	79379	TX	79714	TX
79077	TX	79255	TX	79380	TX	79718	TX
79078	TX	79256	TX	79381	TX	79719	TX
79079	TX	79257	TX	79383	TX	79730	TX
79080	TX	79258	TX	79501	TX	79734	TX
79081	TX	79259	TX	79502	TX	79735	TX
79082	TX	79261	TX	79503	TX	79738	TX
79083	TX	79311	TX	79504	TX	79739	TX
79084	TX	79312	TX	79505	TX	79740	TX
79085	TX	79313	TX	79506	TX	79742	TX
79087	TX	79314	TX	79510	TX	79743	TX
79088	TX	79316	TX	79512	TX	79744	TX
79091	TX	79320	TX	79516	TX	79745	TX
79092	TX	79322	TX	79517	TX	79749	TX
79093	TX	79323	TX	79518	TX	79752	TX
79094	TX	79324	TX	79519	TX	79754	TX
79095	TX	79325	TX	79520	TX	79755	TX
79096	TX	79326	TX	79521	TX	79756	TX
79097	TX	79330	TX	79525	TX	79770	TX
79098	TX	79331	TX	79526	TX	79772	TX
79201	TX	79336	TX	79527	TX	79777	TX
79220	TX	79338	TX	79528	TX	79778	TX
79221	TX	79339	TX	79529	TX	79780	TX
79223	TX	79342	TX	79532	TX	79781	TX
79225	TX	79343	TX	79533	TX	79782	TX
79226	TX	79344	TX	79534	TX	79783	TX
79227	TX	79345	TX	79535	TX	79785	TX
79229	TX	79346	TX	79537	TX	79786	TX
79230	TX	79347	TX	79538	TX	79788	TX
79231	TX	79351	TX	79539	TX	79789	TX
79232	TX	79353	TX	79540	TX	79830	TX
79233	TX	79355	TX	79543	TX	79831	TX
79234	TX	79356	TX	79544	TX	79832	TX
79235	TX	79357	TX	79545	TX	79834	TX
79236	TX	79358	TX	79546	TX	79837	TX

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
79839	TX	80642	CO	80820	CO	81063	CO
79842	TX	80643	CO	80821	CO	81064	CO
79843	TX	80648	CO	80822	CO	81066	CO
79845	TX	80649	CO	80823	CO	81067	CO
79846	TX	80650	CO	80824	CO	81071	CO
79847	TX	80651	CO	80825	CO	81073	CO
79848	TX	80652	CO	80826	CO	81074	CO
79850	TX	80653	CO	80827	CO	81076	CO
79851	TX	80654	CO	80828	CO	81077	CO
79852	TX	80701	CO	80830	CO	81081	CO
79854	TX	80705	CO	80834	CO	81082	CO
79855	TX	80720	CO	80835	CO	81084	CO
80101	CO	80721	CO	80836	CO	81087	CO
80107	CO	80723	CO	80860	CO	81089	CO
80117	CO	80727	CO	80861	CO	81090	CO
80420	CO	80729	CO	80862	CO	81091	CO
80421	CO	80731	CO	80863	CO	81092	CO
80430	CO	80732	CO	80866	CO	81120	CO
80432	CO	80733	CO	81020	CO	81121	CO
80434	CO	80734	CO	81021	CO	81123	CO
80436	CO	80735	CO	81024	CO	81124	CO
80438	CO	80737	CO	81027	CO	81125	CO
80440	CO	80740	CO	81029	CO	81126	CO
80442	CO	80742	CO	81030	CO	81127	CO
80444	CO	80743	CO	81033	CO	81128	CO
80446	CO	80744	CO	81034	CO	81129	CO
80447	CO	80746	CO	81036	CO	81130	CO
80448	CO	80749	CO	81038	CO	81132	CO
80449	CO	80750	CO	81039	CO	81133	CO
80451	CO	80754	CO	81040	CO	81134	CO
80452	CO	80755	CO	81041	CO	81135	CO
80456	CO	80757	CO	81042	CO	81138	CO
80459	CO	80758	CO	81043	CO	81140	CO
80468	CO	80759	CO	81044	CO	81141	CO
80473	CO	80801	CO	81045	CO	81144	CO
80475	CO	80802	CO	81046	CO	81147	CO
80476	CO	80804	CO	81047	CO	81148	CO
80478	CO	80805	CO	81049	CO	81151	CO
80480	CO	80807	CO	81050	CO	81152	CO
80482	CO	80810	CO	81052	CO	81153	CO
80546	CO	80812	CO	81054	CO	81154	CO
80550	CO	80813	CO	81055	CO	81157	CO
80551	CO	80814	CO	81057	CO	81212	CO
80610	CO	80815	CO	81058	CO	81215	CO
80611	CO	80816	CO	81059	CO	81221	CO
80612	CO	80818	CO	81062	CO	81222	CO

ADDENDUM I- 2005 PRIMARY CARE HPSA ZIP CODES

2005 Primary Care HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
01084	MA	12407	NY	12836	NY	13675	NY
01098	MA	12413	NY	12842	NY	13690	NY
01840	MA	12414	NY	12851	NY	13695	NY
01842	MA	12418	NY	12853	NY	13826	NY
02535	MA	12422	NY	12855	NY	14041	NY
02539	MA	12423	NY	12857	NY	14062	NY
02552	MA	12424	NY	12858	NY	14138	NY
02554	MA	12427	NY	12860	NY	14213	NY
02557	MA	12431	NY	12861	NY	14301	NY
02564	MA	12435	NY	12862	NY	14302	NY
02568	MA	12436	NY	12864	NY	14303	NY
02573	MA	12439	NY	12870	NY	14619	NY
02575	MA	12442	NY	12872	NY	14707	NY
02584	MA	12444	NY	12874	NY	14708	NY
02713	MA	12450	NY	12883	NY	14709	NY
02826	RI	12451	NY	12886	NY	14710	NY
02839	RI	12452	NY	12928	NY	14711	NY
02858	RI	12454	NY	12932	NY	14712	NY
03238	NH	12460	NY	12936	NY	14714	NY
03279	NH	12463	NY	12952	NY	14715	NY
04490	ME	12468	NY	12956	NY	14716	NY
04737	ME	12470	NY	12960	NY	14717	NY
04929	ME	12473	NY	12961	NY	14718	NY
04965	ME	12482	NY	12964	NY	14721	NY
05077	VT	12485	NY	12974	NY	14722	NY
05447	VT	12492	NY	12978	NY	14723	NY
10030	NY	12496	NY	12993	NY	14726	NY
10039	NY	12502	NY	12996	NY	14727	NY
10455	NY	12503	NY	12998	NY	14728	NY
11216	NY	12541	NY	13026	NY	14732	NY
11247	NY	12723	NY	13144	NY	14733	NY
11451	NY	12733	NY	13301	NY	14735	NY
12015	NY	12736	NY	13312	NY	14739	NY
12042	NY	12741	NY	13315	NY	14740	NY
12051	NY	12745	NY	13342	NY	14741	NY
12058	NY	12750	NY	13345	NY	14743	NY
12083	NY	12752	NY	13368	NY	14744	NY
12087	NY	12759	NY	13415	NY	14745	NY
12108	NY	12765	NY	13426	NY	14747	NY
12124	NY	12766	NY	13436	NY	14750	NY
12139	NY	12788	NY	13482	NY	14751	NY
12147	NY	12789	NY	13489	NY	14752	NY
12164	NY	12792	NY	13607	NY	14754	NY
12176	NY	12808	NY	13639	NY	14756	NY
12192	NY	12812	NY	13666	NY	14757	NY
12405	NY	12817	NY	13670	NY	14760	NY

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
14774	NY	16622	PA	18352	PA	21628	MD
14777	NY	16623	PA	18355	PA	21629	MD
14781	NY	16633	PA	18370	PA	21631	MD
14782	NY	16634	PA	18372	PA	21632	MD
14784	NY	16645	PA	18415	PA	21634	MD
14785	NY	16672	PA	18425	PA	21636	MD
14786	NY	16674	PA	18435	PA	21638	MD
14788	NY	16679	PA	18439	PA	21639	MD
14802	NY	16685	PA	18449	PA	21640	MD
14803	NY	16694	PA	18451	PA	21641	MD
14804	NY	16829	PA	18454	PA	21643	MD
14806	NY	16864	PA	18455	PA	21644	MD
14813	NY	16930	PA	18457	PA	21648	MD
14822	NY	16939	PA	18462	PA	21649	MD
14847	NY	17005	PA	18614	PA	21655	MD
14860	NY	17017	PA	18616	PA	21656	MD
14880	NY	17023	PA	18619	PA	21657	MD
14884	NY	17030	PA	18632	PA	21658	MD
14895	NY	17048	PA	18813	PA	21659	MD
14897	NY	17061	PA	18824	PA	21660	MD
15411	PA	17066	PA	18826	PA	21664	MD
15413	PA	17075	PA	18828	PA	21666	MD
15420	PA	17080	PA	20059	DC	21668	MD
15444	PA	17097	PA	20610	MD	21669	MD
15463	PA	17220	PA	20615	MD	21670	MD
15475	PA	17223	PA	20629	MD	21672	MD
15629	PA	17239	PA	20639	MD	21675	MD
15641	PA	17243	PA	20657	MD	21677	MD
15686	PA	17249	PA	20676	MD	21681	MD
15690	PA	17253	PA	20678	MD	21682	MD
15721	PA	17255	PA	20685	MD	21683	MD
15832	PA	17264	PA	20688	MD	21684	MD
15834	PA	17271	PA	20689	MD	21685	MD
15861	PA	17723	PA	20714	MD	21687	MD
16022	PA	17727	PA	20732	MD	21835	MD
16030	PA	17739	PA	20736	MD	21869	MD
16048	PA	17742	PA	20754	MD	21901	MD
16050	PA	17763	PA	21607	MD	21902	MD
16233	PA	17774	PA	21609	MD	21903	MD
16321	PA	18322	PA	21613	MD	21904	MD
16332	PA	18331	PA	21617	MD	21911	MD
16334	PA	18332	PA	21619	MD	21912	MD
16361	PA	18334	PA	21622	MD	21913	MD
16364	PA	18344	PA	21623	MD	21914	MD
16436	PA	18346	PA	21626	MD	21915	MD
16621	PA	18350	PA	21627	MD	21916	MD

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
21917	MD	22938	VA	23399	VA	23938	VA
21918	MD	22949	VA	23401	VA	23939	VA
21919	MD	22954	VA	23404	VA	23941	VA
21920	MD	22958	VA	23407	VA	23944	VA
21921	MD	22963	VA	23409	VA	23947	VA
21922	MD	22964	VA	23410	VA	23952	VA
21930	MD	22965	VA	23412	VA	23958	VA
22427	VA	22967	VA	23414	VA	23959	VA
22428	VA	22968	VA	23415	VA	23962	VA
22442	VA	22969	VA	23416	VA	23963	VA
22443	VA	22971	VA	23417	VA	23964	VA
22446	VA	22973	VA	23418	VA	23967	VA
22448	VA	22974	VA	23420	VA	23968	VA
22451	VA	22976	VA	23421	VA	23974	VA
22460	VA	23002	VA	23422	VA	23976	VA
22469	VA	23011	VA	23423	VA	24053	VA
22472	VA	23014	VA	23426	VA	24072	VA
22481	VA	23022	VA	23427	VA	24076	VA
22485	VA	23039	VA	23440	VA	24079	VA
22488	VA	23055	VA	23441	VA	24082	VA
22501	VA	23063	VA	23442	VA	24091	VA
22514	VA	23065	VA	23480	VA	24105	VA
22520	VA	23083	VA	23483	VA	24120	VA
22524	VA	23084	VA	23488	VA	24127	VA
22526	VA	23089	VA	23821	VA	24131	VA
22529	VA	23105	VA	23839	VA	24133	VA
22534	VA	23124	VA	23841	VA	24171	VA
22535	VA	23140	VA	23843	VA	24177	VA
22538	VA	23141	VA	23845	VA	24185	VA
22544	VA	23153	VA	23846	VA	24217	VA
22546	VA	23160	VA	23856	VA	24218	VA
22547	VA	23301	VA	23857	VA	24220	VA
22548	VA	23302	VA	23868	VA	24221	VA
22552	VA	23303	VA	23873	VA	24224	VA
22558	VA	23306	VA	23876	VA	24225	VA
22572	VA	23308	VA	23881	VA	24226	VA
22577	VA	23336	VA	23883	VA	24228	VA
22580	VA	23337	VA	23887	VA	24237	VA
22581	VA	23341	VA	23889	VA	24239	VA
22650	VA	23345	VA	23893	VA	24243	VA
22835	VA	23356	VA	23899	VA	24244	VA
22849	VA	23357	VA	23915	VA	24245	VA
22851	VA	23358	VA	23920	VA	24248	VA
22920	VA	23359	VA	23923	VA	24250	VA
22922	VA	23389	VA	23934	VA	24251	VA
22935	VA	23395	VA	23937	VA	24256	VA

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
24258	VA	24624	VA	25141	WV	25978	WV
24260	VA	24627	VA	25142	WV	25979	WV
24263	VA	24628	VA	25149	WV	25984	WV
24265	VA	24631	VA	25150	WV	25985	WV
24266	VA	24634	VA	25164	WV	26134	WV
24269	VA	24639	VA	25174	WV	26136	WV
24271	VA	24640	VA	25209	WV	26137	WV
24272	VA	24646	VA	25211	WV	26138	WV
24277	VA	24647	VA	25231	WV	26141	WV
24280	VA	24649	VA	25234	WV	26143	WV
24281	VA	24656	VA	25235	WV	26146	WV
24282	VA	24657	VA	25239	WV	26147	WV
24290	VA	24658	VA	25241	WV	26148	WV
24292	VA	24715	WV	25243	WV	26149	WV
24314	VA	24724	WV	25244	WV	26151	WV
24315	VA	24918	WV	25245	WV	26152	WV
24318	VA	24935	WV	25248	WV	26160	WV
24326	VA	24941	WV	25251	WV	26161	WV
24330	VA	24945	WV	25252	WV	26164	WV
24348	VA	24950	WV	25259	WV	26170	WV
24363	VA	24951	WV	25261	WV	26173	WV
24366	VA	24962	WV	25262	WV	26175	WV
24378	VA	24963	WV	25266	WV	26178	WV
24380	VA	24974	WV	25267	WV	26202	WV
24412	VA	24976	WV	25268	WV	26205	WV
24413	VA	24981	WV	25270	WV	26208	WV
24433	VA	24983	WV	25271	WV	26261	WV
24442	VA	24984	WV	25275	WV	26280	WV
24445	VA	24985	WV	25276	WV	26320	WV
24458	VA	24993	WV	25279	WV	26325	WV
24460	VA	25005	WV	25281	WV	26327	WV
24464	VA	25007	WV	25285	WV	26334	WV
24465	VA	25019	WV	25286	WV	26335	WV
24468	VA	25028	WV	25431	WV	26337	WV
24484	VA	25030	WV	25437	WV	26342	WV
24487	VA	25043	WV	25444	WV	26346	WV
24517	VA	25046	WV	25570	WV	26347	WV
24522	VA	25062	WV	25699	WV	26351	WV
24553	VA	25063	WV	25839	WV	26354	WV
24563	VA	25088	WV	25844	WV	26362	WV
24593	VA	25093	WV	25951	WV	26384	WV
24603	VA	25111	WV	25958	WV	26415	WV
24607	VA	25113	WV	25965	WV	26421	WV
24614	VA	25114	WV	25966	WV	26424	WV
24618	VA	25125	WV	25969	WV	26430	WV
24620	VA	25133	WV	25977	WV	26434	WV

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
26435	WV	27586	NC	27950	NC	29080	SC
26440	WV	27589	NC	27956	NC	29106	SC
26443	WV	27594	NC	27957	NC	29129	SC
26601	WV	27801	NC	27958	NC	29130	SC
26611	WV	27802	NC	27962	NC	29132	SC
26615	WV	27805	NC	27964	NC	29135	SC
26617	WV	27808	NC	27965	NC	29138	SC
26619	WV	27809	NC	27966	NC	29142	SC
26621	WV	27819	NC	27969	NC	29163	SC
26623	WV	27820	NC	27970	NC	29166	SC
26624	WV	27831	NC	27973	NC	29176	SC
26627	WV	27832	NC	27979	NC	29180	SC
26629	WV	27842	NC	27983	NC	29436	SC
26631	WV	27845	NC	28007	NC	29448	SC
26636	WV	27847	NC	28091	NC	29468	SC
26638	WV	27849	NC	28102	NC	29469	SC
26639	WV	27852	NC	28119	NC	29487	SC
26641	WV	27853	NC	28133	NC	29512	SC
26676	WV	27854	NC	28135	NC	29516	SC
26681	WV	27862	NC	28170	NC	29518	SC
26684	WV	27864	NC	28361	NC	29525	SC
26704	WV	27866	NC	28376	NC	29554	SC
26711	WV	27867	NC	28421	NC	29556	SC
26714	WV	27868	NC	28425	NC	29564	SC
26722	WV	27869	NC	28435	NC	29570	SC
26755	WV	27872	NC	28443	NC	29580	SC
26757	WV	27876	NC	28454	NC	29590	SC
26761	WV	27877	NC	28457	NC	29594	SC
26763	WV	27886	NC	28478	NC	29596	SC
26802	WV	27897	NC	28636	NC	29688	SC
26804	WV	27916	NC	28678	NC	29821	SC
26807	WV	27917	NC	28681	NC	29824	SC
26808	WV	27923	NC	28733	NC	29832	SC
26814	WV	27924	NC	28771	NC	29835	SC
26815	WV	27925	NC	28902	NC	29838	SC
26817	WV	27926	NC	28904	NC	29840	SC
26823	WV	27927	NC	28909	NC	29844	SC
26824	WV	27928	NC	29010	SC	29845	SC
26852	WV	27929	NC	29015	SC	29847	SC
26865	WV	27935	NC	29030	SC	30055	GA
26866	WV	27937	NC	29046	SC	30102	GA
26884	WV	27938	NC	29048	SC	30104	GA
26886	WV	27939	NC	29052	SC	30107	GA
27551	NC	27941	NC	29056	SC	30114	GA
27563	NC	27946	NC	29059	SC	30115	GA
27570	NC	27947	NC	29065	SC	30125	GA

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
30132	GA	30530	GA	30828	GA	31553	GA
30138	GA	30537	GA	30833	GA	31566	GA
30141	GA	30547	GA	31002	GA	31624	GA
30142	GA	30552	GA	31003	GA	31625	GA
30143	GA	30558	GA	31016	GA	31629	GA
30146	GA	30562	GA	31017	GA	31638	GA
30148	GA	30568	GA	31020	GA	31642	GA
30151	GA	30573	GA	31024	GA	31643	GA
30153	GA	30576	GA	31026	GA	31648	GA
30157	GA	30581	GA	31029	GA	31650	GA
30169	GA	30619	GA	31031	GA	31704	GA
30175	GA	30627	GA	31038	GA	31763	GA
30177	GA	30628	GA	31042	GA	31787	GA
30183	GA	30629	GA	31044	GA	31804	GA
30188	GA	30630	GA	31045	GA	31805	GA
30189	GA	30633	GA	31046	GA	31807	GA
30217	GA	30646	GA	31050	GA	31811	GA
30219	GA	30647	GA	31052	GA	31822	GA
30230	GA	30648	GA	31054	GA	31823	GA
30240	GA	30660	GA	31064	GA	31826	GA
30241	GA	30667	GA	31066	GA	31831	GA
30261	GA	30668	GA	31078	GA	31833	GA
30291	GA	30671	GA	31085	GA	32008	FL
30401	GA	30673	GA	31086	GA	32013	FL
30413	GA	30705	GA	31090	GA	32042	FL
30420	GA	30707	GA	31301	GA	32044	FL
30421	GA	30708	GA	31303	GA	32058	FL
30424	GA	30711	GA	31304	GA	32059	FL
30425	GA	30724	GA	31305	GA	32060	FL
30427	GA	30725	GA	31309	GA	32062	FL
30434	GA	30728	GA	31310	GA	32064	FL
30438	GA	30730	GA	31312	GA	32066	FL
30446	GA	30731	GA	31313	GA	32071	FL
30447	GA	30739	GA	31314	GA	32091	FL
30448	GA	30741	GA	31315	GA	32094	FL
30449	GA	30747	GA	31316	GA	32162	FL
30453	GA	30750	GA	31319	GA	32324	FL
30455	GA	30751	GA	31320	GA	32326	FL
30457	GA	30753	GA	31323	GA	32327	FL
30464	GA	30803	GA	31326	GA	32330	FL
30467	GA	30807	GA	31327	GA	32331	FL
30471	GA	30810	GA	31329	GA	32332	FL
30477	GA	30818	GA	31331	GA	32333	FL
30499	GA	30820	GA	31333	GA	32340	FL
30511	GA	30821	GA	31542	GA	32341	FL
30525	GA	30823	GA	31543	GA	32343	FL

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
32346	FL	35031	AL	35575	AL	36276	AL
32350	FL	35034	AL	35577	AL	36278	AL
32351	FL	35035	AL	35618	AL	36280	AL
32352	FL	35042	AL	35643	AL	36310	AL
32353	FL	35049	AL	35650	AL	36311	AL
32355	FL	35052	AL	35651	AL	36313	AL
32357	FL	35054	AL	35672	AL	36314	AL
32358	FL	35072	AL	35953	AL	36316	AL
32422	FL	35079	AL	35959	AL	36317	AL
32425	FL	35082	AL	35960	AL	36318	AL
32427	FL	35089	AL	35973	AL	36322	AL
32428	FL	35097	AL	35983	AL	36340	AL
32433	FL	35112	AL	35987	AL	36344	AL
32434	FL	35120	AL	36009	AL	36345	AL
32435	FL	35121	AL	36020	AL	36349	AL
32437	FL	35125	AL	36022	AL	36350	AL
32439	FL	35128	AL	36024	AL	36352	AL
32452	FL	35131	AL	36025	AL	36353	AL
32454	FL	35133	AL	36026	AL	36360	AL
32455	FL	35135	AL	36028	AL	36361	AL
32459	FL	35136	AL	36034	AL	36362	AL
32462	FL	35146	AL	36040	AL	36371	AL
32463	FL	35182	AL	36041	AL	36373	AL
32464	FL	35183	AL	36042	AL	36374	AL
32550	FL	35184	AL	36045	AL	36375	AL
32622	FL	35187	AL	36049	AL	36401	AL
32628	FL	35188	AL	36054	AL	36429	AL
32648	FL	35441	AL	36062	AL	36432	AL
32680	FL	35442	AL	36071	AL	36435	AL
32692	FL	35443	AL	36078	AL	36454	AL
33471	FL	35447	AL	36080	AL	36473	AL
33513	FL	35448	AL	36092	AL	36475	AL
33514	FL	35461	AL	36093	AL	36477	AL
33521	FL	35462	AL	36251	AL	36513	AL
33538	FL	35466	AL	36255	AL	36518	AL
33585	FL	35469	AL	36258	AL	36529	AL
33597	FL	35471	AL	36261	AL	36538	AL
33834	FL	35474	AL	36262	AL	36539	AL
33865	FL	35481	AL	36263	AL	36548	AL
33873	FL	35491	AL	36264	AL	36553	AL
33890	FL	35540	AL	36266	AL	36556	AL
33944	FL	35541	AL	36267	AL	36558	AL
34484	FL	35551	AL	36269	AL	36569	AL
34785	FL	35553	AL	36273	AL	36581	AL
35004	AL	35565	AL	36274	AL	36583	AL
35013	AL	35572	AL	36275	AL	36584	AL

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
36585	AL	37301	TN	38001	TN	38472	TN
36720	AL	37305	TN	38006	TN	38473	TN
36721	AL	37313	TN	38008	TN	38477	TN
36722	AL	37339	TN	38010	TN	38478	TN
36723	AL	37352	TN	38012	TN	38549	TN
36726	AL	37356	TN	38021	TN	38562	TN
36728	AL	37365	TN	38034	TN	38564	TN
36740	AL	37366	TN	38036	TN	38585	TN
36741	AL	37387	TN	38037	TN	38588	TN
36744	AL	37640	TN	38039	TN	38602	MS
36751	AL	37642	TN	38040	TN	38603	MS
36753	AL	37645	TN	38041	TN	38606	MS
36756	AL	37650	TN	38042	TN	38609	MS
36765	AL	37657	TN	38044	TN	38610	MS
36766	AL	37680	TN	38045	TN	38611	MS
36768	AL	37683	TN	38046	TN	38618	MS
36769	AL	37688	TN	38048	TN	38619	MS
36776	AL	37691	TN	38050	TN	38620	MS
36786	AL	37692	TN	38052	TN	38621	MS
36792	AL	37707	TN	38057	TN	38622	MS
36793	AL	37711	TN	38060	TN	38623	MS
36904	AL	37715	TN	38061	TN	38625	MS
36906	AL	37724	TN	38063	TN	38626	MS
36908	AL	37726	TN	38066	TN	38628	MS
36910	AL	37730	TN	38067	TN	38629	MS
36912	AL	37731	TN	38068	TN	38632	MS
36913	AL	37752	TN	38069	TN	38633	MS
36915	AL	37765	TN	38074	TN	38634	MS
36916	AL	37770	TN	38075	TN	38635	MS
36919	AL	37773	TN	38076	TN	38637	MS
36921	AL	37779	TN	38311	TN	38638	MS
36922	AL	37807	TN	38329	TN	38641	MS
37015	TN	37811	TN	38332	TN	38642	MS
37025	TN	37824	TN	38336	TN	38643	MS
37033	TN	37825	TN	38337	TN	38646	MS
37035	TN	37829	TN	38340	TN	38647	MS
37082	TN	37851	TN	38347	TN	38649	MS
37083	TN	37857	TN	38352	TN	38651	MS
37096	TN	37866	TN	38363	TN	38654	MS
37097	TN	37867	TN	38374	TN	38658	MS
37098	TN	37869	TN	38380	TN	38659	MS
37137	TN	37870	TN	38381	TN	38661	MS
37140	TN	37872	TN	38449	TN	38663	MS
37143	TN	37873	TN	38454	TN	38664	MS
37146	TN	37879	TN	38455	TN	38665	MS
37150	TN	37887	TN	38460	TN	38666	MS

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
38668	MS	38921	MS	39078	MS	39324	MS
38670	MS	38922	MS	39079	MS	39327	MS
38671	MS	38923	MS	39080	MS	39328	MS
38672	MS	38924	MS	39083	MS	39330	MS
38674	MS	38925	MS	39086	MS	39332	MS
38676	MS	38927	MS	39087	MS	39336	MS
38679	MS	38928	MS	39088	MS	39337	MS
38680	MS	38930	MS	39092	MS	39338	MS
38683	MS	38935	MS	39094	MS	39339	MS
38685	MS	38941	MS	39095	MS	39341	MS
38686	MS	38943	MS	39096	MS	39345	MS
38736	MS	38944	MS	39097	MS	39346	MS
38737	MS	38945	MS	39098	MS	39347	MS
38738	MS	38946	MS	39109	MS	39348	MS
38749	MS	38947	MS	39110	MS	39350	MS
38751	MS	38948	MS	39115	MS	39352	MS
38753	MS	38950	MS	39116	MS	39354	MS
38754	MS	38951	MS	39117	MS	39355	MS
38761	MS	38952	MS	39119	MS	39356	MS
38768	MS	38953	MS	39130	MS	39358	MS
38771	MS	38954	MS	39140	MS	39359	MS
38778	MS	38955	MS	39144	MS	39360	MS
38829	MS	38957	MS	39146	MS	39361	MS
38839	MS	38958	MS	39150	MS	39362	MS
38843	MS	38959	MS	39152	MS	39363	MS
38847	MS	38961	MS	39153	MS	39365	MS
38850	MS	38962	MS	39157	MS	39366	MS
38851	MS	38963	MS	39158	MS	39367	MS
38854	MS	38964	MS	39162	MS	39421	MS
38855	MS	38965	MS	39163	MS	39422	MS
38856	MS	38966	MS	39166	MS	39423	MS
38858	MS	38967	MS	39168	MS	39426	MS
38859	MS	39038	MS	39169	MS	39427	MS
38860	MS	39039	MS	39171	MS	39428	MS
38875	MS	39040	MS	39173	MS	39429	MS
38876	MS	39045	MS	39176	MS	39439	MS
38877	MS	39046	MS	39179	MS	39451	MS
38878	MS	39051	MS	39189	MS	39452	MS
38880	MS	39057	MS	39191	MS	39455	MS
38912	MS	39059	MS	39192	MS	39456	MS
38913	MS	39063	MS	39194	MS	39457	MS
38914	MS	39069	MS	39203	MS	39461	MS
38915	MS	39071	MS	39207	MS	39462	MS
38916	MS	39072	MS	39217	MS	39463	MS
38917	MS	39074	MS	39322	MS	39466	MS
38920	MS	39077	MS	39323	MS	39470	MS

ADDENDUM I- 2005 PRIMARY CARE HPSA ZIP CODES

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
39474	MS	39776	MS	40461	KY	41128	KY
39475	MS	39826	GA	40467	KY	41132	KY
39476	MS	39842	GA	40481	KY	41135	KY
39477	MS	39854	GA	40486	KY	41137	KY
39478	MS	39867	GA	40488	KY	41139	KY
39479	MS	39870	GA	40701	KY	41141	KY
39481	MS	39877	GA	40702	KY	41142	KY
39482	MS	40006	KY	40730	KY	41143	KY
39483	MS	40007	KY	40734	KY	41144	KY
39520	MS	40011	KY	40754	KY	41146	KY
39521	MS	40019	KY	40759	KY	41149	KY
39522	MS	40036	KY	40763	KY	41156	KY
39525	MS	40045	KY	40769	KY	41164	KY
39529	MS	40046	KY	40771	KY	41166	KY
39556	MS	40047	KY	40903	KY	41169	KY
39558	MS	40050	KY	40906	KY	41171	KY
39572	MS	40055	KY	40915	KY	41173	KY
39576	MS	40057	KY	40921	KY	41174	KY
39630	MS	40058	KY	40923	KY	41175	KY
39641	MS	40068	KY	40930	KY	41179	KY
39643	MS	40070	KY	40935	KY	41181	KY
39647	MS	40071	KY	40943	KY	41183	KY
39653	MS	40075	KY	40946	KY	41189	KY
39654	MS	40109	KY	40949	KY	41203	KY
39656	MS	40110	KY	40953	KY	41214	KY
39661	MS	40150	KY	40982	KY	41224	KY
39663	MS	40165	KY	40995	KY	41231	KY
39665	MS	40311	KY	40997	KY	41250	KY
39667	MS	40312	KY	40999	KY	41262	KY
39668	MS	40316	KY	41002	KY	41267	KY
39735	MS	40322	KY	41004	KY	41307	KY
39737	MS	40346	KY	41006	KY	41310	KY
39739	MS	40350	KY	41008	KY	41314	KY
39741	MS	40355	KY	41033	KY	41317	KY
39744	MS	40359	KY	41040	KY	41338	KY
39745	MS	40363	KY	41043	KY	41339	KY
39747	MS	40376	KY	41044	KY	41344	KY
39750	MS	40380	KY	41045	KY	41348	KY
39751	MS	40387	KY	41046	KY	41351	KY
39752	MS	40402	KY	41061	KY	41364	KY
39754	MS	40410	KY	41064	KY	41366	KY
39755	MS	40421	KY	41083	KY	41385	KY
39767	MS	40434	KY	41086	KY	41386	KY
39771	MS	40444	KY	41095	KY	41390	KY
39772	MS	40446	KY	41098	KY	41410	KY
39773	MS	40447	KY	41121	KY	41419	KY

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
41422	KY	42323	KY	42765	KY	45618	OH
41426	KY	42324	KY	43030	OH	45619	OH
41433	KY	42325	KY	43076	OH	45622	OH
41464	KY	42326	KY	43721	OH	45634	OH
41465	KY	42327	KY	43728	OH	45638	OH
41632	KY	42328	KY	43730	OH	45645	OH
42021	KY	42330	KY	43731	OH	45650	OH
42022	KY	42332	KY	43738	OH	45651	OH
42023	KY	42333	KY	43739	OH	45654	OH
42024	KY	42337	KY	43748	OH	45659	OH
42031	KY	42338	KY	43756	OH	45660	OH
42032	KY	42339	KY	43758	OH	45669	OH
42035	KY	42343	KY	43760	OH	45672	OH
42056	KY	42344	KY	43761	OH	45675	OH
42070	KY	42345	KY	43764	OH	45678	OH
42087	KY	42347	KY	43766	OH	45679	OH
42120	KY	42348	KY	43782	OH	45680	OH
42124	KY	42349	KY	43783	OH	45684	OH
42129	KY	42350	KY	43787	OH	45688	OH
42134	KY	42351	KY	43789	OH	45693	OH
42135	KY	42352	KY	43915	OH	45695	OH
42150	KY	42354	KY	44076	OH	45696	OH
42153	KY	42361	KY	44085	OH	45697	OH
42154	KY	42364	KY	44615	OH	45698	OH
42163	KY	42367	KY	44620	OH	45734	OH
42164	KY	42368	KY	44631	OH	45813	OH
42166	KY	42369	KY	44644	OH	45821	OH
42203	KY	42370	KY	44651	OH	45849	OH
42204	KY	42371	KY	44675	OH	45851	OH
42207	KY	42372	KY	45070	OH	45855	OH
42210	KY	42374	KY	45105	OH	45861	OH
42211	KY	42516	KY	45144	OH	45873	OH
42214	KY	42528	KY	45157	OH	45879	OH
42215	KY	42539	KY	45160	OH	45880	OH
42216	KY	42541	KY	45311	OH	46349	IN
42220	KY	42565	KY	45320	OH	46366	IN
42234	KY	42566	KY	45321	OH	46374	IN
42257	KY	42713	KY	45330	OH	46379	IN
42259	KY	42716	KY	45338	OH	46381	IN
42275	KY	42722	KY	45347	OH	46404	IN
42280	KY	42729	KY	45378	OH	46531	IN
42285	KY	42746	KY	45381	OH	46532	IN
42286	KY	42748	KY	45382	OH	46534	IN
42320	KY	42749	KY	45417	OH	46565	IN
42321	KY	42757	KY	45428	OH	46571	IN
42322	KY	42764	KY	45616	OH	46701	IN

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
46710	IN	47368	IN	47970	IN	49657	MI
46732	IN	47380	IN	47971	IN	49665	MI
46746	IN	47382	IN	47975	IN	49667	MI
46755	IN	47390	IN	47982	IN	49677	MI
46760	IN	47394	IN	47984	IN	49679	MI
46761	IN	47427	IN	47986	IN	49688	MI
46763	IN	47431	IN	47987	IN	49709	MI
46767	IN	47433	IN	47988	IN	49743	MI
46771	IN	47456	IN	47991	IN	49746	MI
46784	IN	47460	IN	47993	IN	49756	MI
46786	IN	47501	IN	48617	MI	49759	MI
46789	IN	47519	IN	48619	MI	49765	MI
46794	IN	47529	IN	48621	MI	49776	MI
46795	IN	47558	IN	48622	MI	49777	MI
46796	IN	47562	IN	48625	MI	49779	MI
47010	IN	47564	IN	48632	MI	49853	MI
47011	IN	47567	IN	48633	MI	49868	MI
47012	IN	47568	IN	48636	MI	50002	IA
47016	IN	47585	IN	48647	MI	50040	IA
47020	IN	47590	IN	48705	MI	50104	IA
47024	IN	47598	IN	48721	MI	50136	IA
47030	IN	47830	IN	48728	MI	50173	IA
47036	IN	47832	IN	48737	MI	50249	IA
47038	IN	47836	IN	48738	MI	50255	IA
47043	IN	47856	IN	48740	MI	50268	IA
47116	IN	47859	IN	48742	MI	50423	IA
47118	IN	47860	IN	48745	MI	50426	IA
47123	IN	47862	IN	48762	MI	50430	IA
47137	IN	47868	IN	49304	MI	50432	IA
47140	IN	47872	IN	49420	MI	50438	IA
47145	IN	47874	IN	49421	MI	50439	IA
47174	IN	47917	IN	49436	MI	50447	IA
47175	IN	47918	IN	49446	MI	50449	IA
47223	IN	47921	IN	49449	MI	50451	IA
47227	IN	47922	IN	49452	MI	50454	IA
47245	IN	47932	IN	49455	MI	50455	IA
47265	IN	47942	IN	49459	MI	50460	IA
47270	IN	47944	IN	49623	MI	50461	IA
47273	IN	47948	IN	49631	MI	50472	IA
47282	IN	47949	IN	49632	MI	50476	IA
47340	IN	47951	IN	49639	MI	50480	IA
47348	IN	47952	IN	49642	MI	50481	IA
47354	IN	47958	IN	49644	MI	50483	IA
47355	IN	47963	IN	49651	MI	50484	IA
47358	IN	47964	IN	49655	MI	50511	IA
47359	IN	47969	IN	49656	MI	50517	IA

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
50521	IA	50680	IA	52342	IA	54420	WI
50522	IA	50682	IA	52345	IA	54421	WI
50530	IA	50833	IA	52346	IA	54422	WI
50535	IA	50836	IA	52348	IA	54425	WI
50538	IA	50837	IA	52349	IA	54436	WI
50539	IA	50840	IA	52351	IA	54437	WI
50543	IA	50846	IA	52354	IA	54446	WI
50544	IA	50848	IA	52355	IA	54456	WI
50551	IA	50849	IA	52537	IA	54460	WI
50552	IA	50851	IA	52550	IA	54485	WI
50556	IA	50858	IA	52552	IA	54493	WI
50559	IA	50862	IA	52560	IA	54498	WI
50560	IA	51004	IA	52562	IA	54511	WI
50567	IA	51039	IA	52563	IA	54520	WI
50579	IA	51044	IA	52568	IA	54527	WI
50583	IA	51053	IA	52576	IA	54541	WI
50586	IA	51433	IA	52584	IA	54542	WI
50590	IA	51449	IA	52585	IA	54566	WI
50598	IA	51450	IA	52591	IA	54613	WI
50602	IA	51451	IA	52640	IA	54634	WI
50604	IA	51453	IA	52646	IA	54721	WI
50605	IA	51458	IA	52653	IA	54725	WI
50607	IA	51466	IA	52737	IA	54726	WI
50608	IA	51575	IA	52738	IA	54733	WI
50611	IA	51646	IA	52752	IA	54736	WI
50612	IA	52206	IA	52754	IA	54737	WI
50619	IA	52208	IA	52777	IA	54740	WI
50625	IA	52209	IA	53541	WI	54746	WI
50629	IA	52210	IA	53587	WI	54756	WI
50632	IA	52215	IA	53910	WI	54759	WI
50635	IA	52217	IA	53920	WI	54761	WI
50636	IA	52224	IA	53927	WI	54762	WI
50641	IA	52225	IA	53930	WI	54763	WI
50642	IA	52229	IA	53934	WI	54769	WI
50644	IA	52231	IA	53936	WI	54771	WI
50648	IA	52248	IA	53939	WI	54772	WI
50649	IA	52249	IA	53947	WI	54821	WI
50650	IA	52257	IA	53949	WI	54828	WI
50652	IA	52313	IA	53952	WI	54830	WI
50660	IA	52315	IA	53953	WI	54840	WI
50664	IA	52318	IA	53964	WI	54843	WI
50665	IA	52326	IA	54103	WI	54845	WI
50670	IA	52329	IA	54120	WI	54862	WI
50671	IA	52332	IA	54121	WI	54867	WI
50673	IA	52335	IA	54149	WI	54872	WI
50675	IA	52339	IA	54405	WI	54893	WI

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
54930	WI	56446	MN	56655	MN	57213	SD
54943	WI	56452	MN	56660	MN	57214	SD
54960	WI	56453	MN	56662	MN	57217	SD
54965	WI	56458	MN	56672	MN	57218	SD
54966	WI	56461	MN	56676	MN	57219	SD
54967	WI	56467	MN	56678	MN	57221	SD
54970	WI	56470	MN	56688	MN	57223	SD
54976	WI	56473	MN	56710	MN	57225	SD
54982	WI	56474	MN	56713	MN	57226	SD
54984	WI	56479	MN	56720	MN	57231	SD
55604	MN	56484	MN	56724	MN	57233	SD
55605	MN	56510	MN	56727	MN	57234	SD
55606	MN	56514	MN	56728	MN	57236	SD
55612	MN	56516	MN	56729	MN	57237	SD
55613	MN	56518	MN	56731	MN	57238	SD
55615	MN	56519	MN	56732	MN	57239	SD
55702	MN	56524	MN	56733	MN	57241	SD
55703	MN	56525	MN	56734	MN	57242	SD
55781	MN	56527	MN	56735	MN	57246	SD
55785	MN	56528	MN	56737	MN	57248	SD
56009	MN	56534	MN	56738	MN	57249	SD
56020	MN	56541	MN	56740	MN	57258	SD
56032	MN	56545	MN	56744	MN	57261	SD
56042	MN	56548	MN	56755	MN	57268	SD
56051	MN	56549	MN	56757	MN	57271	SD
56097	MN	56550	MN	56758	MN	57273	SD
56114	MN	56551	MN	56760	MN	57274	SD
56122	MN	56557	MN	56762	MN	57278	SD
56123	MN	56566	MN	57013	SD	57321	SD
56125	MN	56571	MN	57014	SD	57323	SD
56131	MN	56574	MN	57015	SD	57329	SD
56141	MN	56576	MN	57021	SD	57337	SD
56151	MN	56581	MN	57027	SD	57342	SD
56172	MN	56584	MN	57032	SD	57345	SD
56178	MN	56587	MN	57034	SD	57346	SD
56318	MN	56588	MN	57036	SD	57349	SD
56336	MN	56621	MN	57039	SD	57353	SD
56347	MN	56626	MN	57043	SD	57356	SD
56389	MN	56628	MN	57047	SD	57361	SD
56430	MN	56633	MN	57051	SD	57365	SD
56433	MN	56634	MN	57053	SD	57367	SD
56435	MN	56639	MN	57064	SD	57369	SD
56436	MN	56641	MN	57070	SD	57380	SD
56437	MN	56644	MN	57077	SD	57422	SD
56438	MN	56651	MN	57108	SD	57428	SD
56440	MN	56652	MN	57212	SD	57435	SD

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
57438	SD	57657	SD	58341	ND	58482	ND
57448	SD	57661	SD	58343	ND	58484	ND
57451	SD	57716	SD	58344	ND	58486	ND
57466	SD	57720	SD	58346	ND	58487	ND
57468	SD	57724	SD	58348	ND	58488	ND
57470	SD	57735	SD	58351	ND	58490	ND
57471	SD	57747	SD	58352	ND	58523	ND
57473	SD	57750	SD	58353	ND	58524	ND
57521	SD	57752	SD	58355	ND	58528	ND
57531	SD	57755	SD	58356	ND	58529	ND
57540	SD	57756	SD	58357	ND	58530	ND
57542	SD	57763	SD	58361	ND	58531	ND
57543	SD	57764	SD	58366	ND	58533	ND
57544	SD	57766	SD	58367	ND	58538	ND
57547	SD	57770	SD	58369	ND	58540	ND
57548	SD	57772	SD	58370	ND	58541	ND
57552	SD	57776	SD	58372	ND	58542	ND
57553	SD	57782	SD	58374	ND	58544	ND
57555	SD	57794	SD	58379	ND	58545	ND
57559	SD	58013	ND	58380	ND	58549	ND
57560	SD	58017	ND	58381	ND	58552	ND
57562	SD	58032	ND	58386	ND	58559	ND
57563	SD	58040	ND	58415	ND	58561	ND
57566	SD	58043	ND	58416	ND	58562	ND
57567	SD	58058	ND	58418	ND	58564	ND
57568	SD	58060	ND	58422	ND	58565	ND
57569	SD	58067	ND	58423	ND	58566	ND
57570	SD	58069	ND	58425	ND	58568	ND
57572	SD	58212	ND	58428	ND	58569	ND
57576	SD	58224	ND	58430	ND	58570	ND
57577	SD	58239	ND	58431	ND	58571	ND
57579	SD	58249	ND	58433	ND	58573	ND
57585	SD	58254	ND	58438	ND	58575	ND
57620	SD	58255	ND	58440	ND	58576	ND
57625	SD	58259	ND	58442	ND	58577	ND
57630	SD	58260	ND	58444	ND	58579	ND
57632	SD	58269	ND	58448	ND	58580	ND
57633	SD	58272	ND	58451	ND	58620	ND
57636	SD	58281	ND	58452	ND	58621	ND
57644	SD	58311	ND	58454	ND	58625	ND
57646	SD	58316	ND	58456	ND	58626	ND
57648	SD	58319	ND	58458	ND	58627	ND
57650	SD	58323	ND	58463	ND	58632	ND
57651	SD	58329	ND	58466	ND	58634	ND
57652	SD	58332	ND	58475	ND	58636	ND
57656	SD	58335	ND	58478	ND	58640	ND

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
58642	ND	58838	ND	59223	MT	59462	MT
58643	ND	58844	ND	59225	MT	59467	MT
58645	ND	58847	ND	59230	MT	59469	MT
58646	ND	58849	ND	59231	MT	59479	MT
58647	ND	58852	ND	59240	MT	59524	MT
58650	ND	58854	ND	59241	MT	59537	MT
58654	ND	59011	MT	59242	MT	59538	MT
58710	ND	59016	MT	59244	MT	59544	MT
58712	ND	59018	MT	59247	MT	59546	MT
58713	ND	59020	MT	59248	MT	59631	MT
58716	ND	59022	MT	59250	MT	59632	MT
58721	ND	59025	MT	59252	MT	59634	MT
58723	ND	59027	MT	59253	MT	59638	MT
58727	ND	59029	MT	59254	MT	59641	MT
58730	ND	59030	MT	59256	MT	59643	MT
58731	ND	59031	MT	59257	MT	59644	MT
58734	ND	59033	MT	59258	MT	59647	MT
58736	ND	59034	MT	59259	MT	59710	MT
58737	ND	59035	MT	59260	MT	59713	MT
58741	ND	59046	MT	59261	MT	59721	MT
58744	ND	59047	MT	59263	MT	59722	MT
58747	ND	59050	MT	59273	MT	59728	MT
58752	ND	59052	MT	59274	MT	59729	MT
58757	ND	59054	MT	59275	MT	59731	MT
58758	ND	59055	MT	59276	MT	59733	MT
58759	ND	59058	MT	59314	MT	59740	MT
58760	ND	59059	MT	59315	MT	59745	MT
58761	ND	59062	MT	59317	MT	59747	MT
58765	ND	59065	MT	59318	MT	59749	MT
58768	ND	59066	MT	59319	MT	59759	MT
58769	ND	59072	MT	59322	MT	59820	MT
58771	ND	59073	MT	59326	MT	59830	MT
58772	ND	59074	MT	59330	MT	59831	MT
58773	ND	59075	MT	59337	MT	59832	MT
58775	ND	59077	MT	59339	MT	59837	MT
58776	ND	59081	MT	59341	MT	59842	MT
58778	ND	59082	MT	59343	MT	59843	MT
58787	ND	59084	MT	59345	MT	59844	MT
58788	ND	59086	MT	59349	MT	59845	MT
58789	ND	59087	MT	59411	MT	59848	MT
58790	ND	59089	MT	59417	MT	59853	MT
58792	ND	59211	MT	59419	MT	59854	MT
58794	ND	59214	MT	59427	MT	59856	MT
58831	ND	59215	MT	59434	MT	59858	MT
58833	ND	59219	MT	59447	MT	59859	MT
58835	ND	59222	MT	59452	MT	59866	MT

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
59867	MT	62023	IL	62649	IL	62954	IL
59872	MT	62033	IL	62655	IL	62967	IL
59873	MT	62036	IL	62663	IL	62972	IL
59874	MT	62045	IL	62664	IL	62979	IL
60628	IL	62047	IL	62667	IL	62983	IL
61014	IL	62053	IL	62672	IL	62984	IL
61046	IL	62065	IL	62674	IL	62985	IL
61051	IL	62069	IL	62682	IL	62995	IL
61053	IL	62070	IL	62683	IL	62999	IL
61074	IL	62079	IL	62685	IL	63012	MO
61078	IL	62080	IL	62690	IL	63016	MO
61085	IL	62085	IL	62691	IL	63019	MO
61285	IL	62088	IL	62694	IL	63048	MO
61318	IL	62093	IL	62805	IL	63050	MO
61418	IL	62204	IL	62812	IL	63051	MO
61421	IL	62205	IL	62817	IL	63065	MO
61424	IL	62353	IL	62819	IL	63066	MO
61425	IL	62375	IL	62822	IL	63070	MO
61426	IL	62378	IL	62825	IL	63071	MO
61437	IL	62418	IL	62828	IL	63342	MO
61449	IL	62428	IL	62829	IL	63357	MO
61454	IL	62432	IL	62836	IL	63378	MO
61460	IL	62436	IL	62838	IL	63383	MO
61469	IL	62447	IL	62840	IL	63390	MO
61471	IL	62448	IL	62856	IL	63430	MO
61479	IL	62458	IL	62857	IL	63445	MO
61480	IL	62459	IL	62859	IL	63453	MO
61483	IL	62468	IL	62860	IL	63465	MO
61491	IL	62471	IL	62865	IL	63466	MO
61532	IL	62475	IL	62867	IL	63472	MO
61546	IL	62479	IL	62871	IL	63474	MO
61567	IL	62480	IL	62874	IL	63544	MO
61917	IL	62481	IL	62880	IL	63545	MO
61924	IL	62610	IL	62884	IL	63551	MO
61932	IL	62611	IL	62885	IL	63556	MO
61933	IL	62612	IL	62890	IL	63560	MO
61940	IL	62617	IL	62891	IL	63565	MO
61944	IL	62618	IL	62896	IL	63566	MO
61949	IL	62621	IL	62897	IL	63567	MO
61955	IL	62622	IL	62908	IL	63622	MO
62006	IL	62626	IL	62909	IL	63630	MO
62009	IL	62627	IL	62912	IL	63631	MO
62011	IL	62630	IL	62923	IL	63632	MO
62012	IL	62633	IL	62934	IL	63648	MO
62013	IL	62640	IL	62939	IL	63660	MO
62014	IL	62644	IL	62943	IL	63662	MO

ADDENDUM I- 2005 PRIMARY CARE HPSA ZIP CODES

2005 Primary Care HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
63664	MO	63964	MO	64779	MO	65661	MO
63674	MO	63965	MO	64780	MO	65666	MO
63750	MO	63966	MO	65013	MO	65676	MO
63751	MO	63967	MO	65017	MO	65682	MO
63760	MO	64421	MO	65026	MO	65685	MO
63763	MO	64424	MO	65031	MO	65690	MO
63764	MO	64426	MO	65047	MO	65692	MO
63781	MO	64427	MO	65064	MO	65715	MO
63782	MO	64436	MO	65075	MO	65729	MO
63787	MO	64437	MO	65082	MO	65741	MO
63821	MO	64442	MO	65083	MO	65752	MO
63828	MO	64449	MO	65325	MO	65755	MO
63829	MO	64451	MO	65326	MO	65760	MO
63833	MO	64458	MO	65335	MO	65761	MO
63837	MO	64459	MO	65338	MO	65762	MO
63847	MO	64466	MO	65355	MO	65764	MO
63848	MO	64467	MO	65438	MO	65766	MO
63852	MO	64470	MO	65443	MO	65767	MO
63855	MO	64471	MO	65452	MO	65768	MO
63857	MO	64473	MO	65457	MO	65773	MO
63860	MO	64480	MO	65459	MO	65778	MO
63862	MO	64481	MO	65466	MO	65783	MO
63863	MO	64483	MO	65473	MO	65784	MO
63866	MO	64485	MO	65486	MO	65791	MO
63867	MO	64622	MO	65534	MO	66008	KS
63868	MO	64623	MO	65546	MO	66010	KS
63869	MO	64632	MO	65556	MO	66017	KS
63870	MO	64633	MO	65572	MO	66024	KS
63873	MO	64639	MO	65580	MO	66035	KS
63874	MO	64642	MO	65582	MO	66040	KS
63875	MO	64643	MO	65583	MO	66054	KS
63876	MO	64645	MO	65584	MO	66056	KS
63878	MO	64646	MO	65588	MO	66060	KS
63880	MO	64655	MO	65590	MO	66066	KS
63933	MO	64667	MO	65603	MO	66070	KS
63934	MO	64668	MO	65606	MO	66072	KS
63937	MO	64672	MO	65608	MO	66073	KS
63941	MO	64680	MO	65609	MO	66075	KS
63943	MO	64682	MO	65618	MO	66087	KS
63944	MO	64720	MO	65622	MO	66088	KS
63950	MO	64722	MO	65635	MO	66090	KS
63951	MO	64723	MO	65637	MO	66094	KS
63952	MO	64730	MO	65638	MO	66097	KS
63956	MO	64742	MO	65644	MO	66413	KS
63957	MO	64745	MO	65646	MO	66414	KS
63963	MO	64752	MO	65655	MO	66429	KS

ADDENDUM I- 2005 PRIMARY CARE HPSA ZIP CODES

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
66451	KS	67346	KS	67857	KS	68736	NE
66510	KS	67349	KS	67861	KS	68739	NE
66512	KS	67352	KS	67863	KS	68745	NE
66523	KS	67353	KS	67864	KS	68749	NE
66524	KS	67355	KS	67869	KS	68751	NE
66528	KS	67360	KS	67870	KS	68753	NE
66537	KS	67361	KS	67877	KS	68757	NE
66543	KS	67418	KS	67878	KS	68759	NE
66713	KS	67423	KS	67951	KS	68768	NE
66725	KS	67437	KS	67952	KS	68770	NE
66728	KS	67455	KS	68003	NE	68771	NE
66739	KS	67473	KS	68015	NE	68774	NE
66767	KS	67474	KS	68016	NE	68778	NE
66770	KS	67481	KS	68017	NE	68779	NE
66773	KS	67519	KS	68018	NE	68784	NE
66778	KS	67523	KS	68033	NE	68785	NE
66781	KS	67529	KS	68037	NE	68792	NE
66782	KS	67547	KS	68040	NE	68816	NE
66843	KS	67550	KS	68041	NE	68821	NE
66845	KS	67552	KS	68042	NE	68826	NE
66850	KS	67563	KS	68048	NE	68827	NE
66862	KS	67574	KS	68050	NE	68833	NE
66869	KS	67621	KS	68058	NE	68864	NE
66936	KS	67623	KS	68065	NE	68920	NE
66941	KS	67632	KS	68066	NE	68924	NE
66942	KS	67639	KS	68070	NE	68945	NE
66949	KS	67644	KS	68073	NE	68959	NE
66956	KS	67646	KS	68304	NE	68966	NE
66963	KS	67647	KS	68307	NE	68969	NE
66970	KS	67651	KS	68347	NE	68971	NE
67024	KS	67657	KS	68349	NE	68977	NE
67029	KS	67661	KS	68366	NE	68982	NE
67035	KS	67663	KS	68403	NE	69024	NE
67054	KS	67664	KS	68407	NE	69032	NE
67059	KS	67669	KS	68409	NE	69040	NE
67068	KS	67675	KS	68413	NE	69043	NE
67109	KS	67730	KS	68455	NE	69044	NE
67111	KS	67731	KS	68463	NE	69121	NE
67112	KS	67739	KS	68628	NE	69125	NE
67118	KS	67744	KS	68648	NE	69128	NE
67127	KS	67745	KS	68663	NE	69133	NE
67142	KS	67756	KS	68710	NE	69135	NE
67155	KS	67836	KS	68717	NE	69145	NE
67159	KS	67844	KS	68727	NE	69147	NE
67334	KS	67849	KS	68728	NE	69148	NE
67345	KS	67854	KS	68732	NE	69154	NE

ADDENDUM I- 2005 PRIMARY CARE HPSA ZIP CODES

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
69157	NE	70510	LA	71030	LA	71276	LA
69190	NE	70511	LA	71032	LA	71277	LA
69210	NE	70528	LA	71034	LA	71282	LA
69214	NE	70533	LA	71036	LA	71284	LA
69217	NE	70542	LA	71039	LA	71286	LA
69331	NE	70548	LA	71043	LA	71316	LA
69334	NE	70555	LA	71045	LA	71320	LA
69335	NE	70575	LA	71046	LA	71322	LA
69336	NE	70631	LA	71049	LA	71323	LA
69340	NE	70632	LA	71050	LA	71326	LA
69343	NE	70639	LA	71052	LA	71327	LA
69345	NE	70643	LA	71055	LA	71329	LA
69347	NE	70645	LA	71058	LA	71330	LA
69351	NE	70656	LA	71063	LA	71331	LA
69360	NE	70659	LA	71065	LA	71333	LA
69365	NE	70711	LA	71068	LA	71334	LA
70030	LA	70715	LA	71070	LA	71339	LA
70031	LA	70732	LA	71071	LA	71341	LA
70032	LA	70736	LA	71072	LA	71342	LA
70039	LA	70747	LA	71073	LA	71350	LA
70043	LA	70749	LA	71075	LA	71351	LA
70044	LA	70752	LA	71078	LA	71354	LA
70047	LA	70753	LA	71080	LA	71355	LA
70057	LA	70754	LA	71222	LA	71357	LA
70070	LA	70755	LA	71226	LA	71362	LA
70075	LA	70756	LA	71227	LA	71366	LA
70078	LA	70759	LA	71233	LA	71369	LA
70079	LA	70760	LA	71234	LA	71371	LA
70080	LA	70762	LA	71235	LA	71373	LA
70085	LA	70773	LA	71237	LA	71375	LA
70087	LA	70783	LA	71241	LA	71403	LA
70090	LA	70813	LA	71242	LA	71404	LA
70092	LA	71001	LA	71245	LA	71406	LA
70127	LA	71002	LA	71247	LA	71407	LA
70128	LA	71004	LA	71251	LA	71410	LA
70187	LA	71008	LA	71253	LA	71417	LA
70339	LA	71016	LA	71254	LA	71419	LA
70341	LA	71018	LA	71256	LA	71422	LA
70355	LA	71019	LA	71260	LA	71423	LA
70372	LA	71021	LA	71263	LA	71426	LA
70375	LA	71023	LA	71266	LA	71429	LA
70390	LA	71024	LA	71268	LA	71432	LA
70391	LA	71025	LA	71270	LA	71439	LA
70393	LA	71027	LA	71272	LA	71440	LA
70441	LA	71028	LA	71273	LA	71443	LA
70453	LA	71029	LA	71275	LA	71446	LA

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
71449	LA	72001	AR	72640	AR	73460	OK
71454	LA	72013	AR	72641	AR	73461	OK
71459	LA	72016	AR	72645	AR	73531	OK
71460	LA	72017	AR	72648	AR	73562	OK
71461	LA	72025	AR	72650	AR	73568	OK
71462	LA	72028	AR	72655	AR	73572	OK
71465	LA	72031	AR	72666	AR	73628	OK
71467	LA	72040	AR	72669	AR	73638	OK
71473	LA	72041	AR	72670	AR	73642	OK
71474	LA	72057	AR	72675	AR	73650	OK
71475	LA	72064	AR	72683	AR	73660	OK
71479	LA	72066	AR	72685	AR	73666	OK
71480	LA	72070	AR	72686	AR	73716	OK
71483	LA	72083	AR	72721	AR	73719	OK
71486	LA	72084	AR	72738	AR	73722	OK
71496	LA	72088	AR	72740	AR	73726	OK
71643	AR	72125	AR	72742	AR	73728	OK
71644	AR	72126	AR	72749	AR	73739	OK
71652	AR	72128	AR	72752	AR	73741	OK
71659	AR	72129	AR	72760	AR	73749	OK
71660	AR	72141	AR	72773	AR	73758	OK
71665	AR	72150	AR	72776	AR	73759	OK
71667	AR	72152	AR	72827	AR	73761	OK
71678	AR	72153	AR	72828	AR	73766	OK
71722	AR	72170	AR	72841	AR	73771	OK
71744	AR	72322	AR	72856	AR	73834	OK
71745	AR	72324	AR	72924	AR	73848	OK
71766	AR	72326	AR	72926	AR	73851	OK
71826	AR	72335	AR	72944	AR	73855	OK
71827	AR	72336	AR	72950	AR	74026	OK
71828	AR	72340	AR	72958	AR	74027	OK
71835	AR	72346	AR	73027	OK	74042	OK
71844	AR	72347	AR	73028	OK	74048	OK
71845	AR	72348	AR	73044	OK	74072	OK
71857	AR	72359	AR	73050	OK	74079	OK
71858	AR	72372	AR	73056	OK	74083	OK
71860	AR	72373	AR	73058	OK	74110	OK
71864	AR	72387	AR	73063	OK	74130	OK
71935	AR	72392	AR	73073	OK	74359	OK
71957	AR	72394	AR	73432	OK	74368	OK
71960	AR	72396	AR	73439	OK	74440	OK
71961	AR	72624	AR	73440	OK	74462	OK
71965	AR	72628	AR	73446	OK	74472	OK
71969	AR	72629	AR	73447	OK	74525	OK
71970	AR	72636	AR	73450	OK	74530	OK
71973	AR	72639	AR	73455	OK	74531	OK

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
74533	OK	75169	TX	75657	TX	76009	TX
74534	OK	75412	TX	75658	TX	76028	TX
74535	OK	75413	TX	75667	TX	76031	TX
74538	OK	75415	TX	75668	TX	76033	TX
74540	OK	75417	TX	75669	TX	76044	TX
74549	OK	75418	TX	75680	TX	76050	TX
74552	OK	75426	TX	75681	TX	76058	TX
74555	OK	75432	TX	75682	TX	76059	TX
74556	OK	75436	TX	75683	TX	76061	TX
74558	OK	75438	TX	75684	TX	76084	TX
74567	OK	75439	TX	75685	TX	76093	TX
74569	OK	75440	TX	75687	TX	76097	TX
74570	OK	75441	TX	75689	TX	76351	TX
74572	OK	75443	TX	75691	TX	76366	TX
74577	OK	75446	TX	75754	TX	76370	TX
74636	OK	75447	TX	75755	TX	76379	TX
74643	OK	75448	TX	75790	TX	76389	TX
74748	OK	75449	TX	75797	TX	76424	TX
74824	OK	75450	TX	75831	TX	76429	TX
74827	OK	75452	TX	75833	TX	76430	TX
74829	OK	75469	TX	75834	TX	76435	TX
74832	OK	75472	TX	75845	TX	76437	TX
74833	OK	75475	TX	75846	TX	76445	TX
74834	OK	75476	TX	75850	TX	76448	TX
74836	OK	75479	TX	75852	TX	76454	TX
74839	OK	75488	TX	75855	TX	76464	TX
74848	OK	75490	TX	75856	TX	76466	TX
74850	OK	75492	TX	75862	TX	76470	TX
74855	OK	75550	TX	75865	TX	76471	TX
74856	OK	75554	TX	75926	TX	76518	TX
74859	OK	75564	TX	75929	TX	76519	TX
74860	OK	75568	TX	75930	TX	76520	TX
74864	OK	75571	TX	75931	TX	76522	TX
74869	OK	75631	TX	75934	TX	76523	TX
74875	OK	75633	TX	75936	TX	76525	TX
74880	OK	75636	TX	75938	TX	76526	TX
74881	OK	75637	TX	75939	TX	76528	TX
74883	OK	75638	TX	75942	TX	76538	TX
74941	OK	75639	TX	75947	TX	76556	TX
74943	OK	75640	TX	75948	TX	76558	TX
74944	OK	75643	TX	75959	TX	76561	TX
74957	OK	75644	TX	75960	TX	76566	TX
75103	TX	75645	TX	75968	TX	76567	TX
75117	TX	75652	TX	75972	TX	76570	TX
75127	TX	75653	TX	75979	TX	76577	TX
75140	TX	75654	TX	75990	TX	76597	TX

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
76598	TX	76937	TX	77582	TX	77993	TX
76599	TX	76941	TX	77585	TX	78001	TX
76629	TX	76943	TX	77597	TX	78003	TX
76632	TX	76945	TX	77616	TX	78005	TX
76656	TX	76949	TX	77624	TX	78007	TX
76661	TX	76950	TX	77625	TX	78008	TX
76680	TX	76951	TX	77656	TX	78009	TX
76685	TX	76953	TX	77657	TX	78011	TX
76820	TX	77011	TX	77659	TX	78012	TX
76821	TX	77306	TX	77660	TX	78014	TX
76824	TX	77326	TX	77661	TX	78016	TX
76828	TX	77327	TX	77663	TX	78017	TX
76832	TX	77328	TX	77664	TX	78019	TX
76834	TX	77331	TX	77665	TX	78021	TX
76837	TX	77332	TX	77836	TX	78022	TX
76841	TX	77335	TX	77837	TX	78026	TX
76842	TX	77350	TX	77838	TX	78039	TX
76844	TX	77351	TX	77850	TX	78050	TX
76845	TX	77359	TX	77852	TX	78052	TX
76848	TX	77360	TX	77853	TX	78055	TX
76849	TX	77364	TX	77855	TX	78056	TX
76854	TX	77368	TX	77856	TX	78057	TX
76855	TX	77369	TX	77857	TX	78059	TX
76856	TX	77371	TX	77859	TX	78060	TX
76859	TX	77374	TX	77863	TX	78061	TX
76861	TX	77376	TX	77864	TX	78062	TX
76862	TX	77399	TX	77865	TX	78063	TX
76864	TX	77418	TX	77867	TX	78064	TX
76865	TX	77423	TX	77870	TX	78065	TX
76866	TX	77445	TX	77871	TX	78066	TX
76869	TX	77452	TX	77872	TX	78067	TX
76870	TX	77466	TX	77878	TX	78071	TX
76871	TX	77473	TX	77879	TX	78072	TX
76873	TX	77474	TX	77882	TX	78075	TX
76874	TX	77476	TX	77950	TX	78076	TX
76875	TX	77485	TX	77957	TX	78102	TX
76877	TX	77514	TX	77960	TX	78104	TX
76878	TX	77519	TX	77961	TX	78107	TX
76880	TX	77533	TX	77962	TX	78111	TX
76882	TX	77535	TX	77963	TX	78113	TX
76883	TX	77538	TX	77969	TX	78114	TX
76884	TX	77547	TX	77970	TX	78116	TX
76888	TX	77560	TX	77971	TX	78117	TX
76930	TX	77561	TX	77978	TX	78118	TX
76933	TX	77564	TX	77990	TX	78119	TX
76936	TX	77575	TX	77991	TX	78121	TX

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
78125	TX	78502	TX	78636	TX	79031	TX
78142	TX	78503	TX	78644	TX	79034	TX
78143	TX	78504	TX	78648	TX	79035	TX
78144	TX	78505	TX	78650	TX	79039	TX
78145	TX	78516	TX	78655	TX	79040	TX
78146	TX	78536	TX	78656	TX	79042	TX
78147	TX	78537	TX	78659	TX	79043	TX
78151	TX	78538	TX	78661	TX	79044	TX
78160	TX	78539	TX	78662	TX	79045	TX
78161	TX	78540	TX	78663	TX	79046	TX
78162	TX	78541	TX	78721	TX	79052	TX
78203	TX	78543	TX	78725	TX	79053	TX
78214	TX	78545	TX	78742	TX	79056	TX
78221	TX	78547	TX	78799	TX	79059	TX
78224	TX	78548	TX	78832	TX	79062	TX
78335	TX	78549	TX	78837	TX	79063	TX
78336	TX	78557	TX	78840	TX	79064	TX
78338	TX	78558	TX	78841	TX	79068	TX
78340	TX	78560	TX	78842	TX	79077	TX
78341	TX	78562	TX	78843	TX	79080	TX
78349	TX	78563	TX	78847	TX	79081	TX
78350	TX	78564	TX	78850	TX	79082	TX
78352	TX	78565	TX	78851	TX	79084	TX
78353	TX	78570	TX	78861	TX	79085	TX
78355	TX	78572	TX	78871	TX	79088	TX
78357	TX	78573	TX	78883	TX	79092	TX
78358	TX	78574	TX	78885	TX	79094	TX
78359	TX	78576	TX	78886	TX	79095	TX
78360	TX	78577	TX	78931	TX	79097	TX
78361	TX	78579	TX	78933	TX	79098	TX
78362	TX	78582	TX	78942	TX	79220	TX
78368	TX	78584	TX	78944	TX	79226	TX
78370	TX	78585	TX	78947	TX	79227	TX
78374	TX	78588	TX	78948	TX	79229	TX
78376	TX	78589	TX	78950	TX	79230	TX
78377	TX	78591	TX	78953	TX	79233	TX
78381	TX	78595	TX	78957	TX	79234	TX
78382	TX	78596	TX	79001	TX	79237	TX
78384	TX	78599	TX	79005	TX	79239	TX
78385	TX	78602	TX	79009	TX	79243	TX
78387	TX	78606	TX	79010	TX	79244	TX
78389	TX	78612	TX	79018	TX	79245	TX
78390	TX	78616	TX	79019	TX	79251	TX
78391	TX	78621	TX	79024	TX	79255	TX
78393	TX	78622	TX	79025	TX	79256	TX
78501	TX	78635	TX	79027	TX	79257	TX

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
79261	TX	79718	TX	80440	CO	81126	CO
79312	TX	79719	TX	80442	CO	81127	CO
79314	TX	79731	TX	80444	CO	81128	CO
79322	TX	79734	TX	80446	CO	81130	CO
79323	TX	79738	TX	80447	CO	81133	CO
79325	TX	79739	TX	80448	CO	81134	CO
79326	TX	79742	TX	80449	CO	81138	CO
79331	TX	79745	TX	80451	CO	81147	CO
79339	TX	79752	TX	80452	CO	81152	CO
79342	TX	79754	TX	80456	CO	81153	CO
79343	TX	79755	TX	80459	CO	81157	CO
79346	TX	79756	TX	80461	CO	81235	CO
79351	TX	79770	TX	80468	CO	81251	CO
79355	TX	79772	TX	80473	CO	81252	CO
79357	TX	79777	TX	80475	CO	81253	CO
79359	TX	79778	TX	80476	CO	81320	CO
79360	TX	79780	TX	80478	CO	81324	CO
79369	TX	79785	TX	80480	CO	81332	CO
79370	TX	79786	TX	80482	CO	81433	CO
79371	TX	79788	TX	80720	CO	82201	WY
79373	TX	79789	TX	80721	CO	82210	WY
79377	TX	79837	TX	80728	CO	82213	WY
79379	TX	79839	TX	80731	CO	82214	WY
79381	TX	79843	TX	80734	CO	82215	WY
79383	TX	79845	TX	80740	CO	82222	WY
79501	TX	79846	TX	80743	CO	82224	WY
79502	TX	79847	TX	80746	CO	82225	WY
79503	TX	79848	TX	80757	CO	82227	WY
79512	TX	79851	TX	80801	CO	82229	WY
79518	TX	79854	TX	80802	CO	82242	WY
79519	TX	79855	TX	80810	CO	82301	WY
79520	TX	79928	TX	80812	CO	82321	WY
79525	TX	80101	CO	80820	CO	82322	WY
79528	TX	80102	CO	80825	CO	82323	WY
79532	TX	80103	CO	80827	CO	82324	WY
79533	TX	80117	CO	80830	CO	82325	WY
79534	TX	80136	CO	80835	CO	82327	WY
79538	TX	80420	CO	80862	CO	82329	WY
79540	TX	80421	CO	81029	CO	82331	WY
79543	TX	80422	CO	81064	CO	82332	WY
79546	TX	80427	CO	81073	CO	82334	WY
79553	TX	80430	CO	81084	CO	82335	WY
79560	TX	80432	CO	81087	CO	82336	WY
79565	TX	80434	CO	81090	CO	82410	WY
79566	TX	80436	CO	81121	CO	82411	WY
79567	TX	80438	CO	81123	CO	82412	WY

ADDENDUM I- 2005 PRIMARY CARE HPSA ZIP CODES

2005 Primary Care HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
82420	WY	83227	ID	83466	ID	84034	UT
82421	WY	83228	ID	83467	ID	84035	UT
82422	WY	83229	ID	83468	ID	84038	UT
82423	WY	83232	ID	83469	ID	84039	UT
82426	WY	83237	ID	83546	ID	84046	UT
82428	WY	83246	ID	83601	ID	84050	UT
82431	WY	83253	ID	83602	ID	84055	UT
82432	WY	83263	ID	83604	ID	84061	UT
82434	WY	83283	ID	83610	ID	84063	UT
82441	WY	83286	ID	83612	ID	84064	UT
82633	WY	83322	ID	83619	ID	84069	UT
82637	WY	83324	ID	83622	ID	84071	UT
82701	WY	83325	ID	83623	ID	84074	UT
82710	WY	83327	ID	83624	ID	84076	UT
82711	WY	83335	ID	83627	ID	84078	UT
82712	WY	83337	ID	83628	ID	84079	UT
82714	WY	83338	ID	83629	ID	84080	UT
82715	WY	83349	ID	83631	ID	84083	UT
82720	WY	83352	ID	83632	ID	84085	UT
82721	WY	83420	ID	83633	ID	84086	UT
82723	WY	83421	ID	83637	ID	84510	UT
82729	WY	83422	ID	83639	ID	84511	UT
82730	WY	83423	ID	83643	ID	84512	UT
82901	WY	83424	ID	83645	ID	84513	UT
82902	WY	83425	ID	83647	ID	84516	UT
82922	WY	83429	ID	83648	ID	84518	UT
82923	WY	83431	ID	83650	ID	84521	UT
82925	WY	83433	ID	83654	ID	84522	UT
82929	WY	83434	ID	83655	ID	84523	UT
82930	WY	83435	ID	83661	ID	84525	UT
82931	WY	83436	ID	83666	ID	84528	UT
82932	WY	83438	ID	83672	ID	84530	UT
82933	WY	83442	ID	83805	ID	84531	UT
82934	WY	83443	ID	83809	ID	84533	UT
82935	WY	83444	ID	83813	ID	84534	UT
82936	WY	83445	ID	83826	ID	84535	UT
82937	WY	83446	ID	83845	ID	84536	UT
82938	WY	83447	ID	83847	ID	84537	UT
82939	WY	83450	ID	83853	ID	84620	UT
82941	WY	83451	ID	84008	UT	84624	UT
82942	WY	83452	ID	84018	UT	84631	UT
82943	WY	83455	ID	84022	UT	84635	UT
82944	WY	83462	ID	84023	UT	84636	UT
82945	WY	83463	ID	84026	UT	84637	UT
83113	WY	83464	ID	84028	UT	84638	UT
83115	WY	83465	ID	84029	UT	84640	UT

ADDENDUM I- 2005 PRIMARY CARE HPSA ZIP CODES

2005 Primary Care HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
84644	UT	85618	AZ	87024	NM	87328	NM
84649	UT	85621	AZ	87026	NM	87347	NM
84650	UT	85624	AZ	87027	NM	87357	NM
84652	UT	85628	AZ	87028	NM	87364	NM
84654	UT	85637	AZ	87029	NM	87365	NM
84656	UT	85640	AZ	87031	NM	87375	NM
84657	UT	85645	AZ	87032	NM	87401	NM
84701	UT	85646	AZ	87034	NM	87402	NM
84711	UT	85648	AZ	87035	NM	87410	NM
84715	UT	85662	AZ	87036	NM	87412	NM
84723	UT	85701	AZ	87037	NM	87413	NM
84724	UT	85702	AZ	87038	NM	87415	NM
84728	UT	86030	AZ	87040	NM	87416	NM
84730	UT	86034	AZ	87041	NM	87417	NM
84732	UT	86039	AZ	87042	NM	87418	NM
84734	UT	86042	AZ	87045	NM	87419	NM
84739	UT	86043	AZ	87046	NM	87420	NM
84740	UT	86044	AZ	87049	NM	87421	NM
84743	UT	86053	AZ	87051	NM	87455	NM
84744	UT	86054	AZ	87052	NM	87461	NM
84747	UT	86343	AZ	87060	NM	87499	NM
84749	UT	86435	AZ	87061	NM	87520	NM
84750	UT	86441	AZ	87062	NM	87530	NM
84754	UT	86445	AZ	87063	NM	87540	NM
84766	UT	86507	AZ	87068	NM	87543	NM
84773	UT	86510	AZ	87070	NM	87579	NM
84775	UT	86520	AZ	87072	NM	87711	NM
85322	AZ	86538	AZ	87083	NM	87712	NM
85325	AZ	86547	AZ	87301	NM	87713	NM
85328	AZ	86556	AZ	87302	NM	87715	NM
85333	AZ	87001	NM	87305	NM	87722	NM
85334	AZ	87002	NM	87310	NM	87723	NM
85337	AZ	87005	NM	87311	NM	87724	NM
85342	AZ	87006	NM	87312	NM	87730	NM
85343	AZ	87007	NM	87313	NM	87732	NM
85344	AZ	87009	NM	87315	NM	87733	NM
85346	AZ	87010	NM	87316	NM	87734	NM
85348	AZ	87011	NM	87317	NM	87735	NM
85354	AZ	87012	NM	87319	NM	87736	NM
85357	AZ	87014	NM	87320	NM	87743	NM
85359	AZ	87016	NM	87321	NM	87746	NM
85361	AZ	87018	NM	87322	NM	87750	NM
85371	AZ	87020	NM	87323	NM	87752	NM
85601	AZ	87021	NM	87325	NM	87753	NM
85611	AZ	87022	NM	87326	NM	87801	NM
85617	AZ	87023	NM	87327	NM	87820	NM

ADDENDUM I- 2005 PRIMARY CARE HPSA ZIP CODES

2005 Primary Care HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
87821	NM	88321	NM	89319	NV	93528	CA
87823	NM	88347	NM	89403	NV	93531	CA
87824	NM	88353	NM	89408	NV	93553	CA
87825	NM	88401	NM	89409	NV	93596	CA
87827	NM	88410	NM	89415	NV	93602	CA
87828	NM	88411	NM	89418	NV	93603	CA
87829	NM	88414	NM	89419	NV	93604	CA
87830	NM	88415	NM	89420	NV	93605	CA
87831	NM	88417	NM	89422	NV	93609	CA
87832	NM	88418	NM	89427	NV	93614	CA
87901	NM	88419	NM	89429	NV	93621	CA
87930	NM	88422	NM	89430	NV	93627	CA
87931	NM	88424	NM	89440	NV	93634	CA
87933	NM	88426	NM	89444	NV	93641	CA
87935	NM	88427	NM	89447	NV	93642	CA
87939	NM	88430	NM	89820	NV	93643	CA
87941	NM	88433	NM	89821	NV	93645	CA
87942	NM	88434	NM	90002	CA	93651	CA
87943	NM	88435	NM	91905	CA	93652	CA
88009	NM	88436	NM	92066	CA	93664	CA
88020	NM	88437	NM	92249	CA	93667	CA
88039	NM	89003	NV	92250	CA	93668	CA
88042	NM	89010	NV	92317	CA	93669	CA
88045	NM	89013	NV	92325	CA	93675	CA
88056	NM	89020	NV	92352	CA	93925	CA
88072	NM	89022	NV	92521	CA	94951	CA
88119	NM	89023	NV	93203	CA	95303	CA
88121	NM	89024	NV	93206	CA	95315	CA
88134	NM	89027	NV	93208	CA	95412	CA
88136	NM	89041	NV	93218	CA	95429	CA
88201	NM	89045	NV	93237	CA	95462	CA
88202	NM	89047	NV	93239	CA	95480	CA
88203	NM	89048	NV	93241	CA	95511	CA
88210	NM	89049	NV	93256	CA	95546	CA
88211	NM	89060	NV	93257	CA	95552	CA
88220	NM	89061	NV	93258	CA	95556	CA
88221	NM	89135	NV	93262	CA	95560	CA
88230	NM	89148	NV	93265	CA	95562	CA
88232	NM	89301	NV	93266	CA	95585	CA
88250	NM	89310	NV	93270	CA	95636	CA
88253	NM	89311	NV	93271	CA	95735	CA
88254	NM	89314	NV	93501	CA	95910	CA
88255	NM	89315	NV	93502	CA	95912	CA
88256	NM	89316	NV	93504	CA	95932	CA
88263	NM	89317	NV	93505	CA	95936	CA
88268	NM	89318	NV	93516	CA	95944	CA

ADDENDUM I- 2005 PRIMARY CARE HPSA ZIP CODES

2005 Primary Care HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
95950	CA	97621	OR	99033	WA	99584	AK
95955	CA	97639	OR	99039	WA	99585	AK
95970	CA	97750	OR	99104	WA	99589	AK
95979	CA	97812	OR	99107	WA	99590	AK
95987	CA	97817	OR	99110	WA	99591	AK
96006	CA	97820	OR	99118	WA	99602	AK
96013	CA	97825	OR	99119	WA	99604	AK
96016	CA	97830	OR	99121	WA	99606	AK
96027	CA	97844	OR	99131	WA	99607	AK
96028	CA	97845	OR	99136	WA	99609	AK
96039	CA	97848	OR	99137	WA	99612	AK
96040	CA	97856	OR	99138	WA	99613	AK
96062	CA	97861	OR	99139	WA	99614	AK
96085	CA	97864	OR	99140	WA	99620	AK
96086	CA	97865	OR	99150	WA	99621	AK
96087	CA	97869	OR	99152	WA	99622	AK
96096	CA	97873	OR	99153	WA	99625	AK
96757	HI	97874	OR	99156	WA	99626	AK
96910	GU	98283	WA	99158	WA	99627	AK
96911	GU	98303	WA	99160	WA	99630	AK
96912	GU	98305	WA	99166	WA	99632	AK
96913	GU	98323	WA	99176	WA	99633	AK
96914	GU	98336	WA	99180	WA	99634	AK
96915	GU	98349	WA	99181	WA	99637	AK
96916	GU	98351	WA	99347	WA	99638	AK
96917	GU	98394	WA	99546	AK	99640	AK
96918	GU	98524	WA	99547	AK	99641	AK
96919	GU	98528	WA	99548	AK	99647	AK
96921	GU	98533	WA	99549	AK	99648	AK
96922	GU	98535	WA	99551	AK	99649	AK
96923	GU	98546	WA	99552	AK	99650	AK
96925	GU	98548	WA	99553	AK	99651	AK
96926	GU	98555	WA	99554	AK	99653	AK
96927	GU	98560	WA	99557	AK	99655	AK
96928	GU	98584	WA	99558	AK	99656	AK
96929	GU	98588	WA	99559	AK	99657	AK
96930	GU	98592	WA	99561	AK	99658	AK
96931	GU	98610	WA	99563	AK	99660	AK
96932	GU	98639	WA	99564	AK	99661	AK
96940	PW	98648	WA	99565	AK	99662	AK
97039	OR	98651	WA	99571	AK	99665	AK
97050	OR	98846	WA	99575	AK	99666	AK
97531	OR	99005	WA	99578	AK	99668	AK
97534	OR	99006	WA	99579	AK	99670	AK
97543	OR	99012	WA	99581	AK	99675	AK
97544	OR	99018	WA	99583	AK	99676	AK

ADDENDUM I- 2005 PRIMARY CARE HPSA ZIP CODES

2005 Primary Care HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
99679	AK	99766	AK				
99680	AK	99767	AK				
99681	AK	99768	AK				
99685	AK	99770	AK				
99689	AK	99773	AK				
99690	AK	99774	AK				
99691	AK	99776	AK				
99692	AK	99777	AK				
99720	AK	99778	AK				
99721	AK	99779	AK				
99722	AK	99780	AK				
99723	AK	99781	AK				
99724	AK	99782	AK				
99726	AK	99786	AK				
99727	AK	99788	AK				
99729	AK	99789	AK				
99730	AK	99791	AK				
99732	AK	99820	AK				
99733	AK	99825	AK				
99734	AK	99826	AK				
99736	AK	99829	AK				
99737	AK	99832	AK				
99738	AK	99840	AK				
99740	AK	99841	AK				
99741	AK	99903	AK				
99743	AK	99919	AK				
99744	AK	99921	AK				
99745	AK	99922	AK				
99746	AK	99923	AK				
99747	AK	99925	AK				
99748	AK	99926	AK				
99749	AK	99927	AK				
99750	AK						
99751	AK						
99752	AK						
99754	AK						
99755	AK						
99756	AK						
99757	AK						
99758	AK						
99759	AK						
99760	AK						
99761	AK						
99763	AK						
99764	AK						
99765	AK						

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
00606	PR	02360	MA	02738	MA	04455	ME
00611	PR	02361	MA	02740	MA	04457	ME
00617	PR	02362	MA	02741	MA	04459	ME
00627	PR	02375	MA	02742	MA	04460	ME
00641	PR	02381	MA	02743	MA	04462	ME
00646	PR	02558	MA	02744	MA	04487	ME
00650	PR	02561	MA	02745	MA	04493	ME
00664	PR	02562	MA	02746	MA	04495	ME
00667	PR	02563	MA	02747	MA	04765	ME
00670	PR	02601	MA	02748	MA	04777	ME
00677	PR	02630	MA	02760	MA	04782	ME
00685	PR	02632	MA	02761	MA	04928	ME
00687	PR	02634	MA	02763	MA	04930	ME
00692	PR	02635	MA	02764	MA	04933	ME
00703	PR	02636	MA	02766	MA	04953	ME
00707	PR	02637	MA	02767	MA	05440	VT
00718	PR	02638	MA	02768	MA	05463	VT
00719	PR	02639	MA	02769	MA	05474	VT
00720	PR	02641	MA	02771	MA	05824	VT
00721	PR	02644	MA	02777	MA	05837	VT
00723	PR	02647	MA	02779	MA	05840	VT
00735	PR	02648	MA	02780	MA	05846	VT
00739	PR	02649	MA	02790	MA	05858	VT
00742	PR	02655	MA	02791	MA	05901	VT
00744	PR	02660	MA	03218	NH	05902	VT
00745	PR	02664	MA	03220	NH	05903	VT
00751	PR	02668	MA	03225	NH	05904	VT
00754	PR	02670	MA	03226	NH	05905	VT
00757	PR	02672	MA	03237	NH	05906	VT
00765	PR	02673	MA	03246	NH	05907	VT
00766	PR	02675	MA	03247	NH	06029	CT
00767	PR	02702	MA	03249	NH	06043	CT
00769	PR	02703	MA	03252	NH	06066	CT
00772	PR	02712	MA	03253	NH	06071	CT
00773	PR	02714	MA	03256	NH	06072	CT
00794	PR	02715	MA	03269	NH	06075	CT
00795	PR	02717	MA	03276	NH	06076	CT
00953	PR	02718	MA	03289	NH	06077	CT
00954	PR	02719	MA	03298	NH	06084	CT
02031	MA	02720	MA	03299	NH	06231	CT
02048	MA	02721	MA	03809	NH	06232	CT
02334	MA	02722	MA	03810	NH	06237	CT
02345	MA	02723	MA	03837	NH	06238	CT
02346	MA	02724	MA	04430	ME	06248	CT
02356	MA	02725	MA	04448	ME	06265	CT
02357	MA	02726	MA	04451	ME	06279	CT

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
08001	NJ	08753	NJ	12134	NY	12485	NY
08005	NJ	08754	NJ	12139	NY	12492	NY
08023	NJ	08755	NJ	12148	NY	12496	NY
08038	NJ	08756	NJ	12151	NY	12701	NY
08067	NJ	08757	NJ	12157	NY	12719	NY
08069	NJ	08758	NJ	12164	NY	12720	NY
08070	NJ	08759	NJ	12166	NY	12721	NY
08072	NJ	12010	NY	12167	NY	12722	NY
08087	NJ	12015	NY	12170	NY	12723	NY
08098	NJ	12016	NY	12176	NY	12724	NY
08202	NJ	12019	NY	12177	NY	12725	NY
08204	NJ	12020	NY	12188	NY	12726	NY
08210	NJ	12022	NY	12190	NY	12727	NY
08212	NJ	12024	NY	12192	NY	12732	NY
08214	NJ	12025	NY	12405	NY	12733	NY
08218	NJ	12027	NY	12406	NY	12734	NY
08219	NJ	12028	NY	12407	NY	12736	NY
08242	NJ	12032	NY	12413	NY	12737	NY
08243	NJ	12035	NY	12414	NY	12738	NY
08247	NJ	12040	NY	12418	NY	12740	NY
08251	NJ	12042	NY	12421	NY	12741	NY
08252	NJ	12051	NY	12422	NY	12742	NY
08260	NJ	12057	NY	12423	NY	12743	NY
08270	NJ	12058	NY	12424	NY	12745	NY
08318	NJ	12065	NY	12427	NY	12747	NY
08343	NJ	12066	NY	12430	NY	12748	NY
08347	NJ	12068	NY	12431	NY	12749	NY
08527	NJ	12069	NY	12434	NY	12750	NY
08533	NJ	12070	NY	12436	NY	12751	NY
08701	NJ	12072	NY	12438	NY	12752	NY
08721	NJ	12073	NY	12439	NY	12754	NY
08722	NJ	12074	NY	12442	NY	12758	NY
08723	NJ	12078	NY	12444	NY	12759	NY
08724	NJ	12083	NY	12450	NY	12760	NY
08731	NJ	12086	NY	12451	NY	12762	NY
08732	NJ	12087	NY	12452	NY	12763	NY
08733	NJ	12089	NY	12454	NY	12764	NY
08734	NJ	12090	NY	12455	NY	12765	NY
08735	NJ	12092	NY	12459	NY	12766	NY
08738	NJ	12095	NY	12460	NY	12767	NY
08739	NJ	12108	NY	12463	NY	12768	NY
08740	NJ	12117	NY	12468	NY	12769	NY
08741	NJ	12118	NY	12470	NY	12770	NY
08742	NJ	12122	NY	12473	NY	12775	NY
08751	NJ	12124	NY	12474	NY	12776	NY
08752	NJ	12133	NY	12482	NY	12777	NY

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
12778	NY	12878	NY	13126	NY	13452	NY
12779	NY	12879	NY	13131	NY	13454	NY
12781	NY	12883	NY	13132	NY	13460	NY
12783	NY	12885	NY	13135	NY	13461	NY
12784	NY	12886	NY	13136	NY	13464	NY
12785	NY	12913	NY	13142	NY	13470	NY
12786	NY	12928	NY	13143	NY	13472	NY
12787	NY	12932	NY	13144	NY	13475	NY
12788	NY	12936	NY	13145	NY	13491	NY
12789	NY	12941	NY	13146	NY	13493	NY
12790	NY	12942	NY	13148	NY	13730	NY
12791	NY	12943	NY	13154	NY	13731	NY
12792	NY	12946	NY	13155	NY	13733	NY
12803	NY	12950	NY	13156	NY	13739	NY
12808	NY	12956	NY	13165	NY	13740	NY
12810	NY	12960	NY	13166	NY	13750	NY
12811	NY	12961	NY	13167	NY	13751	NY
12812	NY	12964	NY	13301	NY	13752	NY
12814	NY	12974	NY	13302	NY	13753	NY
12815	NY	12975	NY	13309	NY	13754	NY
12817	NY	12977	NY	13316	NY	13755	NY
12824	NY	12987	NY	13317	NY	13756	NY
12827	NY	12993	NY	13320	NY	13757	NY
12828	NY	12996	NY	13324	NY	13758	NY
12831	NY	12997	NY	13329	NY	13774	NY
12836	NY	12998	NY	13331	NY	13775	NY
12838	NY	13028	NY	13332	NY	13778	NY
12839	NY	13033	NY	13339	NY	13780	NY
12842	NY	13036	NY	13340	NY	13782	NY
12843	NY	13042	NY	13350	NY	13783	NY
12845	NY	13044	NY	13353	NY	13786	NY
12847	NY	13064	NY	13357	NY	13788	NY
12851	NY	13065	NY	13360	NY	13801	NY
12852	NY	13069	NY	13361	NY	13804	NY
12853	NY	13074	NY	13365	NY	13806	NY
12855	NY	13076	NY	13406	NY	13809	NY
12856	NY	13083	NY	13407	NY	13814	NY
12857	NY	13093	NY	13410	NY	13815	NY
12858	NY	13103	NY	13411	NY	13830	NY
12860	NY	13107	NY	13416	NY	13832	NY
12862	NY	13111	NY	13420	NY	13837	NY
12863	NY	13113	NY	13426	NY	13838	NY
12864	NY	13114	NY	13428	NY	13839	NY
12870	NY	13115	NY	13431	NY	13841	NY
12872	NY	13121	NY	13436	NY	13842	NY
12874	NY	13124	NY	13437	NY	13843	NY

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13844	NY	14113	NY	14480	NY	14706	NY
13846	NY	14120	NY	14482	NY	14707	NY
13847	NY	14125	NY	14485	NY	14708	NY
13856	NY	14126	NY	14486	NY	14709	NY
13860	NY	14129	NY	14487	NY	14710	NY
14003	NY	14130	NY	14488	NY	14711	NY
14005	NY	14131	NY	14489	NY	14712	NY
14008	NY	14132	NY	14502	NY	14714	NY
14009	NY	14133	NY	14505	NY	14715	NY
14011	NY	14135	NY	14507	NY	14716	NY
14012	NY	14136	NY	14513	NY	14717	NY
14013	NY	14138	NY	14516	NY	14718	NY
14020	NY	14143	NY	14519	NY	14719	NY
14021	NY	14144	NY	14520	NY	14720	NY
14024	NY	14145	NY	14521	NY	14721	NY
14028	NY	14166	NY	14522	NY	14722	NY
14029	NY	14167	NY	14525	NY	14723	NY
14036	NY	14168	NY	14527	NY	14724	NY
14037	NY	14171	NY	14530	NY	14726	NY
14039	NY	14172	NY	14533	NY	14727	NY
14040	NY	14173	NY	14536	NY	14728	NY
14041	NY	14174	NY	14538	NY	14729	NY
14042	NY	14301	NY	14539	NY	14730	NY
14048	NY	14302	NY	14541	NY	14731	NY
14054	NY	14303	NY	14542	NY	14732	NY
14056	NY	14304	NY	14544	NY	14733	NY
14058	NY	14305	NY	14549	NY	14735	NY
14060	NY	14413	NY	14550	NY	14736	NY
14062	NY	14414	NY	14551	NY	14737	NY
14063	NY	14415	NY	14555	NY	14738	NY
14065	NY	14416	NY	14557	NY	14739	NY
14066	NY	14418	NY	14558	NY	14740	NY
14067	NY	14422	NY	14560	NY	14741	NY
14070	NY	14423	NY	14563	NY	14742	NY
14081	NY	14427	NY	14568	NY	14743	NY
14082	NY	14429	NY	14569	NY	14744	NY
14083	NY	14433	NY	14571	NY	14745	NY
14092	NY	14435	NY	14588	NY	14747	NY
14094	NY	14441	NY	14589	NY	14748	NY
14095	NY	14449	NY	14590	NY	14750	NY
14098	NY	14452	NY	14591	NY	14751	NY
14101	NY	14466	NY	14592	NY	14752	NY
14105	NY	14470	NY	14701	NY	14753	NY
14107	NY	14476	NY	14702	NY	14754	NY
14108	NY	14477	NY	14703	NY	14755	NY
14109	NY	14478	NY	14704	NY	14756	NY

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14757	NY	14887	NY	15364	PA	15467	PA
14758	NY	14891	NY	15370	PA	15468	PA
14760	NY	14892	NY	15380	PA	15469	PA
14766	NY	14893	NY	15401	PA	15470	PA
14767	NY	14895	NY	15410	PA	15472	PA
14769	NY	14897	NY	15411	PA	15473	PA
14770	NY	15001	PA	15413	PA	15474	PA
14772	NY	15003	PA	15415	PA	15475	PA
14774	NY	15005	PA	15416	PA	15476	PA
14775	NY	15009	PA	15417	PA	15478	PA
14777	NY	15010	PA	15420	PA	15480	PA
14778	NY	15012	PA	15421	PA	15482	PA
14779	NY	15026	PA	15422	PA	15484	PA
14781	NY	15027	PA	15424	PA	15485	PA
14782	NY	15042	PA	15425	PA	15486	PA
14783	NY	15043	PA	15428	PA	15488	PA
14784	NY	15050	PA	15430	PA	15489	PA
14785	NY	15052	PA	15431	PA	15490	PA
14786	NY	15059	PA	15433	PA	15492	PA
14787	NY	15061	PA	15435	PA	15501	PA
14788	NY	15066	PA	15436	PA	15502	PA
14802	NY	15074	PA	15437	PA	15510	PA
14803	NY	15077	PA	15438	PA	15520	PA
14804	NY	15081	PA	15439	PA	15521	PA
14805	NY	15310	PA	15440	PA	15522	PA
14806	NY	15315	PA	15442	PA	15530	PA
14812	NY	15316	PA	15443	PA	15531	PA
14813	NY	15320	PA	15444	PA	15532	PA
14815	NY	15322	PA	15445	PA	15533	PA
14818	NY	15325	PA	15446	PA	15534	PA
14822	NY	15327	PA	15447	PA	15535	PA
14824	NY	15334	PA	15449	PA	15537	PA
14837	NY	15337	PA	15450	PA	15538	PA
14841	NY	15338	PA	15451	PA	15539	PA
14842	NY	15341	PA	15454	PA	15540	PA
14847	NY	15344	PA	15455	PA	15541	PA
14857	NY	15346	PA	15456	PA	15542	PA
14859	NY	15348	PA	15458	PA	15544	PA
14860	NY	15349	PA	15459	PA	15545	PA
14863	NY	15351	PA	15460	PA	15546	PA
14865	NY	15352	PA	15461	PA	15547	PA
14869	NY	15353	PA	15462	PA	15548	PA
14876	NY	15354	PA	15463	PA	15549	PA
14878	NY	15357	PA	15464	PA	15550	PA
14880	NY	15359	PA	15465	PA	15551	PA
14884	NY	15362	PA	15466	PA	15552	PA

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15553	PA	15752	PA	15957	PA	16142	PA
15554	PA	15753	PA	15959	PA	16143	PA
15555	PA	15754	PA	15963	PA	16155	PA
15557	PA	15756	PA	16001	PA	16156	PA
15558	PA	15757	PA	16002	PA	16157	PA
15559	PA	15758	PA	16003	PA	16160	PA
15560	PA	15759	PA	16016	PA	16201	PA
15561	PA	15761	PA	16017	PA	16210	PA
15562	PA	15763	PA	16018	PA	16211	PA
15563	PA	15765	PA	16020	PA	16212	PA
15564	PA	15771	PA	16021	PA	16215	PA
15565	PA	15772	PA	16022	PA	16217	PA
15630	PA	15774	PA	16025	PA	16218	PA
15631	PA	15777	PA	16029	PA	16222	PA
15656	PA	15783	PA	16030	PA	16223	PA
15673	PA	15801	PA	16034	PA	16226	PA
15681	PA	15821	PA	16035	PA	16228	PA
15682	PA	15822	PA	16038	PA	16229	PA
15686	PA	15823	PA	16039	PA	16236	PA
15701	PA	15827	PA	16040	PA	16238	PA
15705	PA	15828	PA	16041	PA	16239	PA
15710	PA	15831	PA	16045	PA	16244	PA
15712	PA	15832	PA	16048	PA	16245	PA
15713	PA	15834	PA	16049	PA	16246	PA
15716	PA	15841	PA	16050	PA	16249	PA
15717	PA	15845	PA	16051	PA	16250	PA
15720	PA	15846	PA	16052	PA	16253	PA
15721	PA	15848	PA	16053	PA	16256	PA
15723	PA	15849	PA	16057	PA	16259	PA
15724	PA	15853	PA	16061	PA	16261	PA
15725	PA	15856	PA	16101	PA	16262	PA
15727	PA	15857	PA	16102	PA	16263	PA
15728	PA	15861	PA	16103	PA	16301	PA
15729	PA	15866	PA	16105	PA	16312	PA
15731	PA	15868	PA	16107	PA	16313	PA
15732	PA	15870	PA	16108	PA	16317	PA
15734	PA	15920	PA	16112	PA	16319	PA
15736	PA	15924	PA	16115	PA	16321	PA
15739	PA	15926	PA	16116	PA	16322	PA
15741	PA	15928	PA	16117	PA	16323	PA
15742	PA	15929	PA	16120	PA	16329	PA
15745	PA	15935	PA	16123	PA	16340	PA
15746	PA	15936	PA	16132	PA	16341	PA
15747	PA	15937	PA	16136	PA	16342	PA
15748	PA	15949	PA	16140	PA	16343	PA
15750	PA	15953	PA	16141	PA	16344	PA

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16345	PA	16681	PA	17097	PA	17931	PA
16346	PA	16692	PA	17098	PA	17932	PA
16347	PA	16694	PA	17211	PA	17933	PA
16350	PA	16695	PA	17730	PA	17934	PA
16351	PA	16698	PA	17731	PA	17935	PA
16352	PA	16728	PA	17737	PA	17936	PA
16353	PA	16734	PA	17740	PA	17938	PA
16362	PA	16821	PA	17742	PA	17941	PA
16364	PA	16825	PA	17749	PA	17942	PA
16365	PA	16830	PA	17752	PA	17943	PA
16366	PA	16833	PA	17756	PA	17944	PA
16367	PA	16834	PA	17758	PA	17945	PA
16368	PA	16836	PA	17762	PA	17946	PA
16369	PA	16837	PA	17768	PA	17948	PA
16370	PA	16838	PA	17769	PA	17949	PA
16371	PA	16839	PA	17772	PA	17951	PA
16372	PA	16840	PA	17774	PA	17952	PA
16373	PA	16843	PA	17777	PA	17953	PA
16374	PA	16845	PA	17801	PA	17954	PA
16402	PA	16847	PA	17823	PA	17957	PA
16405	PA	16849	PA	17824	PA	17959	PA
16416	PA	16850	PA	17825	PA	17960	PA
16420	PA	16855	PA	17830	PA	17961	PA
16436	PA	16858	PA	17832	PA	17963	PA
16614	PA	16860	PA	17834	PA	17964	PA
16616	PA	16861	PA	17836	PA	17965	PA
16620	PA	16863	PA	17840	PA	17966	PA
16627	PA	16871	PA	17847	PA	17967	PA
16633	PA	16873	PA	17850	PA	17968	PA
16645	PA	16876	PA	17851	PA	17970	PA
16650	PA	16878	PA	17857	PA	17972	PA
16651	PA	16879	PA	17860	PA	17974	PA
16655	PA	16881	PA	17865	PA	17976	PA
16656	PA	17014	PA	17866	PA	17978	PA
16659	PA	17017	PA	17867	PA	17979	PA
16661	PA	17021	PA	17868	PA	17980	PA
16663	PA	17035	PA	17872	PA	17981	PA
16664	PA	17048	PA	17877	PA	17982	PA
16666	PA	17049	PA	17881	PA	17983	PA
16667	PA	17056	PA	17901	PA	17985	PA
16670	PA	17058	PA	17921	PA	18010	PA
16671	PA	17059	PA	17922	PA	18012	PA
16672	PA	17076	PA	17923	PA	18013	PA
16678	PA	17082	PA	17925	PA	18030	PA
16679	PA	17086	PA	17929	PA	18050	PA
16680	PA	17094	PA	17930	PA	18071	PA

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18210	PA	18614	PA	21523	MD	21683	MD
18211	PA	18616	PA	21531	MD	21684	MD
18212	PA	18619	PA	21536	MD	21685	MD
18214	PA	18624	PA	21538	MD	21686	MD
18216	PA	18626	PA	21541	MD	21687	MD
18218	PA	18628	PA	21550	MD	21688	MD
18220	PA	18632	PA	21561	MD	21690	MD
18229	PA	18801	PA	21607	MD	21727	MD
18230	PA	18812	PA	21609	MD	21750	MD
18231	PA	18813	PA	21613	MD	21759	MD
18232	PA	18816	PA	21617	MD	21811	MD
18235	PA	18818	PA	21619	MD	21813	MD
18237	PA	18820	PA	21622	MD	21817	MD
18240	PA	18821	PA	21623	MD	21821	MD
18241	PA	18822	PA	21626	MD	21822	MD
18242	PA	18823	PA	21627	MD	21824	MD
18244	PA	18824	PA	21628	MD	21829	MD
18245	PA	18825	PA	21629	MD	21835	MD
18248	PA	18826	PA	21631	MD	21836	MD
18250	PA	18827	PA	21632	MD	21838	MD
18252	PA	18828	PA	21634	MD	21841	MD
18254	PA	18830	PA	21636	MD	21842	MD
18255	PA	18834	PA	21638	MD	21843	MD
18324	PA	18839	PA	21639	MD	21851	MD
18328	PA	18842	PA	21640	MD	21853	MD
18336	PA	18843	PA	21641	MD	21857	MD
18337	PA	18844	PA	21643	MD	21862	MD
18340	PA	18847	PA	21644	MD	21863	MD
18343	PA	19311	PA	21648	MD	21864	MD
18351	PA	19362	PA	21649	MD	21866	MD
18371	PA	19363	PA	21655	MD	21867	MD
18373	PA	19374	PA	21656	MD	21869	MD
18413	PA	19549	PA	21657	MD	21870	MD
18421	PA	20106	VA	21658	MD	21871	MD
18425	PA	20113	VA	21659	MD	21872	MD
18426	PA	20130	VA	21660	MD	21890	MD
18428	PA	20135	VA	21664	MD	21901	MD
18430	PA	20137	VA	21666	MD	21902	MD
18435	PA	20140	VA	21668	MD	21903	MD
18441	PA	20184	VA	21669	MD	21904	MD
18451	PA	20185	VA	21670	MD	21911	MD
18457	PA	20188	VA	21672	MD	21912	MD
18458	PA	20198	VA	21675	MD	21913	MD
18464	PA	20682	MD	21677	MD	21914	MD
18465	PA	21520	MD	21681	MD	21915	MD
18470	PA	21522	MD	21682	MD	21916	MD

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21917	MD	22548	VA	22727	VA	22960	VA
21918	MD	22552	VA	22730	VA	22963	VA
21919	MD	22553	VA	22731	VA	22964	VA
21920	MD	22558	VA	22732	VA	22965	VA
21921	MD	22565	VA	22735	VA	22967	VA
21922	MD	22567	VA	22738	VA	22968	VA
21930	MD	22570	VA	22743	VA	22969	VA
22002	VA	22572	VA	22748	VA	22971	VA
22134	VA	22577	VA	22810	VA	22972	VA
22407	VA	22579	VA	22811	VA	22973	VA
22408	VA	22580	VA	22812	VA	22974	VA
22427	VA	22581	VA	22815	VA	22976	VA
22428	VA	22602	VA	22820	VA	22980	VA
22432	VA	22603	VA	22821	VA	22989	VA
22433	VA	22610	VA	22824	VA	23001	VA
22435	VA	22611	VA	22827	VA	23002	VA
22442	VA	22620	VA	22830	VA	23003	VA
22443	VA	22622	VA	22831	VA	23004	VA
22446	VA	22624	VA	22832	VA	23009	VA
22448	VA	22625	VA	22833	VA	23011	VA
22451	VA	22626	VA	22834	VA	23014	VA
22456	VA	22630	VA	22835	VA	23017	VA
22460	VA	22637	VA	22840	VA	23018	VA
22469	VA	22641	VA	22841	VA	23021	VA
22472	VA	22642	VA	22842	VA	23022	VA
22473	VA	22644	VA	22844	VA	23023	VA
22481	VA	22645	VA	22845	VA	23024	VA
22485	VA	22646	VA	22846	VA	23025	VA
22488	VA	22649	VA	22847	VA	23027	VA
22501	VA	22650	VA	22848	VA	23030	VA
22508	VA	22652	VA	22849	VA	23031	VA
22511	VA	22654	VA	22850	VA	23032	VA
22514	VA	22655	VA	22851	VA	23035	VA
22520	VA	22656	VA	22853	VA	23038	VA
22524	VA	22657	VA	22920	VA	23039	VA
22526	VA	22660	VA	22922	VA	23040	VA
22529	VA	22663	VA	22923	VA	23043	VA
22530	VA	22664	VA	22935	VA	23045	VA
22534	VA	22709	VA	22938	VA	23050	VA
22535	VA	22711	VA	22942	VA	23055	VA
22538	VA	22715	VA	22948	VA	23056	VA
22539	VA	22719	VA	22949	VA	23061	VA
22542	VA	22721	VA	22953	VA	23062	VA
22544	VA	22722	VA	22954	VA	23063	VA
22546	VA	22723	VA	22957	VA	23064	VA
22547	VA	22725	VA	22958	VA	23065	VA

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23066	VA	23160	VA	23417	VA	23878	VA
23067	VA	23161	VA	23418	VA	23881	VA
23068	VA	23163	VA	23420	VA	23882	VA
23070	VA	23169	VA	23421	VA	23883	VA
23071	VA	23170	VA	23422	VA	23884	VA
23072	VA	23175	VA	23423	VA	23885	VA
23076	VA	23176	VA	23424	VA	23887	VA
23079	VA	23177	VA	23426	VA	23888	VA
23083	VA	23178	VA	23427	VA	23889	VA
23084	VA	23180	VA	23430	VA	23890	VA
23085	VA	23181	VA	23431	VA	23891	VA
23086	VA	23183	VA	23440	VA	23893	VA
23089	VA	23184	VA	23441	VA	23894	VA
23091	VA	23190	VA	23442	VA	23897	VA
23092	VA	23191	VA	23480	VA	23898	VA
23093	VA	23238	VA	23483	VA	23899	VA
23101	VA	23301	VA	23487	VA	23915	VA
23102	VA	23302	VA	23488	VA	23917	VA
23103	VA	23303	VA	23662	VA	23919	VA
23105	VA	23304	VA	23801	VA	23920	VA
23106	VA	23306	VA	23821	VA	23921	VA
23107	VA	23308	VA	23822	VA	23923	VA
23108	VA	23314	VA	23827	VA	23924	VA
23109	VA	23315	VA	23828	VA	23927	VA
23110	VA	23336	VA	23829	VA	23934	VA
23117	VA	23337	VA	23830	VA	23936	VA
23119	VA	23341	VA	23833	VA	23937	VA
23123	VA	23345	VA	23837	VA	23938	VA
23124	VA	23356	VA	23839	VA	23939	VA
23125	VA	23357	VA	23840	VA	23941	VA
23126	VA	23358	VA	23841	VA	23944	VA
23128	VA	23359	VA	23842	VA	23947	VA
23129	VA	23389	VA	23843	VA	23950	VA
23130	VA	23395	VA	23844	VA	23952	VA
23131	VA	23396	VA	23845	VA	23958	VA
23138	VA	23397	VA	23846	VA	23959	VA
23139	VA	23399	VA	23850	VA	23962	VA
23140	VA	23401	VA	23856	VA	23963	VA
23141	VA	23404	VA	23857	VA	23964	VA
23147	VA	23407	VA	23866	VA	23967	VA
23148	VA	23409	VA	23868	VA	23968	VA
23149	VA	23410	VA	23872	VA	23970	VA
23153	VA	23412	VA	23873	VA	23974	VA
23154	VA	23414	VA	23874	VA	23976	VA
23155	VA	23415	VA	23875	VA	24053	VA
23156	VA	23416	VA	23876	VA	24054	VA

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
24055	VA	24203	VA	24314	VA	24473	VA
24064	VA	24209	VA	24315	VA	24483	VA
24065	VA	24215	VA	24317	VA	24484	VA
24066	VA	24216	VA	24318	VA	24487	VA
24067	VA	24217	VA	24319	VA	24517	VA
24069	VA	24218	VA	24322	VA	24520	VA
24072	VA	24219	VA	24323	VA	24521	VA
24076	VA	24220	VA	24325	VA	24522	VA
24077	VA	24221	VA	24326	VA	24527	VA
24078	VA	24224	VA	24328	VA	24528	VA
24079	VA	24225	VA	24330	VA	24529	VA
24082	VA	24226	VA	24343	VA	24530	VA
24083	VA	24228	VA	24348	VA	24531	VA
24085	VA	24230	VA	24350	VA	24533	VA
24088	VA	24237	VA	24351	VA	24534	VA
24089	VA	24239	VA	24352	VA	24535	VA
24090	VA	24243	VA	24354	VA	24536	VA
24091	VA	24244	VA	24360	VA	24538	VA
24092	VA	24245	VA	24363	VA	24539	VA
24095	VA	24246	VA	24366	VA	24549	VA
24101	VA	24248	VA	24368	VA	24550	VA
24102	VA	24250	VA	24370	VA	24551	VA
24105	VA	24251	VA	24373	VA	24553	VA
24120	VA	24256	VA	24374	VA	24554	VA
24122	VA	24258	VA	24375	VA	24555	VA
24127	VA	24260	VA	24378	VA	24556	VA
24130	VA	24263	VA	24379	VA	24557	VA
24131	VA	24265	VA	24380	VA	24558	VA
24133	VA	24266	VA	24381	VA	24562	VA
24137	VA	24269	VA	24382	VA	24563	VA
24139	VA	24271	VA	24401	VA	24565	VA
24146	VA	24272	VA	24402	VA	24566	VA
24148	VA	24277	VA	24407	VA	24569	VA
24151	VA	24279	VA	24412	VA	24571	VA
24161	VA	24280	VA	24415	VA	24572	VA
24165	VA	24281	VA	24416	VA	24574	VA
24168	VA	24282	VA	24426	VA	24576	VA
24171	VA	24283	VA	24435	VA	24577	VA
24175	VA	24285	VA	24438	VA	24578	VA
24176	VA	24289	VA	24439	VA	24579	VA
24177	VA	24290	VA	24441	VA	24580	VA
24178	VA	24292	VA	24445	VA	24581	VA
24184	VA	24293	VA	24460	VA	24585	VA
24185	VA	24311	VA	24464	VA	24586	VA
24201	VA	24312	VA	24471	VA	24588	VA
24202	VA	24313	VA	24472	VA	24589	VA

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
24592	VA	24831	WV	24892	WV	25133	WV
24593	VA	24832	WV	24894	WV	25141	WV
24594	VA	24834	WV	24895	WV	25142	WV
24595	VA	24836	WV	24896	WV	25148	WV
24597	VA	24839	WV	24897	WV	25149	WV
24598	VA	24841	WV	24898	WV	25150	WV
24599	VA	24842	WV	24899	WV	25154	WV
24603	VA	24843	WV	24918	WV	25164	WV
24607	VA	24844	WV	24919	WV	25165	WV
24614	VA	24845	WV	24935	WV	25169	WV
24618	VA	24846	WV	24941	WV	25180	WV
24620	VA	24847	WV	24942	WV	25181	WV
24624	VA	24848	WV	24945	WV	25193	WV
24627	VA	24849	WV	24951	WV	25203	WV
24628	VA	24850	WV	24962	WV	25204	WV
24631	VA	24851	WV	24963	WV	25205	WV
24634	VA	24852	WV	24974	WV	25206	WV
24639	VA	24853	WV	24976	WV	25208	WV
24646	VA	24854	WV	24981	WV	25209	WV
24647	VA	24855	WV	24983	WV	25211	WV
24649	VA	24856	WV	24984	WV	25231	WV
24656	VA	24857	WV	24985	WV	25239	WV
24657	VA	24859	WV	24993	WV	25241	WV
24658	VA	24860	WV	25005	WV	25243	WV
24716	WV	24861	WV	25009	WV	25244	WV
24719	WV	24862	WV	25010	WV	25245	WV
24726	WV	24866	WV	25018	WV	25248	WV
24801	WV	24867	WV	25019	WV	25251	WV
24808	WV	24868	WV	25021	WV	25252	WV
24811	WV	24869	WV	25024	WV	25256	WV
24813	WV	24870	WV	25028	WV	25258	WV
24815	WV	24871	WV	25030	WV	25259	WV
24816	WV	24872	WV	25043	WV	25262	WV
24817	WV	24873	WV	25049	WV	25266	WV
24818	WV	24874	WV	25051	WV	25267	WV
24820	WV	24877	WV	25053	WV	25270	WV
24821	WV	24878	WV	25063	WV	25271	WV
24822	WV	24879	WV	25081	WV	25275	WV
24823	WV	24880	WV	25088	WV	25276	WV
24824	WV	24881	WV	25093	WV	25279	WV
24825	WV	24882	WV	25108	WV	25281	WV
24826	WV	24883	WV	25111	WV	25283	WV
24827	WV	24884	WV	25113	WV	25285	WV
24828	WV	24887	WV	25114	WV	25286	WV
24829	WV	24888	WV	25125	WV	25411	WV
24830	WV	24889	WV	25130	WV	25419	WV

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
25422	WV	25678	WV	26058	WV	26354	WV
25431	WV	25682	WV	26070	WV	26362	WV
25434	WV	25685	WV	26075	WV	26372	WV
25437	WV	25686	WV	26134	WV	26374	WV
25444	WV	25687	WV	26135	WV	26376	WV
25501	WV	25688	WV	26138	WV	26378	WV
25506	WV	25690	WV	26141	WV	26384	WV
25507	WV	25691	WV	26143	WV	26405	WV
25511	WV	25692	WV	26146	WV	26407	WV
25512	WV	25694	WV	26148	WV	26410	WV
25514	WV	25696	WV	26149	WV	26411	WV
25517	WV	25697	WV	26160	WV	26412	WV
25519	WV	25699	WV	26161	WV	26415	WV
25521	WV	25704	WV	26164	WV	26416	WV
25523	WV	25770	WV	26170	WV	26421	WV
25524	WV	25771	WV	26173	WV	26424	WV
25529	WV	25810	WV	26175	WV	26425	WV
25530	WV	25811	WV	26178	WV	26430	WV
25534	WV	25826	WV	26203	WV	26434	WV
25535	WV	25845	WV	26206	WV	26435	WV
25540	WV	25848	WV	26208	WV	26436	WV
25544	WV	25870	WV	26217	WV	26440	WV
25555	WV	25875	WV	26222	WV	26443	WV
25557	WV	25876	WV	26238	WV	26444	WV
25562	WV	25882	WV	26250	WV	26447	WV
25564	WV	25913	WV	26266	WV	26452	WV
25565	WV	25916	WV	26275	WV	26456	WV
25567	WV	25928	WV	26288	WV	26519	WV
25570	WV	25943	WV	26298	WV	26520	WV
25571	WV	25951	WV	26320	WV	26524	WV
25573	WV	25965	WV	26321	WV	26525	WV
25608	WV	25966	WV	26325	WV	26535	WV
25621	WV	25969	WV	26327	WV	26537	WV
25623	WV	25977	WV	26328	WV	26542	WV
25650	WV	25978	WV	26334	WV	26547	WV
25651	WV	25979	WV	26335	WV	26601	WV
25661	WV	25985	WV	26337	WV	26611	WV
25665	WV	25988	WV	26338	WV	26612	WV
25666	WV	26030	WV	26339	WV	26615	WV
25667	WV	26032	WV	26342	WV	26617	WV
25669	WV	26034	WV	26343	WV	26618	WV
25670	WV	26035	WV	26346	WV	26619	WV
25671	WV	26037	WV	26347	WV	26621	WV
25672	WV	26050	WV	26349	WV	26623	WV
25674	WV	26055	WV	26350	WV	26624	WV
25676	WV	26056	WV	26351	WV	26627	WV

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26629	WV	27016	NC	27305	NC	27570	NC
26631	WV	27018	NC	27306	NC	27573	NC
26634	WV	27019	NC	27311	NC	27574	NC
26636	WV	27020	NC	27312	NC	27583	NC
26638	WV	27021	NC	27314	NC	27584	NC
26639	WV	27022	NC	27315	NC	27586	NC
26641	WV	27025	NC	27316	NC	27589	NC
26704	WV	27027	NC	27320	NC	27594	NC
26705	WV	27028	NC	27321	NC	27596	NC
26711	WV	27042	NC	27322	NC	27801	NC
26714	WV	27043	NC	27323	NC	27802	NC
26716	WV	27046	NC	27325	NC	27805	NC
26719	WV	27048	NC	27326	NC	27807	NC
26722	WV	27052	NC	27340	NC	27809	NC
26753	WV	27055	NC	27343	NC	27813	NC
26755	WV	27201	NC	27344	NC	27816	NC
26757	WV	27202	NC	27349	NC	27819	NC
26761	WV	27207	NC	27350	NC	27820	NC
26763	WV	27208	NC	27351	NC	27822	NC
26764	WV	27209	NC	27355	NC	27823	NC
26767	WV	27212	NC	27356	NC	27824	NC
26801	WV	27213	NC	27359	NC	27825	NC
26802	WV	27215	NC	27370	NC	27826	NC
26804	WV	27216	NC	27371	NC	27831	NC
26807	WV	27217	NC	27374	NC	27832	NC
26808	WV	27220	NC	27375	NC	27838	NC
26810	WV	27228	NC	27376	NC	27839	NC
26812	WV	27229	NC	27379	NC	27840	NC
26814	WV	27242	NC	27501	NC	27841	NC
26815	WV	27244	NC	27506	NC	27842	NC
26817	WV	27247	NC	27508	NC	27843	NC
26818	WV	27252	NC	27521	NC	27844	NC
26823	WV	27253	NC	27525	NC	27845	NC
26824	WV	27256	NC	27536	NC	27846	NC
26836	WV	27258	NC	27537	NC	27847	NC
26838	WV	27259	NC	27541	NC	27849	NC
26845	WV	27281	NC	27543	NC	27850	NC
26851	WV	27288	NC	27544	NC	27851	NC
26852	WV	27289	NC	27546	NC	27852	NC
26865	WV	27291	NC	27549	NC	27853	NC
26866	WV	27292	NC	27551	NC	27854	NC
26884	WV	27293	NC	27552	NC	27857	NC
26886	WV	27294	NC	27553	NC	27861	NC
27006	NC	27295	NC	27556	NC	27862	NC
27011	NC	27299	NC	27559	NC	27864	NC
27014	NC	27302	NC	27563	NC	27866	NC

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
27867	NC	27944	NC	28080	NC	28350	NC
27869	NC	27946	NC	28088	NC	28357	NC
27870	NC	27947	NC	28091	NC	28358	NC
27871	NC	27948	NC	28097	NC	28359	NC
27872	NC	27949	NC	28102	NC	28360	NC
27873	NC	27950	NC	28104	NC	28361	NC
27874	NC	27953	NC	28108	NC	28362	NC
27875	NC	27954	NC	28109	NC	28363	NC
27876	NC	27956	NC	28119	NC	28364	NC
27877	NC	27957	NC	28127	NC	28366	NC
27880	NC	27958	NC	28128	NC	28367	NC
27881	NC	27959	NC	28129	NC	28368	NC
27882	NC	27960	NC	28133	NC	28369	NC
27883	NC	27962	NC	28135	NC	28370	NC
27885	NC	27964	NC	28137	NC	28371	NC
27886	NC	27965	NC	28139	NC	28372	NC
27887	NC	27966	NC	28160	NC	28373	NC
27888	NC	27967	NC	28163	NC	28374	NC
27890	NC	27968	NC	28167	NC	28375	NC
27892	NC	27969	NC	28168	NC	28376	NC
27893	NC	27970	NC	28170	NC	28377	NC
27894	NC	27972	NC	28173	NC	28378	NC
27895	NC	27973	NC	28261	NC	28379	NC
27896	NC	27974	NC	28315	NC	28380	NC
27897	NC	27976	NC	28318	NC	28382	NC
27915	NC	27978	NC	28319	NC	28383	NC
27916	NC	27979	NC	28320	NC	28384	NC
27917	NC	27981	NC	28323	NC	28385	NC
27919	NC	27982	NC	28325	NC	28386	NC
27920	NC	27983	NC	28326	NC	28387	NC
27921	NC	27985	NC	28327	NC	28388	NC
27923	NC	28001	NC	28328	NC	28392	NC
27924	NC	28002	NC	28329	NC	28393	NC
27925	NC	28007	NC	28330	NC	28394	NC
27926	NC	28009	NC	28332	NC	28398	NC
27927	NC	28018	NC	28334	NC	28399	NC
27928	NC	28019	NC	28335	NC	28420	NC
27929	NC	28021	NC	28337	NC	28421	NC
27930	NC	28023	NC	28338	NC	28422	NC
27935	NC	28024	NC	28339	NC	28423	NC
27936	NC	28037	NC	28340	NC	28424	NC
27937	NC	28040	NC	28341	NC	28425	NC
27938	NC	28043	NC	28344	NC	28430	NC
27939	NC	28074	NC	28345	NC	28431	NC
27941	NC	28076	NC	28347	NC	28432	NC
27943	NC	28079	NC	28349	NC	28433	NC

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
28434	NC	28516	NC	28651	NC	28782	NC
28435	NC	28518	NC	28654	NC	28902	NC
28436	NC	28520	NC	28656	NC	28904	NC
28438	NC	28521	NC	28659	NC	28909	NC
28439	NC	28524	NC	28665	NC	29001	SC
28441	NC	28525	NC	28666	NC	29006	SC
28442	NC	28528	NC	28667	NC	29010	SC
28443	NC	28529	NC	28669	NC	29014	SC
28444	NC	28531	NC	28670	NC	29015	SC
28446	NC	28537	NC	28672	NC	29018	SC
28447	NC	28538	NC	28674	NC	29030	SC
28448	NC	28551	NC	28678	NC	29038	SC
28450	NC	28552	NC	28681	NC	29039	SC
28451	NC	28553	NC	28683	NC	29041	SC
28452	NC	28554	NC	28684	NC	29046	SC
28453	NC	28556	NC	28685	NC	29047	SC
28454	NC	28557	NC	28693	NC	29048	SC
28455	NC	28570	NC	28694	NC	29051	SC
28456	NC	28571	NC	28697	NC	29055	SC
28457	NC	28572	NC	28705	NC	29056	SC
28458	NC	28575	NC	28708	NC	29058	SC
28459	NC	28577	NC	28712	NC	29059	SC
28461	NC	28579	NC	28718	NC	29065	SC
28462	NC	28580	NC	28720	NC	29067	SC
28463	NC	28581	NC	28722	NC	29080	SC
28464	NC	28582	NC	28733	NC	29101	SC
28465	NC	28583	NC	28737	NC	29102	SC
28466	NC	28587	NC	28743	NC	29105	SC
28467	NC	28589	NC	28746	NC	29106	SC
28468	NC	28594	NC	28747	NC	29107	SC
28469	NC	28606	NC	28749	NC	29111	SC
28470	NC	28612	NC	28750	NC	29112	SC
28471	NC	28615	NC	28752	NC	29113	SC
28472	NC	28617	NC	28753	NC	29115	SC
28478	NC	28624	NC	28754	NC	29116	SC
28479	NC	28626	NC	28756	NC	29117	SC
28501	NC	28629	NC	28761	NC	29118	SC
28502	NC	28630	NC	28762	NC	29129	SC
28503	NC	28631	NC	28765	NC	29130	SC
28504	NC	28635	NC	28766	NC	29132	SC
28508	NC	28636	NC	28768	NC	29133	SC
28509	NC	28637	NC	28771	NC	29135	SC
28510	NC	28640	NC	28772	NC	29137	SC
28511	NC	28642	NC	28773	NC	29138	SC
28512	NC	28643	NC	28774	NC	29142	SC
28515	NC	28649	NC	28777	NC	29143	SC

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
29146	SC	29565	SC	29809	SC	29944	SC
29148	SC	29567	SC	29812	SC	29945	SC
29162	SC	29570	SC	29813	SC	30011	GA
29163	SC	29573	SC	29816	SC	30016	GA
29164	SC	29580	SC	29817	SC	30041	GA
29166	SC	29584	SC	29821	SC	30052	GA
29176	SC	29590	SC	29822	SC	30104	GA
29180	SC	29594	SC	29824	SC	30110	GA
29325	SC	29596	SC	29826	SC	30113	GA
29332	SC	29643	SC	29828	SC	30125	GA
29340	SC	29645	SC	29829	SC	30132	GA
29341	SC	29658	SC	29831	SC	30137	GA
29342	SC	29664	SC	29832	SC	30138	GA
29351	SC	29665	SC	29834	SC	30140	GA
29360	SC	29672	SC	29835	SC	30141	GA
29370	SC	29675	SC	29838	SC	30143	GA
29384	SC	29676	SC	29839	SC	30148	GA
29430	SC	29678	SC	29840	SC	30153	GA
29431	SC	29679	SC	29841	SC	30157	GA
29432	SC	29686	SC	29842	SC	30175	GA
29434	SC	29691	SC	29844	SC	30176	GA
29436	SC	29693	SC	29845	SC	30177	GA
29437	SC	29696	SC	29847	SC	30179	GA
29447	SC	29702	SC	29850	SC	30180	GA
29448	SC	29706	SC	29851	SC	30182	GA
29453	SC	29709	SC	29853	SC	30204	GA
29461	SC	29712	SC	29856	SC	30206	GA
29468	SC	29714	SC	29860	SC	30216	GA
29469	SC	29717	SC	29861	SC	30217	GA
29471	SC	29718	SC	29899	SC	30218	GA
29476	SC	29720	SC	29911	SC	30219	GA
29477	SC	29721	SC	29912	SC	30222	GA
29479	SC	29722	SC	29913	SC	30233	GA
29512	SC	29724	SC	29916	SC	30234	GA
29516	SC	29727	SC	29918	SC	30251	GA
29518	SC	29728	SC	29921	SC	30256	GA
29520	SC	29729	SC	29922	SC	30257	GA
29525	SC	29741	SC	29923	SC	30258	GA
29536	SC	29742	SC	29924	SC	30284	GA
29542	SC	29743	SC	29927	SC	30292	GA
29543	SC	29744	SC	29932	SC	30293	GA
29547	SC	29801	SC	29933	SC	30295	GA
29554	SC	29802	SC	29934	SC	30401	GA
29556	SC	29803	SC	29936	SC	30410	GA
29563	SC	29804	SC	29939	SC	30411	GA
29564	SC	29805	SC	29943	SC	30412	GA

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
30420	GA	30549	GA	30667	GA	31031	GA
30421	GA	30552	GA	30668	GA	31032	GA
30424	GA	30555	GA	30671	GA	31033	GA
30425	GA	30557	GA	30673	GA	31035	GA
30427	GA	30558	GA	30680	GA	31037	GA
30428	GA	30559	GA	30705	GA	31039	GA
30438	GA	30560	GA	30707	GA	31042	GA
30445	GA	30562	GA	30708	GA	31044	GA
30446	GA	30563	GA	30711	GA	31045	GA
30447	GA	30565	GA	30724	GA	31046	GA
30448	GA	30567	GA	30725	GA	31049	GA
30449	GA	30568	GA	30728	GA	31050	GA
30453	GA	30571	GA	30730	GA	31051	GA
30455	GA	30572	GA	30731	GA	31052	GA
30457	GA	30573	GA	30738	GA	31054	GA
30464	GA	30575	GA	30739	GA	31055	GA
30467	GA	30576	GA	30741	GA	31058	GA
30470	GA	30577	GA	30747	GA	31060	GA
30471	GA	30580	GA	30750	GA	31066	GA
30473	GA	30581	GA	30751	GA	31067	GA
30499	GA	30582	GA	30752	GA	31070	GA
30510	GA	30596	GA	30753	GA	31071	GA
30511	GA	30598	GA	30757	GA	31072	GA
30512	GA	30599	GA	30806	GA	31076	GA
30513	GA	30619	GA	30807	GA	31078	GA
30514	GA	30620	GA	30808	GA	31079	GA
30517	GA	30623	GA	30810	GA	31081	GA
30522	GA	30624	GA	30817	GA	31082	GA
30523	GA	30625	GA	30819	GA	31083	GA
30525	GA	30627	GA	30820	GA	31084	GA
30528	GA	30628	GA	30821	GA	31086	GA
30529	GA	30629	GA	30828	GA	31087	GA
30530	GA	30630	GA	31001	GA	31089	GA
30531	GA	30631	GA	31002	GA	31090	GA
30534	GA	30633	GA	31003	GA	31091	GA
30535	GA	30634	GA	31004	GA	31092	GA
30537	GA	30635	GA	31006	GA	31094	GA
30538	GA	30645	GA	31007	GA	31096	GA
30539	GA	30646	GA	31008	GA	31303	GA
30540	GA	30647	GA	31016	GA	31304	GA
30541	GA	30648	GA	31017	GA	31305	GA
30544	GA	30650	GA	31018	GA	31307	GA
30545	GA	30660	GA	31020	GA	31312	GA
30546	GA	30663	GA	31024	GA	31316	GA
30547	GA	30664	GA	31026	GA	31318	GA
30548	GA	30666	GA	31029	GA	31319	GA

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Primary Care PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
31326	GA	31762	GA	32011	FL	32131	FL
31327	GA	31763	GA	32013	FL	32132	FL
31329	GA	31766	GA	32024	FL	32133	FL
31331	GA	31767	GA	32025	FL	32134	FL
31516	GA	31769	GA	32038	FL	32135	FL
31518	GA	31770	GA	32041	FL	32136	FL
31537	GA	31772	GA	32052	FL	32137	FL
31542	GA	31774	GA	32053	FL	32138	FL
31543	GA	31777	GA	32055	FL	32139	FL
31544	GA	31781	GA	32056	FL	32140	FL
31549	GA	31783	GA	32059	FL	32141	FL
31551	GA	31785	GA	32060	FL	32142	FL
31553	GA	31787	GA	32061	FL	32147	FL
31556	GA	31789	GA	32062	FL	32148	FL
31557	GA	31790	GA	32064	FL	32149	FL
31562	GA	31791	GA	32066	FL	32151	FL
31566	GA	31796	GA	32071	FL	32157	FL
31622	GA	31797	GA	32082	FL	32158	FL
31624	GA	31798	GA	32092	FL	32159	FL
31625	GA	31801	GA	32094	FL	32162	FL
31629	GA	31803	GA	32095	FL	32164	FL
31638	GA	31804	GA	32096	FL	32168	FL
31639	GA	31805	GA	32097	FL	32169	FL
31642	GA	31806	GA	32102	FL	32170	FL
31643	GA	31807	GA	32105	FL	32173	FL
31645	GA	31810	GA	32110	FL	32174	FL
31646	GA	31811	GA	32111	FL	32175	FL
31648	GA	31812	GA	32112	FL	32176	FL
31650	GA	31814	GA	32113	FL	32177	FL
31713	GA	31815	GA	32114	FL	32178	FL
31714	GA	31816	GA	32115	FL	32179	FL
31720	GA	31821	GA	32116	FL	32180	FL
31723	GA	31822	GA	32117	FL	32181	FL
31726	GA	31823	GA	32118	FL	32182	FL
31728	GA	31824	GA	32119	FL	32183	FL
31729	GA	31825	GA	32120	FL	32185	FL
31732	GA	31826	GA	32121	FL	32187	FL
31741	GA	31827	GA	32122	FL	32189	FL
31742	GA	31830	GA	32123	FL	32190	FL
31745	GA	31831	GA	32124	FL	32192	FL
31746	GA	31832	GA	32125	FL	32193	FL
31749	GA	31836	GA	32126	FL	32195	FL
31754	GA	32004	FL	32127	FL	32198	FL
31759	GA	32007	FL	32128	FL	32259	FL
31760	GA	32008	FL	32129	FL	32260	FL
31761	GA	32009	FL	32130	FL	32320	FL

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
32321	FL	32447	FL	32722	FL	32923	FL
32322	FL	32448	FL	32723	FL	32924	FL
32323	FL	32449	FL	32724	FL	32925	FL
32328	FL	32452	FL	32725	FL	32926	FL
32329	FL	32454	FL	32726	FL	32927	FL
32331	FL	32455	FL	32727	FL	32931	FL
32333	FL	32456	FL	32728	FL	32932	FL
32334	FL	32457	FL	32735	FL	32934	FL
32335	FL	32459	FL	32736	FL	32935	FL
32336	FL	32460	FL	32738	FL	32936	FL
32337	FL	32461	FL	32739	FL	32937	FL
32340	FL	32462	FL	32744	FL	32940	FL
32341	FL	32463	FL	32753	FL	32941	FL
32343	FL	32464	FL	32754	FL	32948	FL
32344	FL	32465	FL	32756	FL	32949	FL
32345	FL	32538	FL	32757	FL	32950	FL
32347	FL	32550	FL	32759	FL	32951	FL
32348	FL	32565	FL	32763	FL	32952	FL
32350	FL	32570	FL	32764	FL	32953	FL
32356	FL	32572	FL	32767	FL	32954	FL
32357	FL	32617	FL	32774	FL	32955	FL
32359	FL	32619	FL	32775	FL	32956	FL
32360	FL	32621	FL	32776	FL	32957	FL
32361	FL	32625	FL	32778	FL	32958	FL
32420	FL	32626	FL	32780	FL	32959	FL
32421	FL	32628	FL	32781	FL	32960	FL
32422	FL	32634	FL	32782	FL	32961	FL
32423	FL	32639	FL	32783	FL	32962	FL
32424	FL	32644	FL	32784	FL	32963	FL
32425	FL	32648	FL	32796	FL	32964	FL
32426	FL	32663	FL	32899	FL	32965	FL
32427	FL	32664	FL	32901	FL	32966	FL
32428	FL	32666	FL	32902	FL	32967	FL
32430	FL	32668	FL	32903	FL	32968	FL
32431	FL	32680	FL	32904	FL	32969	FL
32432	FL	32681	FL	32905	FL	32970	FL
32433	FL	32683	FL	32906	FL	32971	FL
32434	FL	32686	FL	32907	FL	32976	FL
32435	FL	32692	FL	32908	FL	32978	FL
32437	FL	32693	FL	32909	FL	33471	FL
32439	FL	32696	FL	32910	FL	33513	FL
32440	FL	32702	FL	32911	FL	33514	FL
32442	FL	32706	FL	32912	FL	33521	FL
32443	FL	32713	FL	32919	FL	33523	FL
32445	FL	32720	FL	32920	FL	33524	FL
32446	FL	32721	FL	32922	FL	33525	FL

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
33526	FL	33849	FL	33912	FL	34102	FL
33537	FL	33850	FL	33913	FL	34103	FL
33538	FL	33851	FL	33914	FL	34104	FL
33539	FL	33852	FL	33915	FL	34105	FL
33540	FL	33853	FL	33916	FL	34106	FL
33541	FL	33854	FL	33917	FL	34107	FL
33542	FL	33855	FL	33918	FL	34108	FL
33543	FL	33856	FL	33919	FL	34109	FL
33544	FL	33857	FL	33920	FL	34110	FL
33574	FL	33858	FL	33921	FL	34112	FL
33576	FL	33859	FL	33922	FL	34113	FL
33585	FL	33860	FL	33924	FL	34114	FL
33593	FL	33862	FL	33927	FL	34116	FL
33597	FL	33863	FL	33928	FL	34117	FL
33801	FL	33865	FL	33931	FL	34119	FL
33802	FL	33867	FL	33932	FL	34120	FL
33803	FL	33868	FL	33936	FL	34133	FL
33804	FL	33870	FL	33938	FL	34134	FL
33805	FL	33871	FL	33944	FL	34135	FL
33806	FL	33872	FL	33945	FL	34136	FL
33807	FL	33873	FL	33946	FL	34137	FL
33809	FL	33875	FL	33947	FL	34138	FL
33810	FL	33876	FL	33948	FL	34139	FL
33811	FL	33877	FL	33949	FL	34140	FL
33813	FL	33880	FL	33950	FL	34142	FL
33815	FL	33881	FL	33951	FL	34143	FL
33820	FL	33882	FL	33952	FL	34145	FL
33823	FL	33883	FL	33953	FL	34146	FL
33825	FL	33884	FL	33954	FL	34201	FL
33826	FL	33885	FL	33955	FL	34202	FL
33827	FL	33888	FL	33956	FL	34203	FL
33830	FL	33890	FL	33957	FL	34204	FL
33831	FL	33896	FL	33960	FL	34205	FL
33834	FL	33897	FL	33965	FL	34206	FL
33835	FL	33898	FL	33970	FL	34207	FL
33836	FL	33901	FL	33971	FL	34208	FL
33837	FL	33902	FL	33972	FL	34209	FL
33838	FL	33903	FL	33980	FL	34210	FL
33839	FL	33904	FL	33981	FL	34211	FL
33840	FL	33905	FL	33982	FL	34212	FL
33841	FL	33906	FL	33983	FL	34215	FL
33843	FL	33907	FL	33990	FL	34216	FL
33844	FL	33908	FL	33991	FL	34217	FL
33845	FL	33909	FL	33993	FL	34218	FL
33846	FL	33910	FL	33994	FL	34219	FL
33847	FL	33911	FL	34101	FL	34220	FL

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34221	FL	34293	FL	34492	FL	34762	FL
34222	FL	34295	FL	34498	FL	34785	FL
34223	FL	34420	FL	34601	FL	34788	FL
34224	FL	34421	FL	34602	FL	34789	FL
34228	FL	34423	FL	34603	FL	34797	FL
34229	FL	34428	FL	34604	FL	34945	FL
34230	FL	34429	FL	34605	FL	34946	FL
34231	FL	34430	FL	34606	FL	34947	FL
34232	FL	34431	FL	34607	FL	34948	FL
34233	FL	34432	FL	34608	FL	34949	FL
34234	FL	34433	FL	34609	FL	34950	FL
34235	FL	34434	FL	34610	FL	34951	FL
34236	FL	34436	FL	34611	FL	34952	FL
34237	FL	34442	FL	34613	FL	34953	FL
34238	FL	34445	FL	34614	FL	34954	FL
34239	FL	34446	FL	34636	FL	34956	FL
34240	FL	34447	FL	34639	FL	34972	FL
34241	FL	34448	FL	34652	FL	34973	FL
34242	FL	34449	FL	34653	FL	34974	FL
34243	FL	34450	FL	34654	FL	34979	FL
34250	FL	34451	FL	34655	FL	34981	FL
34251	FL	34452	FL	34656	FL	34982	FL
34260	FL	34453	FL	34661	FL	34983	FL
34264	FL	34460	FL	34667	FL	34984	FL
34265	FL	34461	FL	34668	FL	34985	FL
34266	FL	34464	FL	34669	FL	34986	FL
34267	FL	34465	FL	34673	FL	34987	FL
34268	FL	34470	FL	34674	FL	34988	FL
34269	FL	34471	FL	34679	FL	35004	AL
34270	FL	34472	FL	34680	FL	35010	AL
34272	FL	34473	FL	34690	FL	35011	AL
34274	FL	34474	FL	34691	FL	35014	AL
34275	FL	34475	FL	34705	FL	35016	AL
34276	FL	34476	FL	34711	FL	35032	AL
34277	FL	34477	FL	34712	FL	35034	AL
34278	FL	34478	FL	34713	FL	35035	AL
34280	FL	34479	FL	34729	FL	35038	AL
34281	FL	34480	FL	34731	FL	35042	AL
34282	FL	34481	FL	34736	FL	35044	AL
34284	FL	34482	FL	34737	FL	35045	AL
34285	FL	34483	FL	34748	FL	35046	AL
34286	FL	34484	FL	34749	FL	35051	AL
34287	FL	34487	FL	34753	FL	35052	AL
34288	FL	34488	FL	34755	FL	35054	AL
34289	FL	34489	FL	34756	FL	35063	AL
34292	FL	34491	FL	34759	FL	35072	AL

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
35074	AL	35481	AL	35610	AL	35962	AL
35079	AL	35491	AL	35615	AL	35963	AL
35082	AL	35501	AL	35616	AL	35964	AL
35085	AL	35502	AL	35618	AL	35966	AL
35089	AL	35503	AL	35643	AL	35967	AL
35096	AL	35504	AL	35646	AL	35968	AL
35097	AL	35540	AL	35649	AL	35971	AL
35112	AL	35541	AL	35650	AL	35973	AL
35120	AL	35542	AL	35651	AL	35974	AL
35125	AL	35543	AL	35652	AL	35975	AL
35128	AL	35544	AL	35653	AL	35976	AL
35130	AL	35545	AL	35654	AL	35978	AL
35131	AL	35546	AL	35660	AL	35979	AL
35133	AL	35548	AL	35661	AL	35980	AL
35135	AL	35549	AL	35662	AL	35981	AL
35136	AL	35550	AL	35672	AL	35983	AL
35143	AL	35551	AL	35674	AL	35984	AL
35146	AL	35552	AL	35739	AL	35986	AL
35148	AL	35553	AL	35740	AL	35987	AL
35149	AL	35554	AL	35742	AL	35988	AL
35150	AL	35555	AL	35744	AL	35989	AL
35151	AL	35559	AL	35745	AL	36003	AL
35160	AL	35560	AL	35746	AL	36005	AL
35161	AL	35563	AL	35747	AL	36006	AL
35171	AL	35564	AL	35751	AL	36008	AL
35175	AL	35565	AL	35752	AL	36009	AL
35182	AL	35570	AL	35755	AL	36010	AL
35183	AL	35571	AL	35756	AL	36015	AL
35184	AL	35572	AL	35764	AL	36016	AL
35188	AL	35573	AL	35765	AL	36017	AL
35441	AL	35574	AL	35766	AL	36020	AL
35442	AL	35575	AL	35768	AL	36022	AL
35443	AL	35576	AL	35769	AL	36023	AL
35447	AL	35577	AL	35771	AL	36024	AL
35448	AL	35578	AL	35772	AL	36025	AL
35459	AL	35579	AL	35774	AL	36026	AL
35460	AL	35580	AL	35776	AL	36027	AL
35461	AL	35581	AL	35950	AL	36028	AL
35462	AL	35582	AL	35951	AL	36029	AL
35464	AL	35584	AL	35953	AL	36030	AL
35466	AL	35585	AL	35956	AL	36031	AL
35469	AL	35586	AL	35957	AL	36032	AL
35470	AL	35587	AL	35958	AL	36033	AL
35471	AL	35592	AL	35959	AL	36034	AL
35474	AL	35593	AL	35960	AL	36035	AL
35477	AL	35594	AL	35961	AL	36037	AL

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
36038	AL	36274	AL	36462	AL	36752	AL
36039	AL	36275	AL	36467	AL	36753	AL
36040	AL	36276	AL	36470	AL	36754	AL
36041	AL	36278	AL	36471	AL	36756	AL
36042	AL	36280	AL	36473	AL	36763	AL
36045	AL	36310	AL	36474	AL	36764	AL
36047	AL	36311	AL	36475	AL	36765	AL
36048	AL	36313	AL	36476	AL	36766	AL
36049	AL	36314	AL	36477	AL	36768	AL
36051	AL	36316	AL	36480	AL	36769	AL
36053	AL	36317	AL	36481	AL	36776	AL
36054	AL	36318	AL	36483	AL	36778	AL
36061	AL	36322	AL	36509	AL	36779	AL
36062	AL	36340	AL	36513	AL	36782	AL
36066	AL	36344	AL	36518	AL	36783	AL
36067	AL	36345	AL	36522	AL	36785	AL
36068	AL	36349	AL	36529	AL	36786	AL
36071	AL	36350	AL	36538	AL	36790	AL
36072	AL	36352	AL	36539	AL	36792	AL
36075	AL	36353	AL	36548	AL	36793	AL
36078	AL	36360	AL	36553	AL	36850	AL
36079	AL	36361	AL	36556	AL	36851	AL
36080	AL	36362	AL	36558	AL	36853	AL
36081	AL	36371	AL	36569	AL	36856	AL
36082	AL	36373	AL	36581	AL	36858	AL
36083	AL	36374	AL	36583	AL	36859	AL
36087	AL	36375	AL	36584	AL	36860	AL
36088	AL	36401	AL	36585	AL	36861	AL
36089	AL	36420	AL	36720	AL	36866	AL
36091	AL	36425	AL	36721	AL	36867	AL
36092	AL	36429	AL	36722	AL	36868	AL
36093	AL	36431	AL	36723	AL	36869	AL
36251	AL	36432	AL	36726	AL	36871	AL
36255	AL	36435	AL	36728	AL	36872	AL
36256	AL	36439	AL	36732	AL	36875	AL
36258	AL	36442	AL	36736	AL	36901	AL
36261	AL	36444	AL	36738	AL	36904	AL
36262	AL	36445	AL	36740	AL	36906	AL
36263	AL	36449	AL	36741	AL	36907	AL
36264	AL	36454	AL	36742	AL	36908	AL
36266	AL	36455	AL	36744	AL	36910	AL
36267	AL	36456	AL	36745	AL	36912	AL
36268	AL	36457	AL	36748	AL	36913	AL
36269	AL	36458	AL	36749	AL	36915	AL
36270	AL	36460	AL	36750	AL	36916	AL
36273	AL	36461	AL	36751	AL	36919	AL

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
36921	AL	37162	TN	37369	TN	37753	TN
36922	AL	37175	TN	37370	TN	37754	TN
36925	AL	37178	TN	37371	TN	37755	TN
37015	TN	37180	TN	37380	TN	37756	TN
37016	TN	37183	TN	37381	TN	37757	TN
37020	TN	37184	TN	37385	TN	37760	TN
37023	TN	37185	TN	37387	TN	37762	TN
37025	TN	37187	TN	37391	TN	37763	TN
37026	TN	37188	TN	37395	TN	37765	TN
37028	TN	37190	TN	37397	TN	37766	TN
37029	TN	37301	TN	37640	TN	37770	TN
37032	TN	37303	TN	37642	TN	37771	TN
37033	TN	37305	TN	37643	TN	37772	TN
37035	TN	37307	TN	37644	TN	37773	TN
37049	TN	37309	TN	37645	TN	37774	TN
37050	TN	37313	TN	37650	TN	37779	TN
37058	TN	37314	TN	37657	TN	37807	TN
37061	TN	37316	TN	37658	TN	37819	TN
37071	TN	37317	TN	37680	TN	37820	TN
37073	TN	37321	TN	37682	TN	37821	TN
37078	TN	37322	TN	37683	TN	37822	TN
37079	TN	37325	TN	37687	TN	37824	TN
37082	TN	37326	TN	37688	TN	37825	TN
37083	TN	37327	TN	37691	TN	37826	TN
37087	TN	37328	TN	37692	TN	37829	TN
37088	TN	37329	TN	37694	TN	37840	TN
37090	TN	37331	TN	37707	TN	37841	TN
37096	TN	37332	TN	37708	TN	37843	TN
37097	TN	37333	TN	37709	TN	37845	TN
37098	TN	37334	TN	37713	TN	37846	TN
37101	TN	37335	TN	37714	TN	37847	TN
37121	TN	37336	TN	37715	TN	37848	TN
37122	TN	37337	TN	37719	TN	37851	TN
37134	TN	37338	TN	37722	TN	37852	TN
37136	TN	37339	TN	37724	TN	37854	TN
37137	TN	37348	TN	37725	TN	37861	TN
37140	TN	37352	TN	37726	TN	37866	TN
37143	TN	37354	TN	37727	TN	37867	TN
37144	TN	37356	TN	37729	TN	37869	TN
37146	TN	37359	TN	37730	TN	37870	TN
37147	TN	37360	TN	37731	TN	37871	TN
37149	TN	37361	TN	37732	TN	37872	TN
37150	TN	37362	TN	37733	TN	37873	TN
37152	TN	37365	TN	37742	TN	37874	TN
37160	TN	37366	TN	37748	TN	37879	TN
37161	TN	37367	TN	37752	TN	37880	TN

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
37881	TN	38221	TN	38340	TN	38471	TN
37885	TN	38222	TN	38341	TN	38472	TN
37887	TN	38223	TN	38342	TN	38473	TN
37888	TN	38224	TN	38344	TN	38475	TN
37890	TN	38225	TN	38345	TN	38476	TN
37892	TN	38226	TN	38347	TN	38477	TN
38001	TN	38229	TN	38348	TN	38478	TN
38004	TN	38230	TN	38351	TN	38481	TN
38006	TN	38231	TN	38352	TN	38483	TN
38008	TN	38232	TN	38357	TN	38485	TN
38011	TN	38235	TN	38359	TN	38486	TN
38012	TN	38236	TN	38361	TN	38488	TN
38021	TN	38237	TN	38363	TN	38504	TN
38023	TN	38238	TN	38365	TN	38541	TN
38034	TN	38240	TN	38367	TN	38542	TN
38037	TN	38241	TN	38368	TN	38543	TN
38039	TN	38242	TN	38370	TN	38549	TN
38040	TN	38251	TN	38371	TN	38551	TN
38041	TN	38253	TN	38372	TN	38553	TN
38042	TN	38254	TN	38374	TN	38554	TN
38043	TN	38255	TN	38375	TN	38556	TN
38044	TN	38256	TN	38376	TN	38559	TN
38046	TN	38257	TN	38377	TN	38562	TN
38048	TN	38258	TN	38379	TN	38564	TN
38050	TN	38260	TN	38380	TN	38565	TN
38052	TN	38261	TN	38381	TN	38568	TN
38053	TN	38271	TN	38387	TN	38570	TN
38054	TN	38281	TN	38388	TN	38573	TN
38055	TN	38310	TN	38390	TN	38575	TN
38057	TN	38311	TN	38393	TN	38577	TN
38058	TN	38315	TN	38425	TN	38579	TN
38060	TN	38317	TN	38449	TN	38580	TN
38061	TN	38318	TN	38450	TN	38583	TN
38063	TN	38320	TN	38452	TN	38585	TN
38066	TN	38321	TN	38453	TN	38587	TN
38067	TN	38324	TN	38454	TN	38588	TN
38069	TN	38326	TN	38455	TN	38589	TN
38071	TN	38327	TN	38456	TN	38602	MS
38074	TN	38328	TN	38457	TN	38603	MS
38075	TN	38329	TN	38459	TN	38606	MS
38077	TN	38332	TN	38460	TN	38609	MS
38079	TN	38333	TN	38462	TN	38610	MS
38080	TN	38334	TN	38463	TN	38611	MS
38083	TN	38336	TN	38464	TN	38618	MS
38201	TN	38337	TN	38468	TN	38619	MS
38220	TN	38339	TN	38469	TN	38620	MS

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
38621	MS	38820	MS	38926	MS	39090	MS
38622	MS	38827	MS	38927	MS	39092	MS
38623	MS	38828	MS	38928	MS	39094	MS
38625	MS	38829	MS	38929	MS	39095	MS
38626	MS	38833	MS	38940	MS	39096	MS
38627	MS	38834	MS	38943	MS	39097	MS
38628	MS	38835	MS	38947	MS	39098	MS
38629	MS	38838	MS	38948	MS	39107	MS
38632	MS	38839	MS	38950	MS	39108	MS
38633	MS	38841	MS	38951	MS	39109	MS
38634	MS	38843	MS	38953	MS	39111	MS
38635	MS	38846	MS	38954	MS	39112	MS
38637	MS	38847	MS	38955	MS	39113	MS
38638	MS	38850	MS	38957	MS	39114	MS
38641	MS	38851	MS	38958	MS	39115	MS
38642	MS	38852	MS	38960	MS	39116	MS
38643	MS	38854	MS	38961	MS	39117	MS
38646	MS	38855	MS	38962	MS	39119	MS
38647	MS	38856	MS	38963	MS	39140	MS
38649	MS	38858	MS	38964	MS	39144	MS
38650	MS	38859	MS	38965	MS	39146	MS
38651	MS	38860	MS	38966	MS	39149	MS
38652	MS	38863	MS	39038	MS	39150	MS
38654	MS	38864	MS	39039	MS	39152	MS
38658	MS	38865	MS	39040	MS	39153	MS
38659	MS	38869	MS	39044	MS	39159	MS
38661	MS	38871	MS	39051	MS	39160	MS
38663	MS	38873	MS	39054	MS	39162	MS
38664	MS	38875	MS	39057	MS	39166	MS
38665	MS	38876	MS	39059	MS	39168	MS
38666	MS	38877	MS	39061	MS	39169	MS
38668	MS	38878	MS	39062	MS	39171	MS
38670	MS	38880	MS	39063	MS	39173	MS
38671	MS	38901	MS	39067	MS	39176	MS
38672	MS	38902	MS	39069	MS	39177	MS
38674	MS	38912	MS	39074	MS	39179	MS
38676	MS	38913	MS	39077	MS	39189	MS
38679	MS	38914	MS	39078	MS	39191	MS
38680	MS	38915	MS	39079	MS	39192	MS
38683	MS	38916	MS	39080	MS	39194	MS
38685	MS	38917	MS	39081	MS	39322	MS
38686	MS	38920	MS	39082	MS	39323	MS
38721	MS	38921	MS	39083	MS	39324	MS
38745	MS	38922	MS	39086	MS	39327	MS
38754	MS	38923	MS	39087	MS	39328	MS
38765	MS	38924	MS	39088	MS	39330	MS

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
39332	MS	39481	MS	39776	MS	40057	KY
39336	MS	39482	MS	39813	GA	40058	KY
39337	MS	39483	MS	39823	GA	40060	KY
39338	MS	39520	MS	39826	GA	40061	KY
39339	MS	39521	MS	39827	GA	40062	KY
39341	MS	39522	MS	39828	GA	40063	KY
39345	MS	39525	MS	39829	GA	40065	KY
39346	MS	39529	MS	39832	GA	40066	KY
39347	MS	39556	MS	39841	GA	40067	KY
39348	MS	39558	MS	39842	GA	40068	KY
39352	MS	39561	MS	39845	GA	40069	KY
39354	MS	39572	MS	39846	GA	40070	KY
39355	MS	39573	MS	39854	GA	40071	KY
39356	MS	39576	MS	39859	GA	40075	KY
39358	MS	39577	MS	39861	GA	40076	KY
39359	MS	39630	MS	39862	GA	40078	KY
39360	MS	39631	MS	39866	GA	40104	KY
39361	MS	39633	MS	39867	GA	40107	KY
39362	MS	39638	MS	39870	GA	40108	KY
39363	MS	39641	MS	39877	GA	40109	KY
39366	MS	39643	MS	39897	GA	40110	KY
39367	MS	39645	MS	40003	KY	40111	KY
39421	MS	39647	MS	40004	KY	40115	KY
39422	MS	39653	MS	40006	KY	40117	KY
39423	MS	39654	MS	40007	KY	40119	KY
39426	MS	39656	MS	40008	KY	40129	KY
39427	MS	39661	MS	40009	KY	40140	KY
39428	MS	39663	MS	40011	KY	40142	KY
39429	MS	39664	MS	40012	KY	40143	KY
39439	MS	39665	MS	40013	KY	40144	KY
39451	MS	39668	MS	40019	KY	40145	KY
39452	MS	39669	MS	40020	KY	40146	KY
39455	MS	39735	MS	40022	KY	40150	KY
39456	MS	39737	MS	40033	KY	40152	KY
39457	MS	39739	MS	40036	KY	40153	KY
39460	MS	39741	MS	40037	KY	40155	KY
39461	MS	39744	MS	40040	KY	40157	KY
39462	MS	39745	MS	40045	KY	40161	KY
39463	MS	39750	MS	40046	KY	40164	KY
39466	MS	39751	MS	40047	KY	40165	KY
39470	MS	39752	MS	40048	KY	40170	KY
39474	MS	39754	MS	40049	KY	40171	KY
39475	MS	39755	MS	40050	KY	40176	KY
39476	MS	39771	MS	40051	KY	40178	KY
39478	MS	39772	MS	40052	KY	40311	KY
39479	MS	39773	MS	40055	KY	40312	KY

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
40316	KY	40602	KY	40921	KY	41127	KY
40322	KY	40603	KY	40923	KY	41128	KY
40328	KY	40604	KY	40927	KY	41132	KY
40334	KY	40618	KY	40930	KY	41135	KY
40336	KY	40619	KY	40931	KY	41137	KY
40342	KY	40620	KY	40932	KY	41139	KY
40346	KY	40621	KY	40935	KY	41141	KY
40350	KY	40622	KY	40941	KY	41142	KY
40355	KY	40734	KY	40943	KY	41143	KY
40358	KY	40771	KY	40944	KY	41144	KY
40359	KY	40801	KY	40946	KY	41146	KY
40360	KY	40803	KY	40949	KY	41149	KY
40363	KY	40806	KY	40951	KY	41156	KY
40366	KY	40807	KY	40953	KY	41159	KY
40371	KY	40808	KY	40962	KY	41160	KY
40374	KY	40810	KY	40964	KY	41164	KY
40376	KY	40815	KY	40972	KY	41166	KY
40380	KY	40816	KY	40979	KY	41169	KY
40387	KY	40818	KY	40982	KY	41170	KY
40402	KY	40819	KY	40983	KY	41171	KY
40409	KY	40820	KY	40995	KY	41173	KY
40410	KY	40823	KY	40997	KY	41174	KY
40419	KY	40824	KY	40999	KY	41175	KY
40421	KY	40827	KY	41002	KY	41179	KY
40434	KY	40828	KY	41004	KY	41180	KY
40437	KY	40829	KY	41008	KY	41181	KY
40442	KY	40830	KY	41037	KY	41183	KY
40444	KY	40831	KY	41039	KY	41189	KY
40445	KY	40840	KY	41040	KY	41201	KY
40446	KY	40843	KY	41041	KY	41203	KY
40447	KY	40844	KY	41043	KY	41214	KY
40448	KY	40847	KY	41044	KY	41224	KY
40456	KY	40849	KY	41045	KY	41230	KY
40460	KY	40854	KY	41046	KY	41231	KY
40461	KY	40855	KY	41049	KY	41232	KY
40467	KY	40858	KY	41061	KY	41250	KY
40472	KY	40863	KY	41064	KY	41262	KY
40473	KY	40865	KY	41065	KY	41264	KY
40481	KY	40868	KY	41081	KY	41267	KY
40484	KY	40870	KY	41083	KY	41301	KY
40486	KY	40873	KY	41086	KY	41307	KY
40488	KY	40874	KY	41093	KY	41310	KY
40489	KY	40903	KY	41095	KY	41311	KY
40492	KY	40906	KY	41098	KY	41313	KY
40495	KY	40914	KY	41121	KY	41314	KY
40601	KY	40915	KY	41124	KY	41317	KY

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Primary Care PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
41332	KY	41540	KY	41839	KY	42088	KY
41333	KY	41542	KY	41843	KY	42120	KY
41338	KY	41543	KY	41844	KY	42124	KY
41339	KY	41544	KY	41847	KY	42129	KY
41342	KY	41546	KY	41859	KY	42133	KY
41344	KY	41547	KY	41861	KY	42140	KY
41347	KY	41548	KY	41862	KY	42150	KY
41348	KY	41549	KY	42021	KY	42151	KY
41351	KY	41553	KY	42022	KY	42153	KY
41360	KY	41554	KY	42023	KY	42154	KY
41362	KY	41555	KY	42024	KY	42157	KY
41364	KY	41557	KY	42025	KY	42163	KY
41365	KY	41558	KY	42027	KY	42164	KY
41366	KY	41559	KY	42028	KY	42166	KY
41368	KY	41560	KY	42029	KY	42167	KY
41377	KY	41561	KY	42031	KY	42201	KY
41385	KY	41562	KY	42032	KY	42202	KY
41386	KY	41563	KY	42033	KY	42203	KY
41390	KY	41564	KY	42035	KY	42204	KY
41397	KY	41566	KY	42037	KY	42206	KY
41410	KY	41567	KY	42038	KY	42207	KY
41419	KY	41568	KY	42039	KY	42209	KY
41422	KY	41569	KY	42040	KY	42210	KY
41426	KY	41571	KY	42044	KY	42211	KY
41433	KY	41572	KY	42045	KY	42214	KY
41444	KY	41632	KY	42047	KY	42215	KY
41464	KY	41714	KY	42048	KY	42216	KY
41465	KY	41725	KY	42051	KY	42219	KY
41501	KY	41730	KY	42055	KY	42220	KY
41502	KY	41740	KY	42056	KY	42234	KY
41503	KY	41743	KY	42058	KY	42251	KY
41512	KY	41749	KY	42060	KY	42252	KY
41513	KY	41759	KY	42061	KY	42256	KY
41514	KY	41762	KY	42063	KY	42257	KY
41519	KY	41764	KY	42064	KY	42259	KY
41520	KY	41766	KY	42066	KY	42261	KY
41522	KY	41772	KY	42069	KY	42265	KY
41524	KY	41775	KY	42070	KY	42267	KY
41526	KY	41776	KY	42078	KY	42273	KY
41527	KY	41777	KY	42079	KY	42275	KY
41528	KY	41817	KY	42081	KY	42276	KY
41531	KY	41822	KY	42082	KY	42280	KY
41534	KY	41828	KY	42083	KY	42283	KY
41535	KY	41831	KY	42084	KY	42285	KY
41538	KY	41834	KY	42085	KY	42286	KY
41539	KY	41836	KY	42087	KY	42287	KY

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
42288	KY	42459	KY	43044	OH	43359	OH
42320	KY	42460	KY	43047	OH	43408	OH
42321	KY	42461	KY	43060	OH	43412	OH
42322	KY	42462	KY	43070	OH	43416	OH
42323	KY	42463	KY	43072	OH	43430	OH
42324	KY	42516	KY	43076	OH	43432	OH
42325	KY	42528	KY	43078	OH	43433	OH
42326	KY	42539	KY	43083	OH	43436	OH
42327	KY	42541	KY	43084	OH	43439	OH
42328	KY	42565	KY	43103	OH	43440	OH
42330	KY	42566	KY	43116	OH	43445	OH
42332	KY	42602	KY	43117	OH	43446	OH
42333	KY	42603	KY	43145	OH	43449	OH
42337	KY	42629	KY	43146	OH	43452	OH
42338	KY	42631	KY	43151	OH	43456	OH
42339	KY	42634	KY	43153	OH	43458	OH
42343	KY	42635	KY	43164	OH	43468	OH
42344	KY	42638	KY	43301	OH	43510	OH
42345	KY	42642	KY	43302	OH	43515	OH
42347	KY	42647	KY	43306	OH	43516	OH
42348	KY	42649	KY	43307	OH	43523	OH
42349	KY	42653	KY	43314	OH	43524	OH
42350	KY	42711	KY	43315	OH	43527	OH
42351	KY	42712	KY	43316	OH	43532	OH
42352	KY	42713	KY	43317	OH	43533	OH
42354	KY	42716	KY	43320	OH	43534	OH
42361	KY	42717	KY	43321	OH	43535	OH
42364	KY	42721	KY	43322	OH	43540	OH
42365	KY	42722	KY	43323	OH	43545	OH
42367	KY	42726	KY	43325	OH	43548	OH
42368	KY	42729	KY	43326	OH	43550	OH
42369	KY	42731	KY	43330	OH	43555	OH
42370	KY	42743	KY	43332	OH	43558	OH
42371	KY	42746	KY	43334	OH	43716	OH
42372	KY	42748	KY	43335	OH	43718	OH
42374	KY	42749	KY	43337	OH	43719	OH
42403	KY	42754	KY	43338	OH	43728	OH
42404	KY	42755	KY	43340	OH	43730	OH
42409	KY	42757	KY	43341	OH	43731	OH
42411	KY	42759	KY	43342	OH	43739	OH
42437	KY	42762	KY	43345	OH	43747	OH
42444	KY	42764	KY	43346	OH	43748	OH
42445	KY	42765	KY	43349	OH	43752	OH
42450	KY	42782	KY	43350	OH	43754	OH
42455	KY	42786	KY	43351	OH	43756	OH
42456	KY	43009	OH	43356	OH	43757	OH

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
43758	OH	43942	OH	44288	OH	44841	OH
43759	OH	43943	OH	44408	OH	44844	OH
43760	OH	43944	OH	44431	OH	44845	OH
43761	OH	43946	OH	44490	OH	44849	OH
43764	OH	43947	OH	44493	OH	44853	OH
43766	OH	43948	OH	44607	OH	44861	OH
43782	OH	43950	OH	44609	OH	44867	OH
43783	OH	43951	OH	44612	OH	44882	OH
43786	OH	43952	OH	44615	OH	44883	OH
43787	OH	43953	OH	44619	OH	45070	OH
43789	OH	43961	OH	44620	OH	45102	OH
43793	OH	43963	OH	44621	OH	45103	OH
43804	OH	43964	OH	44622	OH	45105	OH
43832	OH	43966	OH	44624	OH	45106	OH
43837	OH	43967	OH	44625	OH	45112	OH
43840	OH	43970	OH	44629	OH	45118	OH
43901	OH	43971	OH	44631	OH	45119	OH
43902	OH	43972	OH	44639	OH	45120	OH
43903	OH	43973	OH	44644	OH	45122	OH
43905	OH	43974	OH	44651	OH	45130	OH
43906	OH	43976	OH	44653	OH	45140	OH
43907	OH	43977	OH	44656	OH	45144	OH
43908	OH	43981	OH	44663	OH	45145	OH
43909	OH	43984	OH	44671	OH	45147	OH
43910	OH	43985	OH	44672	OH	45150	OH
43912	OH	43986	OH	44675	OH	45153	OH
43913	OH	43988	OH	44678	OH	45154	OH
43914	OH	44003	OH	44679	OH	45156	OH
43915	OH	44004	OH	44680	OH	45157	OH
43916	OH	44005	OH	44681	OH	45158	OH
43917	OH	44010	OH	44682	OH	45160	OH
43925	OH	44030	OH	44683	OH	45168	OH
43926	OH	44032	OH	44693	OH	45171	OH
43927	OH	44041	OH	44695	OH	45176	OH
43928	OH	44047	OH	44697	OH	45245	OH
43930	OH	44048	OH	44699	OH	45311	OH
43931	OH	44068	OH	44802	OH	45320	OH
43932	OH	44076	OH	44803	OH	45321	OH
43933	OH	44082	OH	44807	OH	45330	OH
43934	OH	44084	OH	44809	OH	45337	OH
43935	OH	44085	OH	44815	OH	45338	OH
43937	OH	44088	OH	44818	OH	45339	OH
43938	OH	44093	OH	44827	OH	45347	OH
43939	OH	44099	OH	44828	OH	45361	OH
43940	OH	44231	OH	44830	OH	45371	OH
43941	OH	44234	OH	44836	OH	45378	OH

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
45381	OH	45784	OH	45899	OH	46301	IN
45382	OH	45806	OH	46035	IN	46302	IN
45383	OH	45810	OH	46039	IN	46304	IN
45389	OH	45812	OH	46041	IN	46341	IN
45616	OH	45813	OH	46045	IN	46349	IN
45618	OH	45815	OH	46047	IN	46366	IN
45619	OH	45819	OH	46049	IN	46368	IN
45622	OH	45821	OH	46050	IN	46372	IN
45634	OH	45827	OH	46057	IN	46374	IN
45638	OH	45830	OH	46058	IN	46379	IN
45645	OH	45831	OH	46065	IN	46381	IN
45650	OH	45832	OH	46067	IN	46385	IN
45651	OH	45835	OH	46068	IN	46393	IN
45654	OH	45836	OH	46072	IN	46502	IN
45659	OH	45837	OH	46076	IN	46508	IN
45660	OH	45838	OH	46104	IN	46510	IN
45669	OH	45843	OH	46105	IN	46524	IN
45672	OH	45844	OH	46106	IN	46531	IN
45675	OH	45848	OH	46110	IN	46532	IN
45678	OH	45849	OH	46115	IN	46534	IN
45679	OH	45851	OH	46120	IN	46538	IN
45680	OH	45853	OH	46121	IN	46539	IN
45684	OH	45855	OH	46126	IN	46542	IN
45688	OH	45856	OH	46127	IN	46555	IN
45693	OH	45859	OH	46128	IN	46562	IN
45695	OH	45861	OH	46130	IN	46566	IN
45696	OH	45863	OH	46133	IN	46567	IN
45697	OH	45864	OH	46135	IN	46574	IN
45698	OH	45870	OH	46142	IN	46580	IN
45712	OH	45871	OH	46143	IN	46581	IN
45713	OH	45873	OH	46144	IN	46582	IN
45714	OH	45874	OH	46146	IN	46590	IN
45720	OH	45875	OH	46148	IN	46701	IN
45724	OH	45876	OH	46150	IN	46702	IN
45729	OH	45877	OH	46155	IN	46703	IN
45741	OH	45879	OH	46156	IN	46710	IN
45742	OH	45880	OH	46161	IN	46711	IN
45743	OH	45884	OH	46162	IN	46713	IN
45760	OH	45886	OH	46164	IN	46720	IN
45769	OH	45888	OH	46170	IN	46723	IN
45770	OH	45891	OH	46171	IN	46725	IN
45771	OH	45893	OH	46172	IN	46732	IN
45772	OH	45894	OH	46173	IN	46733	IN
45775	OH	45895	OH	46175	IN	46737	IN
45779	OH	45896	OH	46181	IN	46740	IN
45783	OH	45898	OH	46184	IN	46742	IN

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
46747	IN	46994	IN	47136	IN	47361	IN
46750	IN	46998	IN	47137	IN	47362	IN
46755	IN	47001	IN	47138	IN	47366	IN
46760	IN	47003	IN	47139	IN	47368	IN
46763	IN	47006	IN	47140	IN	47369	IN
46764	IN	47010	IN	47142	IN	47371	IN
46767	IN	47011	IN	47145	IN	47373	IN
46769	IN	47012	IN	47160	IN	47380	IN
46772	IN	47016	IN	47161	IN	47381	IN
46776	IN	47017	IN	47164	IN	47382	IN
46779	IN	47018	IN	47165	IN	47384	IN
46780	IN	47019	IN	47166	IN	47385	IN
46782	IN	47020	IN	47167	IN	47386	IN
46783	IN	47021	IN	47170	IN	47387	IN
46784	IN	47022	IN	47174	IN	47388	IN
46785	IN	47023	IN	47175	IN	47390	IN
46787	IN	47024	IN	47177	IN	47394	IN
46792	IN	47025	IN	47223	IN	47424	IN
46794	IN	47030	IN	47225	IN	47427	IN
46796	IN	47031	IN	47227	IN	47431	IN
46910	IN	47032	IN	47240	IN	47432	IN
46912	IN	47033	IN	47245	IN	47433	IN
46913	IN	47034	IN	47261	IN	47435	IN
46915	IN	47035	IN	47263	IN	47438	IN
46916	IN	47036	IN	47265	IN	47439	IN
46917	IN	47037	IN	47270	IN	47441	IN
46920	IN	47038	IN	47272	IN	47443	IN
46922	IN	47039	IN	47273	IN	47445	IN
46923	IN	47040	IN	47282	IN	47448	IN
46929	IN	47041	IN	47283	IN	47449	IN
46931	IN	47042	IN	47322	IN	47452	IN
46932	IN	47043	IN	47325	IN	47453	IN
46935	IN	47060	IN	47326	IN	47454	IN
46939	IN	47102	IN	47331	IN	47455	IN
46942	IN	47107	IN	47336	IN	47456	IN
46945	IN	47108	IN	47337	IN	47457	IN
46947	IN	47110	IN	47340	IN	47459	IN
46950	IN	47114	IN	47344	IN	47460	IN
46961	IN	47115	IN	47351	IN	47465	IN
46967	IN	47116	IN	47352	IN	47469	IN
46968	IN	47117	IN	47353	IN	47471	IN
46975	IN	47118	IN	47354	IN	47501	IN
46977	IN	47120	IN	47355	IN	47514	IN
46978	IN	47123	IN	47356	IN	47515	IN
46982	IN	47125	IN	47358	IN	47519	IN
46988	IN	47135	IN	47360	IN	47520	IN

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
47522	IN	47840	IN	47964	IN	48621	MI
47523	IN	47842	IN	47966	IN	48622	MI
47525	IN	47846	IN	47969	IN	48624	MI
47529	IN	47847	IN	47970	IN	48625	MI
47531	IN	47848	IN	47971	IN	48627	MI
47536	IN	47849	IN	47974	IN	48629	MI
47537	IN	47850	IN	47975	IN	48630	MI
47550	IN	47852	IN	47980	IN	48632	MI
47551	IN	47854	IN	47982	IN	48633	MI
47552	IN	47855	IN	47984	IN	48636	MI
47553	IN	47856	IN	47986	IN	48647	MI
47556	IN	47859	IN	47987	IN	48651	MI
47558	IN	47860	IN	47988	IN	48652	MI
47562	IN	47861	IN	47991	IN	48653	MI
47564	IN	47862	IN	47993	IN	48656	MI
47567	IN	47864	IN	47995	IN	48658	MI
47568	IN	47865	IN	47997	IN	48659	MI
47574	IN	47868	IN	48032	MI	48701	MI
47576	IN	47872	IN	48039	MI	48703	MI
47577	IN	47874	IN	48097	MI	48705	MI
47579	IN	47875	IN	48110	MI	48720	MI
47581	IN	47879	IN	48117	MI	48721	MI
47584	IN	47881	IN	48131	MI	48723	MI
47585	IN	47882	IN	48133	MI	48725	MI
47586	IN	47884	IN	48140	MI	48726	MI
47588	IN	47917	IN	48144	MI	48728	MI
47590	IN	47918	IN	48157	MI	48729	MI
47598	IN	47921	IN	48159	MI	48730	MI
47601	IN	47922	IN	48160	MI	48731	MI
47611	IN	47923	IN	48166	MI	48733	MI
47612	IN	47925	IN	48177	MI	48735	MI
47615	IN	47926	IN	48179	MI	48736	MI
47616	IN	47928	IN	48182	MI	48737	MI
47617	IN	47929	IN	48413	MI	48738	MI
47620	IN	47932	IN	48432	MI	48739	MI
47631	IN	47942	IN	48435	MI	48740	MI
47633	IN	47944	IN	48441	MI	48741	MI
47634	IN	47948	IN	48445	MI	48742	MI
47635	IN	47949	IN	48467	MI	48743	MI
47638	IN	47950	IN	48468	MI	48744	MI
47830	IN	47951	IN	48470	MI	48745	MI
47831	IN	47952	IN	48475	MI	48746	MI
47832	IN	47958	IN	48610	MI	48748	MI
47833	IN	47959	IN	48612	MI	48749	MI
47836	IN	47960	IN	48617	MI	48750	MI
47838	IN	47963	IN	48619	MI	48754	MI

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
48755	MI	49249	MI	49436	MI	49682	MI
48757	MI	49250	MI	49446	MI	49683	MI
48758	MI	49252	MI	49449	MI	49688	MI
48759	MI	49253	MI	49452	MI	49709	MI
48762	MI	49256	MI	49455	MI	49729	MI
48763	MI	49257	MI	49459	MI	49743	MI
48764	MI	49258	MI	49611	MI	49746	MI
48765	MI	49262	MI	49612	MI	49756	MI
48766	MI	49265	MI	49615	MI	49759	MI
48767	MI	49266	MI	49616	MI	49765	MI
48768	MI	49267	MI	49617	MI	49776	MI
48769	MI	49268	MI	49621	MI	49777	MI
48770	MI	49270	MI	49622	MI	49779	MI
48831	MI	49271	MI	49623	MI	49805	MI
49026	MI	49274	MI	49627	MI	49812	MI
49031	MI	49275	MI	49628	MI	49813	MI
49043	MI	49276	MI	49629	MI	49821	MI
49047	MI	49278	MI	49630	MI	49845	MI
49055	MI	49279	MI	49631	MI	49847	MI
49057	MI	49280	MI	49632	MI	49848	MI
49061	MI	49281	MI	49633	MI	49858	MI
49062	MI	49282	MI	49635	MI	49863	MI
49065	MI	49286	MI	49636	MI	49873	MI
49067	MI	49287	MI	49639	MI	49874	MI
49071	MI	49288	MI	49640	MI	49886	MI
49076	MI	49289	MI	49642	MI	49887	MI
49095	MI	49304	MI	49644	MI	49893	MI
49104	MI	49305	MI	49646	MI	49896	MI
49107	MI	49307	MI	49648	MI	49901	MI
49112	MI	49311	MI	49650	MI	49902	MI
49117	MI	49314	MI	49651	MI	49903	MI
49130	MI	49320	MI	49653	MI	49910	MI
49220	MI	49323	MI	49654	MI	49911	MI
49221	MI	49328	MI	49655	MI	49912	MI
49227	MI	49332	MI	49656	MI	49915	MI
49228	MI	49335	MI	49657	MI	49918	MI
49229	MI	49336	MI	49659	MI	49920	MI
49232	MI	49338	MI	49664	MI	49925	MI
49233	MI	49340	MI	49665	MI	49927	MI
49235	MI	49342	MI	49667	MI	49929	MI
49236	MI	49344	MI	49670	MI	49935	MI
49238	MI	49346	MI	49674	MI	49938	MI
49239	MI	49348	MI	49676	MI	49947	MI
49242	MI	49419	MI	49677	MI	49948	MI
49247	MI	49420	MI	49679	MI	49950	MI
49248	MI	49421	MI	49680	MI	49953	MI

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
49959	MI	50110	IA	50263	IA	50473	IA
49960	MI	50115	IA	50264	IA	50475	IA
49964	MI	50117	IA	50268	IA	50476	IA
49967	MI	50122	IA	50269	IA	50478	IA
49968	MI	50123	IA	50273	IA	50480	IA
49969	MI	50126	IA	50274	IA	50481	IA
49971	MI	50127	IA	50276	IA	50483	IA
50002	IA	50128	IA	50277	IA	50484	IA
50003	IA	50129	IA	50420	IA	50511	IA
50006	IA	50133	IA	50421	IA	50514	IA
50008	IA	50135	IA	50423	IA	50517	IA
50020	IA	50136	IA	50424	IA	50522	IA
50022	IA	50137	IA	50426	IA	50525	IA
50025	IA	50140	IA	50427	IA	50526	IA
50026	IA	50144	IA	50430	IA	50531	IA
50028	IA	50147	IA	50431	IA	50533	IA
50029	IA	50150	IA	50432	IA	50535	IA
50033	IA	50153	IA	50434	IA	50538	IA
50038	IA	50155	IA	50435	IA	50539	IA
50039	IA	50164	IA	50436	IA	50540	IA
50041	IA	50165	IA	50438	IA	50542	IA
50042	IA	50167	IA	50439	IA	50546	IA
50043	IA	50168	IA	50440	IA	50551	IA
50048	IA	50170	IA	50441	IA	50552	IA
50050	IA	50173	IA	50444	IA	50554	IA
50052	IA	50206	IA	50446	IA	50556	IA
50054	IA	50208	IA	50447	IA	50559	IA
50059	IA	50216	IA	50448	IA	50560	IA
50060	IA	50217	IA	50449	IA	50561	IA
50063	IA	50218	IA	50450	IA	50563	IA
50064	IA	50222	IA	50451	IA	50567	IA
50065	IA	50227	IA	50452	IA	50571	IA
50067	IA	50228	IA	50453	IA	50573	IA
50069	IA	50230	IA	50454	IA	50574	IA
50070	IA	50232	IA	50455	IA	50575	IA
50071	IA	50233	IA	50456	IA	50578	IA
50072	IA	50235	IA	50458	IA	50579	IA
50074	IA	50240	IA	50459	IA	50581	IA
50076	IA	50250	IA	50460	IA	50583	IA
50101	IA	50251	IA	50461	IA	50586	IA
50102	IA	50255	IA	50465	IA	50590	IA
50103	IA	50257	IA	50466	IA	50593	IA
50104	IA	50258	IA	50468	IA	50598	IA
50107	IA	50259	IA	50470	IA	50599	IA
50108	IA	50261	IA	50471	IA	50601	IA
50109	IA	50262	IA	50472	IA	50602	IA

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
50603	IA	50666	IA	51024	IA	51448	IA
50604	IA	50668	IA	51028	IA	51449	IA
50605	IA	50669	IA	51029	IA	51450	IA
50606	IA	50670	IA	51031	IA	51453	IA
50607	IA	50671	IA	51035	IA	51454	IA
50608	IA	50672	IA	51037	IA	51458	IA
50609	IA	50673	IA	51038	IA	51460	IA
50611	IA	50674	IA	51045	IA	51461	IA
50612	IA	50675	IA	51046	IA	51462	IA
50616	IA	50676	IA	51048	IA	51465	IA
50619	IA	50677	IA	51049	IA	51466	IA
50620	IA	50680	IA	51050	IA	51467	IA
50621	IA	50681	IA	51053	IA	51520	IA
50622	IA	50682	IA	51058	IA	51525	IA
50624	IA	50833	IA	51061	IA	51527	IA
50625	IA	50835	IA	51062	IA	51528	IA
50627	IA	50836	IA	51201	IA	51529	IA
50628	IA	50837	IA	51230	IA	51530	IA
50629	IA	50839	IA	51231	IA	51531	IA
50630	IA	50840	IA	51235	IA	51533	IA
50631	IA	50841	IA	51237	IA	51534	IA
50632	IA	50843	IA	51240	IA	51535	IA
50633	IA	50845	IA	51241	IA	51536	IA
50635	IA	50846	IA	51242	IA	51537	IA
50636	IA	50848	IA	51243	IA	51540	IA
50638	IA	50849	IA	51245	IA	51541	IA
50641	IA	50851	IA	51246	IA	51543	IA
50642	IA	50853	IA	51248	IA	51544	IA
50644	IA	50854	IA	51331	IA	51545	IA
50645	IA	50857	IA	51334	IA	51546	IA
50647	IA	50858	IA	51344	IA	51549	IA
50648	IA	50859	IA	51346	IA	51550	IA
50649	IA	50860	IA	51347	IA	51551	IA
50650	IA	50862	IA	51351	IA	51552	IA
50652	IA	50863	IA	51355	IA	51554	IA
50653	IA	51001	IA	51360	IA	51555	IA
50654	IA	51004	IA	51363	IA	51556	IA
50655	IA	51005	IA	51364	IA	51557	IA
50657	IA	51008	IA	51365	IA	51560	IA
50658	IA	51009	IA	51432	IA	51561	IA
50659	IA	51012	IA	51433	IA	51562	IA
50660	IA	51014	IA	51439	IA	51563	IA
50661	IA	51016	IA	51441	IA	51564	IA
50662	IA	51017	IA	51442	IA	51565	IA
50664	IA	51018	IA	51446	IA	51570	IA
50665	IA	51019	IA	51447	IA	51571	IA

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
51574	IA	52075	IA	52226	IA	52361	IA
51578	IA	52076	IA	52229	IA	52362	IA
51579	IA	52077	IA	52231	IA	52531	IA
51593	IA	52078	IA	52236	IA	52535	IA
51639	IA	52079	IA	52237	IA	52537	IA
51640	IA	52134	IA	52248	IA	52538	IA
51645	IA	52135	IA	52249	IA	52542	IA
51646	IA	52136	IA	52251	IA	52544	IA
51648	IA	52140	IA	52252	IA	52549	IA
51649	IA	52141	IA	52254	IA	52550	IA
51650	IA	52142	IA	52255	IA	52551	IA
51652	IA	52146	IA	52257	IA	52552	IA
51653	IA	52147	IA	52301	IA	52555	IA
51654	IA	52151	IA	52305	IA	52560	IA
52030	IA	52154	IA	52306	IA	52562	IA
52031	IA	52155	IA	52307	IA	52563	IA
52032	IA	52156	IA	52308	IA	52565	IA
52033	IA	52157	IA	52309	IA	52568	IA
52035	IA	52158	IA	52310	IA	52569	IA
52036	IA	52159	IA	52312	IA	52570	IA
52037	IA	52160	IA	52313	IA	52571	IA
52038	IA	52162	IA	52315	IA	52572	IA
52040	IA	52163	IA	52316	IA	52573	IA
52041	IA	52164	IA	52318	IA	52574	IA
52042	IA	52166	IA	52320	IA	52576	IA
52043	IA	52169	IA	52321	IA	52581	IA
52044	IA	52170	IA	52323	IA	52583	IA
52047	IA	52171	IA	52325	IA	52584	IA
52048	IA	52172	IA	52326	IA	52585	IA
52049	IA	52175	IA	52329	IA	52588	IA
52050	IA	52203	IA	52330	IA	52590	IA
52052	IA	52204	IA	52332	IA	52591	IA
52053	IA	52205	IA	52334	IA	52593	IA
52054	IA	52206	IA	52335	IA	52594	IA
52055	IA	52207	IA	52337	IA	52601	IA
52056	IA	52208	IA	52339	IA	52620	IA
52057	IA	52209	IA	52342	IA	52623	IA
52060	IA	52210	IA	52345	IA	52626	IA
52064	IA	52212	IA	52346	IA	52630	IA
52065	IA	52215	IA	52347	IA	52637	IA
52066	IA	52216	IA	52348	IA	52638	IA
52069	IA	52217	IA	52349	IA	52640	IA
52070	IA	52220	IA	52351	IA	52641	IA
52071	IA	52223	IA	52354	IA	52642	IA
52072	IA	52224	IA	52355	IA	52644	IA
52074	IA	52225	IA	52358	IA	52645	IA

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
52646	IA	53088	WI	53952	WI	54182	WI
52647	IA	53504	WI	53953	WI	54201	WI
52649	IA	53510	WI	53962	WI	54202	WI
52650	IA	53516	WI	53964	WI	54204	WI
52651	IA	53518	WI	53968	WI	54205	WI
52652	IA	53525	WI	54021	WI	54209	WI
52653	IA	53530	WI	54101	WI	54210	WI
52654	IA	53536	WI	54102	WI	54211	WI
52655	IA	53541	WI	54103	WI	54212	WI
52659	IA	53554	WI	54104	WI	54213	WI
52660	IA	53569	WI	54107	WI	54216	WI
52701	IA	53573	WI	54110	WI	54217	WI
52720	IA	53586	WI	54111	WI	54226	WI
52721	IA	53587	WI	54112	WI	54234	WI
52727	IA	53599	WI	54114	WI	54235	WI
52729	IA	53801	WI	54119	WI	54246	WI
52730	IA	53802	WI	54120	WI	54411	WI
52731	IA	53803	WI	54121	WI	54414	WI
52732	IA	53804	WI	54123	WI	54416	WI
52733	IA	53805	WI	54124	WI	54426	WI
52736	IA	53806	WI	54125	WI	54448	WI
52737	IA	53807	WI	54127	WI	54450	WI
52738	IA	53808	WI	54128	WI	54459	WI
52739	IA	53809	WI	54129	WI	54479	WI
52742	IA	53810	WI	54137	WI	54484	WI
52747	IA	53811	WI	54138	WI	54486	WI
52749	IA	53812	WI	54139	WI	54488	WI
52750	IA	53813	WI	54141	WI	54499	WI
52751	IA	53816	WI	54143	WI	54511	WI
52752	IA	53817	WI	54149	WI	54512	WI
52754	IA	53818	WI	54151	WI	54513	WI
52757	IA	53820	WI	54152	WI	54515	WI
52759	IA	53824	WI	54153	WI	54519	WI
52760	IA	53825	WI	54154	WI	54520	WI
52761	IA	53827	WI	54156	WI	54521	WI
52766	IA	53910	WI	54157	WI	54524	WI
52769	IA	53920	WI	54159	WI	54525	WI
52771	IA	53927	WI	54160	WI	54534	WI
52772	IA	53929	WI	54161	WI	54536	WI
52774	IA	53930	WI	54165	WI	54537	WI
52776	IA	53934	WI	54166	WI	54538	WI
52777	IA	53936	WI	54169	WI	54540	WI
52778	IA	53944	WI	54171	WI	54541	WI
53014	WI	53948	WI	54174	WI	54542	WI
53061	WI	53949	WI	54175	WI	54545	WI
53062	WI	53950	WI	54177	WI	54547	WI

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
54550	WI	54832	WI	55373	MN	56044	MN
54552	WI	54839	WI	55376	MN	56045	MN
54554	WI	54840	WI	55380	MN	56047	MN
54555	WI	54844	WI	55382	MN	56050	MN
54556	WI	54845	WI	55389	MN	56051	MN
54557	WI	54847	WI	55390	MN	56056	MN
54558	WI	54856	WI	55396	MN	56057	MN
54559	WI	54865	WI	55748	MN	56058	MN
54560	WI	54872	WI	55760	MN	56060	MN
54561	WI	54891	WI	55785	MN	56062	MN
54565	WI	54893	WI	55787	MN	56068	MN
54566	WI	54922	WI	55921	MN	56069	MN
54610	WI	54928	WI	55922	MN	56076	MN
54612	WI	54930	WI	55923	MN	56081	MN
54613	WI	54943	WI	55931	MN	56083	MN
54616	WI	54948	WI	55935	MN	56089	MN
54618	WI	54960	WI	55939	MN	56096	MN
54622	WI	54965	WI	55943	MN	56097	MN
54625	WI	54966	WI	55949	MN	56098	MN
54627	WI	54967	WI	55954	MN	56111	MN
54629	WI	54970	WI	55961	MN	56113	MN
54630	WI	54976	WI	55962	MN	56114	MN
54637	WI	54978	WI	55965	MN	56120	MN
54641	WI	54982	WI	55971	MN	56122	MN
54646	WI	54984	WI	55974	MN	56123	MN
54661	WI	55040	MN	55975	MN	56125	MN
54721	WI	55301	MN	55990	MN	56131	MN
54722	WI	55307	MN	56007	MN	56136	MN
54736	WI	55310	MN	56009	MN	56137	MN
54738	WI	55314	MN	56013	MN	56141	MN
54741	WI	55320	MN	56014	MN	56142	MN
54743	WI	55324	MN	56016	MN	56143	MN
54747	WI	55325	MN	56017	MN	56149	MN
54755	WI	55328	MN	56020	MN	56150	MN
54756	WI	55329	MN	56022	MN	56151	MN
54758	WI	55332	MN	56023	MN	56152	MN
54759	WI	55333	MN	56025	MN	56160	MN
54760	WI	55334	MN	56027	MN	56161	MN
54769	WI	55335	MN	56028	MN	56166	MN
54770	WI	55338	MN	56029	MN	56172	MN
54773	WI	55341	MN	56032	MN	56178	MN
54814	WI	55342	MN	56033	MN	56180	MN
54816	WI	55355	MN	56035	MN	56208	MN
54821	WI	55358	MN	56036	MN	56212	MN
54827	WI	55363	MN	56042	MN	56214	MN
54830	WI	55366	MN	56043	MN	56215	MN

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Primary Care PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
56218	MN	56336	MN	56533	MN	56629	MN
56220	MN	56339	MN	56534	MN	56633	MN
56222	MN	56347	MN	56535	MN	56634	MN
56223	MN	56350	MN	56536	MN	56641	MN
56224	MN	56357	MN	56537	MN	56644	MN
56226	MN	56361	MN	56538	MN	56646	MN
56228	MN	56367	MN	56540	MN	56649	MN
56230	MN	56379	MN	56541	MN	56651	MN
56231	MN	56389	MN	56542	MN	56652	MN
56232	MN	56430	MN	56543	MN	56653	MN
56237	MN	56431	MN	56545	MN	56654	MN
56241	MN	56434	MN	56546	MN	56655	MN
56243	MN	56435	MN	56547	MN	56658	MN
56245	MN	56437	MN	56548	MN	56660	MN
56248	MN	56438	MN	56549	MN	56661	MN
56249	MN	56440	MN	56550	MN	56662	MN
56252	MN	56446	MN	56551	MN	56668	MN
56255	MN	56452	MN	56552	MN	56669	MN
56256	MN	56453	MN	56553	MN	56672	MN
56257	MN	56464	MN	56556	MN	56676	MN
56260	MN	56469	MN	56557	MN	56679	MN
56262	MN	56473	MN	56560	MN	56684	MN
56263	MN	56474	MN	56561	MN	56710	MN
56265	MN	56477	MN	56565	MN	56712	MN
56266	MN	56478	MN	56566	MN	56713	MN
56270	MN	56479	MN	56567	MN	56715	MN
56271	MN	56481	MN	56568	MN	56716	MN
56274	MN	56482	MN	56571	MN	56720	MN
56277	MN	56484	MN	56572	MN	56721	MN
56280	MN	56510	MN	56573	MN	56722	MN
56283	MN	56513	MN	56574	MN	56723	MN
56284	MN	56514	MN	56576	MN	56724	MN
56285	MN	56515	MN	56579	MN	56727	MN
56287	MN	56516	MN	56580	MN	56728	MN
56292	MN	56517	MN	56581	MN	56729	MN
56293	MN	56518	MN	56584	MN	56731	MN
56294	MN	56519	MN	56585	MN	56732	MN
56295	MN	56520	MN	56586	MN	56733	MN
56297	MN	56522	MN	56587	MN	56734	MN
56304	MN	56523	MN	56588	MN	56735	MN
56309	MN	56524	MN	56590	MN	56736	MN
56311	MN	56525	MN	56592	MN	56737	MN
56318	MN	56527	MN	56594	MN	56738	MN
56324	MN	56528	MN	56621	MN	56742	MN
56329	MN	56529	MN	56626	MN	56744	MN
56333	MN	56531	MN	56627	MN	56748	MN

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
56750	MN	57212	SD	57321	SD	57462	SD
56755	MN	57213	SD	57323	SD	57465	SD
56757	MN	57214	SD	57328	SD	57466	SD
56758	MN	57216	SD	57330	SD	57468	SD
56760	MN	57217	SD	57331	SD	57469	SD
56762	MN	57218	SD	57332	SD	57470	SD
57001	SD	57219	SD	57337	SD	57471	SD
57004	SD	57221	SD	57339	SD	57472	SD
57010	SD	57223	SD	57340	SD	57473	SD
57012	SD	57225	SD	57341	SD	57476	SD
57014	SD	57226	SD	57344	SD	57477	SD
57015	SD	57231	SD	57345	SD	57520	SD
57016	SD	57232	SD	57346	SD	57521	SD
57017	SD	57233	SD	57349	SD	57531	SD
57021	SD	57234	SD	57353	SD	57532	SD
57024	SD	57236	SD	57354	SD	57537	SD
57025	SD	57237	SD	57359	SD	57540	SD
57028	SD	57238	SD	57364	SD	57542	SD
57029	SD	57239	SD	57365	SD	57543	SD
57036	SD	57241	SD	57366	SD	57544	SD
57037	SD	57242	SD	57368	SD	57547	SD
57038	SD	57244	SD	57374	SD	57548	SD
57042	SD	57246	SD	57375	SD	57551	SD
57043	SD	57247	SD	57376	SD	57557	SD
57044	SD	57248	SD	57383	SD	57559	SD
57045	SD	57249	SD	57385	SD	57560	SD
57047	SD	57251	SD	57420	SD	57562	SD
57048	SD	57252	SD	57421	SD	57564	SD
57049	SD	57253	SD	57422	SD	57568	SD
57050	SD	57258	SD	57424	SD	57569	SD
57051	SD	57259	SD	57428	SD	57574	SD
57052	SD	57261	SD	57429	SD	57576	SD
57053	SD	57264	SD	57430	SD	57577	SD
57054	SD	57265	SD	57434	SD	57579	SD
57057	SD	57268	SD	57435	SD	57585	SD
57058	SD	57269	SD	57436	SD	57601	SD
57059	SD	57270	SD	57437	SD	57620	SD
57062	SD	57271	SD	57438	SD	57621	SD
57063	SD	57273	SD	57440	SD	57622	SD
57065	SD	57274	SD	57448	SD	57623	SD
57066	SD	57278	SD	57451	SD	57629	SD
57069	SD	57311	SD	57452	SD	57631	SD
57070	SD	57313	SD	57454	SD	57632	SD
57073	SD	57314	SD	57456	SD	57634	SD
57075	SD	57315	SD	57457	SD	57638	SD
57076	SD	57319	SD	57461	SD	57639	SD

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
57640	SD	58007	ND	58236	ND	58428	ND
57641	SD	58008	ND	58238	ND	58430	ND
57642	SD	58011	ND	58241	ND	58431	ND
57644	SD	58012	ND	58254	ND	58433	ND
57645	SD	58013	ND	58259	ND	58436	ND
57646	SD	58015	ND	58262	ND	58438	ND
57648	SD	58017	ND	58265	ND	58439	ND
57649	SD	58018	ND	58271	ND	58440	ND
57650	SD	58027	ND	58272	ND	58441	ND
57651	SD	58029	ND	58276	ND	58442	ND
57653	SD	58030	ND	58277	ND	58444	ND
57657	SD	58032	ND	58282	ND	58448	ND
57658	SD	58033	ND	58317	ND	58451	ND
57659	SD	58036	ND	58318	ND	58452	ND
57660	SD	58038	ND	58319	ND	58454	ND
57714	SD	58039	ND	58324	ND	58456	ND
57716	SD	58040	ND	58331	ND	58458	ND
57717	SD	58041	ND	58332	ND	58460	ND
57720	SD	58043	ND	58335	ND	58463	ND
57724	SD	58046	ND	58337	ND	58466	ND
57725	SD	58048	ND	58339	ND	58474	ND
57729	SD	58053	ND	58341	ND	58475	ND
57742	SD	58054	ND	58343	ND	58477	ND
57750	SD	58056	ND	58344	ND	58478	ND
57752	SD	58057	ND	58346	ND	58482	ND
57755	SD	58058	ND	58348	ND	58484	ND
57756	SD	58060	ND	58351	ND	58486	ND
57760	SD	58061	ND	58356	ND	58487	ND
57761	SD	58064	ND	58357	ND	58488	ND
57762	SD	58067	ND	58361	ND	58489	ND
57764	SD	58068	ND	58363	ND	58490	ND
57767	SD	58069	ND	58365	ND	58494	ND
57770	SD	58071	ND	58370	ND	58495	ND
57772	SD	58074	ND	58374	ND	58520	ND
57775	SD	58075	ND	58379	ND	58521	ND
57776	SD	58076	ND	58380	ND	58524	ND
57780	SD	58077	ND	58381	ND	58530	ND
57788	SD	58079	ND	58384	ND	58531	ND
57790	SD	58081	ND	58386	ND	58535	ND
57791	SD	58212	ND	58413	ND	58540	ND
57794	SD	58216	ND	58415	ND	58542	ND
58001	ND	58220	ND	58416	ND	58544	ND
58002	ND	58222	ND	58418	ND	58549	ND
58004	ND	58224	ND	58422	ND	58552	ND
58005	ND	58225	ND	58423	ND	58559	ND
58006	ND	58230	ND	58425	ND	58561	ND

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Primary Care PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
58563	ND	58747	ND	59062	MT	59318	MT
58565	ND	58748	ND	59063	MT	59319	SD
58566	ND	58750	ND	59067	MT	59322	MT
58573	ND	58752	ND	59069	MT	59323	MT
58575	ND	58757	ND	59072	MT	59324	MT
58576	ND	58758	ND	59073	MT	59327	MT
58577	ND	58759	ND	59074	MT	59332	MT
58579	ND	58760	ND	59076	MT	59333	MT
58581	ND	58761	ND	59077	MT	59337	MT
58620	ND	58762	ND	59083	MT	59343	MT
58621	ND	58765	ND	59084	MT	59345	MT
58623	ND	58768	ND	59087	MT	59347	MT
58625	ND	58772	ND	59211	MT	59348	MT
58626	ND	58773	ND	59214	MT	59353	MT
58627	ND	58775	ND	59215	MT	59419	MT
58631	ND	58778	ND	59219	MT	59420	MT
58632	ND	58782	ND	59222	MT	59422	MT
58634	ND	58783	ND	59223	MT	59433	MT
58636	ND	58787	ND	59225	MT	59436	MT
58638	ND	58788	ND	59230	MT	59440	MT
58640	ND	58789	ND	59231	MT	59442	MT
58642	ND	58790	ND	59240	MT	59446	MT
58643	ND	58792	ND	59241	MT	59447	MT
58644	ND	58793	ND	59242	MT	59450	MT
58645	ND	58831	ND	59244	MT	59452	MT
58646	ND	58833	ND	59247	MT	59460	MT
58647	ND	58835	ND	59248	MT	59462	MT
58650	ND	58838	ND	59250	MT	59467	MT
58651	ND	58844	ND	59252	MT	59468	MT
58653	ND	58847	ND	59253	MT	59469	MT
58654	ND	58854	ND	59254	MT	59479	MT
58710	ND	59001	MT	59256	MT	59520	MT
58711	ND	59003	MT	59257	MT	59523	MT
58712	ND	59004	MT	59258	MT	59524	MT
58713	ND	59010	MT	59260	MT	59526	MT
58716	ND	59012	MT	59261	MT	59527	MT
58721	ND	59019	MT	59263	MT	59529	MT
58723	ND	59028	MT	59273	MT	59535	MT
58727	ND	59038	MT	59274	MT	59537	MT
58730	ND	59039	MT	59275	MT	59538	MT
58731	ND	59043	MT	59276	MT	59542	MT
58736	ND	59046	MT	59311	MT	59544	MT
58737	ND	59054	MT	59312	MT	59546	MT
58740	ND	59058	MT	59314	MT	59547	MT
58741	ND	59059	MT	59316	MT	59641	MT
58744	ND	59061	MT	59317	MT	59643	MT

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
59644	MT	60930	IL	61085	IL	61335	IL
59647	MT	60931	IL	61087	IL	61336	IL
59711	MT	60932	IL	61230	IL	61337	IL
59756	MT	60938	IL	61231	IL	61338	IL
59820	MT	60939	IL	61233	IL	61340	IL
59827	MT	60942	IL	61234	IL	61341	IL
59828	MT	60945	IL	61235	IL	61342	IL
59829	MT	60948	IL	61238	IL	61344	IL
59830	MT	60951	IL	61241	IL	61345	IL
59831	MT	60953	IL	61243	IL	61346	IL
59832	MT	60954	IL	61250	IL	61348	IL
59833	MT	60955	IL	61251	IL	61349	IL
59835	MT	60956	IL	61252	IL	61350	IL
59837	MT	60960	IL	61254	IL	61354	IL
59840	MT	60963	IL	61258	IL	61356	IL
59841	MT	60966	IL	61260	IL	61358	IL
59842	MT	60967	IL	61261	IL	61359	IL
59844	MT	60968	IL	61262	IL	61360	IL
59845	MT	60970	IL	61263	IL	61361	IL
59848	MT	60973	IL	61270	IL	61362	IL
59853	MT	60974	IL	61272	IL	61363	IL
59856	MT	61001	IL	61273	IL	61364	IL
59858	MT	61011	IL	61274	IL	61368	IL
59859	MT	61012	IL	61276	IL	61369	IL
59866	MT	61014	IL	61277	IL	61370	IL
59867	MT	61015	IL	61281	IL	61371	IL
59870	MT	61020	IL	61283	IL	61372	IL
59871	MT	61025	IL	61285	IL	61373	IL
59872	MT	61028	IL	61301	IL	61374	IL
59873	MT	61036	IL	61312	IL	61375	IL
59874	MT	61037	IL	61314	IL	61376	IL
59875	MT	61041	IL	61315	IL	61377	IL
60470	IL	61043	IL	61316	IL	61379	IL
60518	IL	61046	IL	61317	IL	61412	IL
60531	IL	61049	IL	61320	IL	61413	IL
60549	IL	61051	IL	61321	IL	61415	IL
60551	IL	61052	IL	61322	IL	61418	IL
60557	IL	61053	IL	61323	IL	61419	IL
60911	IL	61059	IL	61325	IL	61421	IL
60912	IL	61065	IL	61326	IL	61424	IL
60918	IL	61071	IL	61327	IL	61425	IL
60922	IL	61074	IL	61328	IL	61426	IL
60924	IL	61075	IL	61329	IL	61427	IL
60926	IL	61078	IL	61330	IL	61431	IL
60927	IL	61081	IL	61332	IL	61432	IL
60928	IL	61084	IL	61334	IL	61433	IL

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
61434	IL	61553	IL	61842	IL	62010	IL
61437	IL	61554	IL	61844	IL	62011	IL
61441	IL	61555	IL	61846	IL	62012	IL
61442	IL	61558	IL	61848	IL	62013	IL
61443	IL	61560	IL	61850	IL	62014	IL
61449	IL	61561	IL	61854	IL	62015	IL
61450	IL	61563	IL	61855	IL	62016	IL
61452	IL	61564	IL	61856	IL	62017	IL
61454	IL	61565	IL	61857	IL	62018	IL
61459	IL	61567	IL	61858	IL	62019	IL
61460	IL	61568	IL	61865	IL	62021	IL
61465	IL	61570	IL	61866	IL	62022	IL
61466	IL	61571	IL	61870	IL	62023	IL
61468	IL	61610	IL	61876	IL	62024	IL
61469	IL	61611	IL	61882	IL	62025	IL
61471	IL	61721	IL	61883	IL	62026	IL
61476	IL	61727	IL	61884	IL	62027	IL
61477	IL	61729	IL	61910	IL	62028	IL
61479	IL	61733	IL	61911	IL	62030	IL
61480	IL	61734	IL	61913	IL	62031	IL
61482	IL	61735	IL	61914	IL	62032	IL
61483	IL	61738	IL	61917	IL	62033	IL
61484	IL	61742	IL	61919	IL	62034	IL
61486	IL	61747	IL	61924	IL	62035	IL
61490	IL	61749	IL	61925	IL	62036	IL
61491	IL	61750	IL	61928	IL	62037	IL
61501	IL	61755	IL	61929	IL	62040	IL
61516	IL	61759	IL	61930	IL	62044	IL
61519	IL	61760	IL	61932	IL	62045	IL
61520	IL	61771	IL	61933	IL	62046	IL
61524	IL	61777	IL	61936	IL	62047	IL
61530	IL	61778	IL	61937	IL	62048	IL
61531	IL	61810	IL	61940	IL	62049	IL
61532	IL	61811	IL	61941	IL	62050	IL
61534	IL	61812	IL	61942	IL	62051	IL
61535	IL	61813	IL	61944	IL	62052	IL
61537	IL	61814	IL	61949	IL	62053	IL
61540	IL	61817	IL	61951	IL	62054	IL
61541	IL	61818	IL	61953	IL	62056	IL
61542	IL	61830	IL	61955	IL	62058	IL
61543	IL	61831	IL	61956	IL	62060	IL
61544	IL	61832	IL	61957	IL	62061	IL
61545	IL	61833	IL	62001	IL	62062	IL
61546	IL	61834	IL	62002	IL	62063	IL
61548	IL	61839	IL	62006	IL	62065	IL
61550	IL	61841	IL	62009	IL	62067	IL

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
62069	IL	62313	IL	62433	IL	62556	IL
62070	IL	62314	IL	62434	IL	62557	IL
62074	IL	62316	IL	62435	IL	62560	IL
62075	IL	62318	IL	62436	IL	62565	IL
62076	IL	62319	IL	62438	IL	62567	IL
62077	IL	62321	IL	62439	IL	62568	IL
62078	IL	62323	IL	62441	IL	62570	IL
62079	IL	62329	IL	62442	IL	62571	IL
62080	IL	62330	IL	62444	IL	62572	IL
62081	IL	62334	IL	62446	IL	62610	IL
62082	IL	62336	IL	62447	IL	62611	IL
62083	IL	62340	IL	62448	IL	62612	IL
62084	IL	62341	IL	62449	IL	62613	IL
62085	IL	62343	IL	62451	IL	62617	IL
62086	IL	62344	IL	62454	IL	62618	IL
62087	IL	62345	IL	62458	IL	62621	IL
62088	IL	62352	IL	62459	IL	62622	IL
62089	IL	62353	IL	62460	IL	62624	IL
62090	IL	62354	IL	62462	IL	62626	IL
62091	IL	62355	IL	62463	IL	62627	IL
62092	IL	62356	IL	62464	IL	62630	IL
62093	IL	62357	IL	62465	IL	62633	IL
62094	IL	62358	IL	62466	IL	62639	IL
62095	IL	62361	IL	62468	IL	62640	IL
62097	IL	62362	IL	62471	IL	62642	IL
62098	IL	62363	IL	62474	IL	62644	IL
62215	IL	62366	IL	62475	IL	62649	IL
62218	IL	62367	IL	62476	IL	62655	IL
62234	IL	62370	IL	62477	IL	62659	IL
62238	IL	62373	IL	62478	IL	62662	IL
62245	IL	62375	IL	62479	IL	62663	IL
62246	IL	62378	IL	62480	IL	62664	IL
62247	IL	62379	IL	62481	IL	62667	IL
62249	IL	62380	IL	62510	IL	62672	IL
62262	IL	62410	IL	62511	IL	62673	IL
62265	IL	62413	IL	62517	IL	62674	IL
62266	IL	62415	IL	62531	IL	62675	IL
62273	IL	62417	IL	62533	IL	62681	IL
62274	IL	62418	IL	62534	IL	62682	IL
62275	IL	62420	IL	62538	IL	62683	IL
62281	IL	62422	IL	62540	IL	62685	IL
62284	IL	62423	IL	62546	IL	62686	IL
62294	IL	62427	IL	62547	IL	62688	IL
62310	IL	62428	IL	62550	IL	62690	IL
62311	IL	62431	IL	62553	IL	62691	IL
62312	IL	62432	IL	62555	IL	62694	IL

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
62801	IL	62862	IL	62953	IL	63052	MO
62805	IL	62863	IL	62954	IL	63053	MO
62806	IL	62865	IL	62956	IL	63056	MO
62807	IL	62867	IL	62957	IL	63057	MO
62809	IL	62869	IL	62960	IL	63060	MO
62811	IL	62870	IL	62962	IL	63061	MO
62812	IL	62871	IL	62963	IL	63065	MO
62815	IL	62874	IL	62964	IL	63066	MO
62817	IL	62875	IL	62965	IL	63069	MO
62818	IL	62878	IL	62967	IL	63070	MO
62819	IL	62879	IL	62969	IL	63071	MO
62820	IL	62880	IL	62970	IL	63072	MO
62821	IL	62881	IL	62972	IL	63079	MO
62822	IL	62882	IL	62973	IL	63330	MO
62823	IL	62884	IL	62976	IL	63333	MO
62824	IL	62885	IL	62977	IL	63334	MO
62825	IL	62886	IL	62979	IL	63336	MO
62827	IL	62887	IL	62983	IL	63339	MO
62828	IL	62888	IL	62984	IL	63342	MO
62829	IL	62890	IL	62985	IL	63343	MO
62832	IL	62891	IL	62987	IL	63344	MO
62833	IL	62892	IL	62988	IL	63347	MO
62834	IL	62893	IL	62990	IL	63349	MO
62835	IL	62895	IL	62991	IL	63350	MO
62836	IL	62896	IL	62992	IL	63351	MO
62837	IL	62897	IL	62993	IL	63353	MO
62838	IL	62899	IL	62995	IL	63357	MO
62839	IL	62908	IL	62996	IL	63359	MO
62840	IL	62909	IL	62997	IL	63361	MO
62842	IL	62910	IL	62999	IL	63362	MO
62843	IL	62912	IL	63010	MO	63363	MO
62844	IL	62913	IL	63012	MO	63369	MO
62847	IL	62914	IL	63015	MO	63370	MO
62849	IL	62917	IL	63016	MO	63377	MO
62850	IL	62923	IL	63019	MO	63378	MO
62851	IL	62928	IL	63020	MO	63379	MO
62852	IL	62930	IL	63023	MO	63381	MO
62853	IL	62934	IL	63028	MO	63383	MO
62854	IL	62935	IL	63030	MO	63384	MO
62855	IL	62938	IL	63037	MO	63387	MO
62856	IL	62939	IL	63041	MO	63389	MO
62857	IL	62941	IL	63047	MO	63390	MO
62858	IL	62943	IL	63048	MO	63430	MO
62859	IL	62944	IL	63049	MO	63431	MO
62860	IL	62946	IL	63050	MO	63432	MO
62861	IL	62947	IL	63051	MO	63433	MO

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
63434	MO	63552	MO	63823	MO	63951	MO
63435	MO	63555	MO	63825	MO	63952	MO
63436	MO	63556	MO	63826	MO	63953	MO
63437	MO	63558	MO	63827	MO	63955	MO
63438	MO	63560	MO	63828	MO	63956	MO
63439	MO	63563	MO	63830	MO	63957	MO
63440	MO	63565	MO	63833	MO	63960	MO
63441	MO	63566	MO	63834	MO	63963	MO
63442	MO	63567	MO	63838	MO	63964	MO
63443	MO	63622	MO	63839	MO	63965	MO
63445	MO	63625	MO	63840	MO	63966	MO
63446	MO	63627	MO	63841	MO	63967	MO
63447	MO	63629	MO	63845	MO	64001	MO
63448	MO	63630	MO	63846	MO	64011	MO
63450	MO	63631	MO	63848	MO	64012	MO
63451	MO	63632	MO	63849	MO	64017	MO
63452	MO	63633	MO	63850	MO	64020	MO
63453	MO	63638	MO	63851	MO	64021	MO
63456	MO	63645	MO	63853	MO	64022	MO
63457	MO	63648	MO	63860	MO	64037	MO
63458	MO	63654	MO	63862	MO	64062	MO
63459	MO	63655	MO	63866	MO	64067	MO
63460	MO	63660	MO	63867	MO	64071	MO
63462	MO	63661	MO	63868	MO	64074	MO
63464	MO	63662	MO	63869	MO	64076	MO
63465	MO	63664	MO	63870	MO	64077	MO
63466	MO	63665	MO	63871	MO	64078	MO
63467	MO	63666	MO	63873	MO	64079	MO
63468	MO	63670	MO	63874	MO	64080	MO
63469	MO	63673	MO	63877	MO	64083	MO
63472	MO	63674	MO	63878	MO	64084	MO
63473	MO	63730	MO	63879	MO	64090	MO
63474	MO	63735	MO	63881	MO	64096	MO
63530	MO	63738	MO	63882	MO	64097	MO
63531	MO	63750	MO	63931	MO	64098	MO
63532	MO	63751	MO	63934	MO	64402	MO
63534	MO	63753	MO	63935	MO	64420	MO
63537	MO	63760	MO	63936	MO	64421	MO
63538	MO	63763	MO	63937	MO	64422	MO
63539	MO	63764	MO	63939	MO	64424	MO
63543	MO	63772	MO	63941	MO	64426	MO
63544	MO	63781	MO	63942	MO	64427	MO
63545	MO	63782	MO	63943	MO	64430	MO
63547	MO	63787	MO	63944	MO	64436	MO
63549	MO	63820	MO	63947	MO	64437	MO
63551	MO	63822	MO	63950	MO	64438	MO

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
64441	MO	64642	MO	64747	MO	65025	MO
64442	MO	64643	MO	64750	MO	65026	MO
64447	MO	64644	MO	64751	MO	65031	MO
64449	MO	64645	MO	64752	MO	65034	MO
64451	MO	64646	MO	64756	MO	65035	MO
64453	MO	64647	MO	64765	MO	65037	MO
64454	MO	64648	MO	64767	MO	65038	MO
64456	MO	64649	MO	64771	MO	65042	MO
64458	MO	64650	MO	64772	MO	65046	MO
64459	MO	64652	MO	64777	MO	65047	MO
64463	MO	64654	MO	64778	MO	65048	MO
64465	MO	64655	MO	64779	MO	65050	MO
64466	MO	64656	MO	64780	MO	65051	MO
64467	MO	64657	MO	64783	MO	65054	MO
64469	MO	64660	MO	64784	MO	65055	MO
64470	MO	64661	MO	64790	MO	65058	MO
64471	MO	64664	MO	64831	MO	65064	MO
64473	MO	64667	MO	64833	MO	65069	MO
64474	MO	64668	MO	64836	MO	65072	MO
64480	MO	64670	MO	64840	MO	65075	MO
64481	MO	64671	MO	64842	MO	65078	MO
64483	MO	64672	MO	64843	MO	65081	MO
64485	MO	64673	MO	64844	MO	65082	MO
64486	MO	64676	MO	64847	MO	65083	MO
64489	MO	64679	MO	64848	MO	65084	MO
64490	MO	64680	MO	64853	MO	65085	MO
64492	MO	64681	MO	64854	MO	65230	MO
64493	MO	64682	MO	64856	MO	65236	MO
64494	MO	64683	MO	64858	MO	65240	MO
64497	MO	64686	MO	64859	MO	65246	MO
64499	MO	64687	MO	64861	MO	65247	MO
64601	MO	64688	MO	64862	MO	65248	MO
64620	MO	64689	MO	64863	MO	65250	MO
64622	MO	64720	MO	64864	MO	65254	MO
64623	MO	64722	MO	64865	MO	65258	MO
64624	MO	64723	MO	64866	MO	65261	MO
64625	MO	64725	MO	64868	MO	65263	MO
64632	MO	64728	MO	64873	MO	65274	MO
64633	MO	64730	MO	64874	MO	65275	MO
64635	MO	64734	MO	65001	MO	65281	MO
64636	MO	64741	MO	65011	MO	65282	MO
64637	MO	64742	MO	65013	MO	65283	MO
64638	MO	64743	MO	65016	MO	65286	MO
64639	MO	64744	MO	65017	MO	65301	MO
64640	MO	64745	MO	65018	MO	65302	MO
64641	MO	64746	MO	65024	MO	65325	MO

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
65326	MO	65564	MO	65661	MO	65746	MO
65327	MO	65565	MO	65662	MO	65747	MO
65329	MO	65567	MO	65664	MO	65752	MO
65332	MO	65570	MO	65666	MO	65753	MO
65333	MO	65571	MO	65667	MO	65754	MO
65334	MO	65580	MO	65668	MO	65755	MO
65335	MO	65582	MO	65669	MO	65756	MO
65337	MO	65586	MO	65675	MO	65760	MO
65338	MO	65588	MO	65676	MO	65761	MO
65345	MO	65589	MO	65681	MO	65762	MO
65350	MO	65590	MO	65682	MO	65764	MO
65354	MO	65603	MO	65685	MO	65766	MO
65355	MO	65605	MO	65686	MO	65767	MO
65433	MO	65606	MO	65688	MO	65768	MO
65438	MO	65608	MO	65689	MO	65769	MO
65440	MO	65609	MO	65690	MO	65772	MO
65441	MO	65610	MO	65692	MO	65773	MO
65443	MO	65611	MO	65701	MO	65774	MO
65444	MO	65618	MO	65702	MO	65775	MO
65446	MO	65620	MO	65704	MO	65776	MO
65449	MO	65622	MO	65705	MO	65777	MO
65453	MO	65623	MO	65706	MO	65778	MO
65456	MO	65624	MO	65707	MO	65779	MO
65463	MO	65625	MO	65708	MO	65783	MO
65464	MO	65626	MO	65711	MO	65784	MO
65466	MO	65629	MO	65712	MO	65785	MO
65468	MO	65630	MO	65713	MO	65788	MO
65470	MO	65631	MO	65714	MO	65789	MO
65479	MO	65632	MO	65715	MO	65790	MO
65483	MO	65633	MO	65717	MO	65791	MO
65484	MO	65634	MO	65720	MO	65793	MO
65486	MO	65635	MO	65721	MO	66002	KS
65501	MO	65636	MO	65722	MO	66007	KS
65532	MO	65637	MO	65723	MO	66008	KS
65535	MO	65638	MO	65724	MO	66010	KS
65536	MO	65641	MO	65725	MO	66013	KS
65540	MO	65644	MO	65728	MO	66014	KS
65541	MO	65646	MO	65729	MO	66015	KS
65542	MO	65647	MO	65730	MO	66016	KS
65543	MO	65652	MO	65732	MO	66017	KS
65546	MO	65654	MO	65734	MO	66023	KS
65548	MO	65655	MO	65735	MO	66024	KS
65552	MO	65656	MO	65737	MO	66026	KS
65555	MO	65657	MO	65741	MO	66032	KS
65557	MO	65658	MO	65742	MO	66033	KS
65560	MO	65660	MO	65745	MO	66035	KS

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
66036	KS	66418	KS	66748	KS	66933	KS
66039	KS	66419	KS	66749	KS	66936	KS
66040	KS	66423	KS	66751	KS	66937	KS
66041	KS	66427	KS	66755	KS	66938	KS
66042	KS	66428	KS	66757	KS	66941	KS
66052	KS	66429	KS	66758	KS	66942	KS
66053	KS	66431	KS	66759	KS	66943	KS
66054	KS	66436	KS	66761	KS	66944	KS
66056	KS	66438	KS	66767	KS	66945	KS
66058	KS	66440	KS	66770	KS	66946	KS
66060	KS	66451	KS	66772	KS	66948	KS
66064	KS	66501	KS	66773	KS	66949	KS
66066	KS	66507	KS	66777	KS	66951	KS
66067	KS	66508	KS	66778	KS	66952	KS
66070	KS	66509	KS	66781	KS	66953	KS
66071	KS	66510	KS	66782	KS	66955	KS
66072	KS	66512	KS	66783	KS	66956	KS
66073	KS	66516	KS	66834	KS	66958	KS
66075	KS	66518	KS	66838	KS	66962	KS
66076	KS	66522	KS	66839	KS	66963	KS
66077	KS	66523	KS	66840	KS	66967	KS
66078	KS	66524	KS	66843	KS	66968	KS
66079	KS	66526	KS	66845	KS	66970	KS
66080	KS	66528	KS	66846	KS	67002	KS
66086	KS	66534	KS	66849	KS	67003	KS
66087	KS	66537	KS	66850	KS	67004	KS
66088	KS	66538	KS	66851	KS	67009	KS
66090	KS	66540	KS	66852	KS	67010	KS
66091	KS	66541	KS	66853	KS	67013	KS
66092	KS	66543	KS	66855	KS	67017	KS
66093	KS	66544	KS	66856	KS	67018	KS
66094	KS	66548	KS	66857	KS	67022	KS
66095	KS	66550	KS	66858	KS	67024	KS
66097	KS	66552	KS	66859	KS	67029	KS
66401	KS	66555	KS	66860	KS	67031	KS
66403	KS	66710	KS	66861	KS	67035	KS
66404	KS	66713	KS	66862	KS	67036	KS
66406	KS	66714	KS	66863	KS	67039	KS
66408	KS	66717	KS	66866	KS	67045	KS
66411	KS	66725	KS	66869	KS	67047	KS
66412	KS	66727	KS	66870	KS	67049	KS
66413	KS	66728	KS	66871	KS	67051	KS
66414	KS	66732	KS	66872	KS	67053	KS
66415	KS	66736	KS	66873	KS	67054	KS
66416	KS	66739	KS	66901	KS	67058	KS
66417	KS	66742	KS	66932	KS	67059	KS

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
67063	KS	67449	KS	67623	KS	67839	KS
67068	KS	67450	KS	67625	KS	67841	KS
67073	KS	67451	KS	67626	KS	67844	KS
67103	KS	67454	KS	67628	KS	67849	KS
67105	KS	67455	KS	67629	KS	67850	KS
67106	KS	67457	KS	67632	KS	67853	KS
67109	KS	67459	KS	67634	KS	67854	KS
67111	KS	67466	KS	67635	KS	67857	KS
67112	KS	67473	KS	67638	KS	67861	KS
67118	KS	67474	KS	67640	KS	67863	KS
67119	KS	67475	KS	67642	KS	67864	KS
67120	KS	67480	KS	67643	KS	67867	KS
67122	KS	67481	KS	67645	KS	67869	KS
67123	KS	67482	KS	67648	KS	67878	KS
67127	KS	67483	KS	67649	KS	67951	KS
67133	KS	67490	KS	67650	KS	67952	KS
67137	KS	67492	KS	67651	KS	68001	NE
67140	KS	67511	KS	67653	KS	68003	NE
67142	KS	67512	KS	67654	KS	68014	NE
67144	KS	67513	KS	67657	KS	68015	NE
67150	KS	67519	KS	67658	KS	68016	NE
67152	KS	67520	KS	67659	KS	68017	NE
67154	KS	67524	KS	67663	KS	68018	NE
67155	KS	67525	KS	67665	KS	68019	NE
67159	KS	67526	KS	67669	KS	68020	NE
67334	KS	67530	KS	67673	KS	68023	NE
67345	KS	67544	KS	67675	KS	68025	NE
67346	KS	67545	KS	67730	KS	68026	NE
67349	KS	67547	KS	67731	KS	68030	NE
67352	KS	67548	KS	67733	KS	68031	NE
67353	KS	67552	KS	67735	KS	68033	NE
67355	KS	67553	KS	67739	KS	68034	NE
67360	KS	67554	KS	67741	KS	68036	NE
67361	KS	67556	KS	67744	KS	68037	NE
67410	KS	67557	KS	67745	KS	68038	NE
67417	KS	67559	KS	67747	KS	68039	NE
67418	KS	67563	KS	67748	KS	68040	NE
67423	KS	67564	KS	67749	KS	68041	NE
67427	KS	67565	KS	67756	KS	68042	NE
67431	KS	67567	KS	67758	KS	68044	NE
67437	KS	67573	KS	67761	KS	68045	NE
67438	KS	67575	KS	67762	KS	68047	NE
67439	KS	67576	KS	67764	KS	68048	NE
67441	KS	67578	KS	67835	KS	68050	NE
67444	KS	67579	KS	67836	KS	68055	NE
67445	KS	67622	KS	67837	KS	68057	NE

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
68058	NE	68350	NE	68444	NE	68726	NE
68061	NE	68351	NE	68445	NE	68727	NE
68062	NE	68352	NE	68447	NE	68728	NE
68063	NE	68354	NE	68450	NE	68729	NE
68065	NE	68355	NE	68452	NE	68730	NE
68066	NE	68357	NE	68453	NE	68731	NE
68067	NE	68359	NE	68455	NE	68732	NE
68070	NE	68360	NE	68456	NE	68733	NE
68071	NE	68361	NE	68457	NE	68736	NE
68072	NE	68362	NE	68458	NE	68739	NE
68073	NE	68364	NE	68463	NE	68740	NE
68301	NE	68365	NE	68464	NE	68741	NE
68303	NE	68366	NE	68465	NE	68743	NE
68304	NE	68370	NE	68466	NE	68745	NE
68305	NE	68374	NE	68621	NE	68749	NE
68307	NE	68375	NE	68622	NE	68751	NE
68309	NE	68376	NE	68623	NE	68753	NE
68310	NE	68377	NE	68624	NE	68756	NE
68313	NE	68378	NE	68626	NE	68757	NE
68314	NE	68380	NE	68628	NE	68759	NE
68315	NE	68381	NE	68632	NE	68760	NE
68318	NE	68403	NE	68633	NE	68761	NE
68320	NE	68405	NE	68635	NE	68764	NE
68321	NE	68406	NE	68636	NE	68768	NE
68322	NE	68407	NE	68637	NE	68770	NE
68323	NE	68409	NE	68638	NE	68771	NE
68325	NE	68413	NE	68640	NE	68772	NE
68326	NE	68414	NE	68648	NE	68773	NE
68327	NE	68415	NE	68649	NE	68774	NE
68328	NE	68416	NE	68651	NE	68776	NE
68329	NE	68420	NE	68654	NE	68778	NE
68330	NE	68421	NE	68658	NE	68779	NE
68331	NE	68422	NE	68662	NE	68783	NE
68332	NE	68423	NE	68663	NE	68784	NE
68333	NE	68424	NE	68664	NE	68785	NE
68335	NE	68429	NE	68665	NE	68786	NE
68337	NE	68431	NE	68666	NE	68787	NE
68338	NE	68433	NE	68667	NE	68789	NE
68340	NE	68434	NE	68669	NE	68790	NE
68341	NE	68436	NE	68710	NE	68792	NE
68342	NE	68437	NE	68714	NE	68815	NE
68343	NE	68439	NE	68717	NE	68816	NE
68345	NE	68440	NE	68718	NE	68817	NE
68347	NE	68441	NE	68720	NE	68820	NE
68348	NE	68442	NE	68723	NE	68821	NE
68349	NE	68443	NE	68724	NE	68823	NE

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
68826	NE	68957	NE	69140	NE	70044	LA
68827	NE	68960	NE	69142	NE	70046	LA
68831	NE	68961	NE	69145	NE	70047	LA
68833	NE	68964	NE	69147	NE	70050	LA
68834	NE	68966	NE	69148	NE	70051	LA
68835	NE	68967	NE	69150	NE	70057	LA
68837	NE	68969	NE	69154	NE	70066	LA
68838	NE	68970	NE	69157	NE	70070	LA
68842	NE	68971	NE	69161	NE	70075	LA
68844	NE	68972	NE	69163	NE	70076	LA
68850	NE	68974	NE	69166	NE	70078	LA
68852	NE	68975	NE	69167	NE	70079	LA
68853	NE	68977	NE	69168	NE	70080	LA
68859	NE	68978	NE	69171	NE	70081	LA
68862	NE	68979	NE	69190	NE	70082	LA
68863	NE	68980	NE	69201	NE	70083	LA
68864	NE	68981	NE	69210	NE	70084	LA
68871	NE	69001	NE	69211	NE	70085	LA
68872	NE	69020	NE	69212	NE	70087	LA
68873	NE	69022	NE	69214	NE	70091	LA
68875	NE	69024	NE	69216	NE	70092	LA
68878	NE	69025	NE	69217	NE	70339	LA
68879	NE	69026	NE	69218	NE	70340	LA
68882	NE	69028	NE	69219	NE	70341	LA
68920	NE	69029	NE	69220	NE	70342	LA
68922	NE	69031	NE	69221	NE	70343	LA
68926	NE	69032	NE	69301	NE	70344	LA
68928	NE	69034	NE	69331	NE	70352	LA
68929	NE	69036	NE	69333	NE	70353	LA
68930	NE	69038	NE	69334	NE	70356	LA
68932	NE	69039	NE	69336	NE	70359	LA
68933	NE	69040	NE	69345	NE	70360	LA
68934	NE	69042	NE	69346	NE	70361	LA
68935	NE	69043	NE	69348	NE	70363	LA
68936	NE	69044	NE	69350	NE	70364	LA
68938	NE	69046	NE	69366	NE	70372	LA
68939	NE	69121	NE	70030	LA	70377	LA
68941	NE	69122	NE	70031	LA	70380	LA
68942	NE	69125	NE	70032	LA	70381	LA
68943	NE	69128	NE	70037	LA	70390	LA
68944	NE	69129	NE	70038	LA	70391	LA
68946	NE	69130	NE	70039	LA	70392	LA
68947	NE	69133	NE	70040	LA	70393	LA
68948	NE	69134	NE	70041	LA	70395	LA
68952	NE	69135	NE	70042	LA	70397	LA
68954	NE	69138	NE	70043	LA	70426	LA

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
70427	LA	70640	LA	70767	LA	71071	LA
70429	LA	70643	LA	70772	LA	71072	LA
70438	LA	70644	LA	70773	LA	71073	LA
70449	LA	70645	LA	70776	LA	71075	LA
70450	LA	70648	LA	70777	LA	71078	LA
70462	LA	70650	LA	70780	LA	71079	LA
70467	LA	70651	LA	70781	LA	71080	LA
70510	LA	70654	LA	70783	LA	71082	LA
70511	LA	70655	LA	70785	LA	71218	LA
70512	LA	70656	LA	70786	LA	71219	LA
70514	LA	70658	LA	70788	LA	71220	LA
70516	LA	70659	LA	70789	LA	71221	LA
70517	LA	70706	LA	71001	LA	71222	LA
70519	LA	70710	LA	71002	LA	71223	LA
70521	LA	70711	LA	71003	LA	71226	LA
70522	LA	70715	LA	71008	LA	71229	LA
70523	LA	70716	LA	71016	LA	71230	LA
70525	LA	70717	LA	71018	LA	71232	LA
70526	LA	70719	LA	71019	LA	71233	LA
70527	LA	70720	LA	71021	LA	71234	LA
70528	LA	70721	LA	71023	LA	71237	LA
70531	LA	70722	LA	71024	LA	71241	LA
70532	LA	70726	LA	71025	LA	71242	LA
70533	LA	70727	LA	71027	LA	71243	LA
70534	LA	70729	LA	71028	LA	71247	LA
70537	LA	70730	LA	71030	LA	71249	LA
70538	LA	70732	LA	71031	LA	71250	LA
70540	LA	70733	LA	71032	LA	71251	LA
70542	LA	70736	LA	71034	LA	71253	LA
70543	LA	70740	LA	71036	LA	71254	LA
70546	LA	70744	LA	71038	LA	71256	LA
70548	LA	70747	LA	71039	LA	71259	LA
70549	LA	70748	LA	71040	LA	71260	LA
70555	LA	70749	LA	71045	LA	71261	LA
70556	LA	70752	LA	71046	LA	71263	LA
70559	LA	70753	LA	71048	LA	71264	LA
70575	LA	70754	LA	71049	LA	71266	LA
70578	LA	70755	LA	71050	LA	71268	LA
70581	LA	70756	LA	71052	LA	71269	LA
70582	LA	70757	LA	71055	LA	71276	LA
70584	LA	70759	LA	71058	LA	71277	LA
70591	LA	70760	LA	71063	LA	71279	LA
70631	LA	70761	LA	71065	LA	71282	LA
70632	LA	70762	LA	71066	LA	71284	LA
70638	LA	70764	LA	71068	LA	71286	LA
70639	LA	70765	LA	71070	LA	71295	LA

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
71316	LA	71426	LA	71659	AR	71841	AR
71320	LA	71428	LA	71660	AR	71842	AR
71322	LA	71429	LA	71661	AR	71844	AR
71323	LA	71432	LA	71662	AR	71845	AR
71324	LA	71434	LA	71663	AR	71846	AR
71326	LA	71435	LA	71665	AR	71851	AR
71327	LA	71439	LA	71666	AR	71852	AR
71329	LA	71441	LA	71667	AR	71853	AR
71330	LA	71443	LA	71670	AR	71854	AR
71331	LA	71446	LA	71671	AR	71857	AR
71333	LA	71449	LA	71674	AR	71858	AR
71334	LA	71450	LA	71676	AR	71859	AR
71336	LA	71452	LA	71678	AR	71860	AR
71339	LA	71454	LA	71701	AR	71861	AR
71340	LA	71456	LA	71711	AR	71864	AR
71341	LA	71457	LA	71720	AR	71865	AR
71342	LA	71458	LA	71721	AR	71866	AR
71343	LA	71459	LA	71722	AR	71901	AR
71350	LA	71460	LA	71726	AR	71902	AR
71351	LA	71461	LA	71728	AR	71903	AR
71354	LA	71462	LA	71740	AR	71909	AR
71355	LA	71463	LA	71743	AR	71910	AR
71357	LA	71465	LA	71744	AR	71913	AR
71362	LA	71467	LA	71745	AR	71914	AR
71363	LA	71468	LA	71751	AR	71920	AR
71366	LA	71469	LA	71752	AR	71921	AR
71368	LA	71474	LA	71753	AR	71922	AR
71369	LA	71475	LA	71754	AR	71923	AR
71371	LA	71479	LA	71764	AR	71929	AR
71373	LA	71480	LA	71766	AR	71932	AR
71375	LA	71486	LA	71770	AR	71933	AR
71377	LA	71496	LA	71772	AR	71935	AR
71378	LA	71497	LA	71820	AR	71937	AR
71401	LA	71630	AR	71822	AR	71940	AR
71403	LA	71631	AR	71823	AR	71941	AR
71406	LA	71635	AR	71826	AR	71942	AR
71407	LA	71639	AR	71827	AR	71943	AR
71411	LA	71642	AR	71828	AR	71944	AR
71414	LA	71643	AR	71832	AR	71945	AR
71415	LA	71644	AR	71833	AR	71949	AR
71416	LA	71646	AR	71834	AR	71950	AR
71417	LA	71647	AR	71835	AR	71951	AR
71418	LA	71651	AR	71836	AR	71952	AR
71419	LA	71652	AR	71837	AR	71953	AR
71423	LA	71654	AR	71839	AR	71956	AR
71425	LA	71658	AR	71840	AR	71957	AR

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
71958	AR	72046	AR	72133	AR	72352	AR
71959	AR	72048	AR	72134	AR	72354	AR
71960	AR	72051	AR	72136	AR	72358	AR
71961	AR	72052	AR	72137	AR	72359	AR
71962	AR	72055	AR	72139	AR	72360	AR
71964	AR	72057	AR	72140	AR	72365	AR
71965	AR	72059	AR	72141	AR	72368	AR
71966	AR	72060	AR	72143	AR	72370	AR
71968	AR	72063	AR	72145	AR	72372	AR
71969	AR	72064	AR	72149	AR	72373	AR
71970	AR	72065	AR	72150	AR	72377	AR
71971	AR	72066	AR	72153	AR	72379	AR
71972	AR	72067	AR	72156	AR	72385	AR
71973	AR	72068	AR	72157	AR	72386	AR
71998	AR	72069	AR	72160	AR	72387	AR
72001	AR	72070	AR	72166	AR	72391	AR
72002	AR	72071	AR	72168	AR	72392	AR
72003	AR	72072	AR	72170	AR	72394	AR
72006	AR	72073	AR	72176	AR	72395	AR
72007	AR	72074	AR	72178	AR	72396	AR
72010	AR	72080	AR	72179	AR	72410	AR
72011	AR	72081	AR	72189	AR	72412	AR
72012	AR	72082	AR	72310	AR	72413	AR
72013	AR	72083	AR	72311	AR	72415	AR
72016	AR	72084	AR	72313	AR	72422	AR
72017	AR	72085	AR	72315	AR	72424	AR
72020	AR	72086	AR	72316	AR	72425	AR
72021	AR	72087	AR	72319	AR	72426	AR
72022	AR	72088	AR	72320	AR	72428	AR
72023	AR	72101	AR	72321	AR	72429	AR
72024	AR	72102	AR	72322	AR	72430	AR
72025	AR	72103	AR	72324	AR	72432	AR
72026	AR	72104	AR	72326	AR	72433	AR
72027	AR	72105	AR	72329	AR	72434	AR
72028	AR	72107	AR	72330	AR	72435	AR
72029	AR	72108	AR	72331	AR	72436	AR
72030	AR	72110	AR	72335	AR	72438	AR
72031	AR	72121	AR	72336	AR	72439	AR
72036	AR	72123	AR	72338	AR	72440	AR
72037	AR	72125	AR	72340	AR	72441	AR
72038	AR	72126	AR	72341	AR	72442	AR
72040	AR	72127	AR	72346	AR	72443	AR
72041	AR	72128	AR	72347	AR	72444	AR
72042	AR	72129	AR	72348	AR	72445	AR
72044	AR	72130	AR	72350	AR	72449	AR
72045	AR	72131	AR	72351	AR	72450	AR

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
72451	AR	72561	AR	72680	AR	72951	AR
72453	AR	72565	AR	72683	AR	72958	AR
72454	AR	72566	AR	72685	AR	73001	OK
72455	AR	72567	AR	72686	AR	73005	OK
72456	AR	72569	AR	72687	AR	73006	OK
72457	AR	72572	AR	72718	AR	73009	OK
72458	AR	72573	AR	72721	AR	73010	OK
72459	AR	72577	AR	72738	AR	73012	OK
72460	AR	72581	AR	72740	AR	73015	OK
72461	AR	72584	AR	72742	AR	73016	OK
72462	AR	72585	AR	72745	AR	73017	OK
72464	AR	72587	AR	72752	AR	73021	OK
72465	AR	72610	AR	72760	AR	73022	OK
72466	AR	72617	AR	72773	AR	73024	OK
72469	AR	72619	AR	72776	AR	73027	OK
72470	AR	72623	AR	72820	AR	73028	OK
72472	AR	72624	AR	72821	AR	73029	OK
72474	AR	72626	AR	72824	AR	73031	OK
72475	AR	72628	AR	72826	AR	73033	OK
72476	AR	72629	AR	72827	AR	73036	OK
72478	AR	72634	AR	72828	AR	73038	OK
72479	AR	72635	AR	72829	AR	73040	OK
72482	AR	72636	AR	72833	AR	73041	OK
72512	AR	72639	AR	72834	AR	73042	OK
72513	AR	72640	AR	72835	AR	73043	OK
72517	AR	72641	AR	72838	AR	73044	OK
72519	AR	72642	AR	72841	AR	73047	OK
72521	AR	72645	AR	72842	AR	73048	OK
72523	AR	72648	AR	72851	AR	73050	OK
72525	AR	72650	AR	72853	AR	73052	OK
72528	AR	72651	AR	72855	AR	73053	OK
72529	AR	72653	AR	72856	AR	73055	OK
72530	AR	72654	AR	72857	AR	73056	OK
72532	AR	72655	AR	72860	AR	73057	OK
72533	AR	72657	AR	72863	AR	73058	OK
72536	AR	72658	AR	72865	AR	73061	OK
72537	AR	72659	AR	72924	AR	73062	OK
72540	AR	72661	AR	72926	AR	73063	OK
72542	AR	72663	AR	72927	AR	73065	OK
72543	AR	72666	AR	72928	AR	73073	OK
72544	AR	72668	AR	72930	AR	73074	OK
72545	AR	72669	AR	72933	AR	73075	OK
72546	AR	72670	AR	72943	AR	73077	OK
72555	AR	72672	AR	72944	AR	73078	OK
72556	AR	72675	AR	72949	AR	73080	OK
72560	AR	72677	AR	72950	AR	73090	OK

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73093	OK	73569	OK	73750	OK	74039	OK
73094	OK	73570	OK	73755	OK	74041	OK
73095	OK	73572	OK	73756	OK	74042	OK
73098	OK	73573	OK	73757	OK	74044	OK
73425	OK	73575	OK	73758	OK	74047	OK
73430	OK	73622	OK	73759	OK	74048	OK
73432	OK	73624	OK	73760	OK	74051	OK
73433	OK	73626	OK	73761	OK	74052	OK
73434	OK	73628	OK	73762	OK	74053	OK
73439	OK	73632	OK	73763	OK	74054	OK
73440	OK	73638	OK	73764	OK	74056	OK
73441	OK	73641	OK	73766	OK	74060	OK
73442	OK	73642	OK	73768	OK	74061	OK
73446	OK	73646	OK	73770	OK	74066	OK
73447	OK	73647	OK	73771	OK	74067	OK
73448	OK	73650	OK	73772	OK	74068	OK
73449	OK	73651	OK	73835	OK	74071	OK
73450	OK	73654	OK	73838	OK	74072	OK
73453	OK	73655	OK	73842	OK	74079	OK
73455	OK	73658	OK	73844	OK	74080	OK
73456	OK	73659	OK	73847	OK	74082	OK
73459	OK	73660	OK	73859	OK	74083	OK
73460	OK	73661	OK	73860	OK	74084	OK
73461	OK	73663	OK	73931	OK	74131	OK
73476	OK	73664	OK	73932	OK	74301	OK
73491	OK	73666	OK	73933	OK	74330	OK
73520	OK	73667	OK	73937	OK	74331	OK
73529	OK	73716	OK	73938	OK	74332	OK
73530	OK	73717	OK	73946	OK	74333	OK
73531	OK	73718	OK	73947	OK	74335	OK
73533	OK	73719	OK	73950	OK	74337	OK
73534	OK	73722	OK	74001	OK	74338	OK
73536	OK	73724	OK	74002	OK	74339	OK
73542	OK	73726	OK	74003	OK	74340	OK
73546	OK	73728	OK	74004	OK	74342	OK
73548	OK	73729	OK	74005	OK	74343	OK
73551	OK	73731	OK	74006	OK	74344	OK
73553	OK	73734	OK	74009	OK	74345	OK
73555	OK	73737	OK	74014	OK	74346	OK
73559	OK	73739	OK	74015	OK	74347	OK
73561	OK	73741	OK	74022	OK	74349	OK
73562	OK	73742	OK	74026	OK	74350	OK
73564	OK	73744	OK	74027	OK	74352	OK
73565	OK	73746	OK	74029	OK	74354	OK
73566	OK	73747	OK	74035	OK	74355	OK
73568	OK	73749	OK	74036	OK	74358	OK

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74359	OK	74538	OK	74721	OK	74845	OK
74360	OK	74540	OK	74722	OK	74848	OK
74361	OK	74542	OK	74723	OK	74849	OK
74362	OK	74543	OK	74724	OK	74850	OK
74363	OK	74546	OK	74726	OK	74855	OK
74364	OK	74547	OK	74727	OK	74856	OK
74365	OK	74549	OK	74728	OK	74859	OK
74366	OK	74552	OK	74729	OK	74860	OK
74367	OK	74553	OK	74730	OK	74864	OK
74368	OK	74554	OK	74731	OK	74867	OK
74369	OK	74555	OK	74733	OK	74868	OK
74370	OK	74556	OK	74734	OK	74869	OK
74425	OK	74557	OK	74735	OK	74872	OK
74426	OK	74558	OK	74736	OK	74875	OK
74429	OK	74560	OK	74737	OK	74878	OK
74430	OK	74561	OK	74738	OK	74880	OK
74432	OK	74562	OK	74740	OK	74881	OK
74435	OK	74565	OK	74741	OK	74883	OK
74438	OK	74567	OK	74743	OK	74884	OK
74440	OK	74569	OK	74745	OK	74901	OK
74442	OK	74570	OK	74747	OK	74902	OK
74446	OK	74572	OK	74748	OK	74930	OK
74454	OK	74574	OK	74750	OK	74931	OK
74457	OK	74576	OK	74752	OK	74932	OK
74458	OK	74577	OK	74753	OK	74935	OK
74459	OK	74601	OK	74754	OK	74936	OK
74461	OK	74602	OK	74755	OK	74937	OK
74462	OK	74603	OK	74756	OK	74939	OK
74466	OK	74604	OK	74759	OK	74940	OK
74467	OK	74630	OK	74760	OK	74941	OK
74472	OK	74631	OK	74761	OK	74942	OK
74477	OK	74632	OK	74764	OK	74943	OK
74501	OK	74633	OK	74766	OK	74944	OK
74502	OK	74636	OK	74818	OK	74945	OK
74521	OK	74637	OK	74824	OK	74946	OK
74522	OK	74641	OK	74826	OK	74947	OK
74523	OK	74643	OK	74827	OK	74948	OK
74525	OK	74644	OK	74829	OK	74949	OK
74528	OK	74646	OK	74830	OK	74951	OK
74529	OK	74647	OK	74831	OK	74953	OK
74530	OK	74651	OK	74832	OK	74954	OK
74531	OK	74652	OK	74833	OK	74955	OK
74533	OK	74653	OK	74834	OK	74956	OK
74534	OK	74701	OK	74836	OK	74957	OK
74535	OK	74702	OK	74837	OK	74959	OK
74536	OK	74720	OK	74839	OK	74960	OK

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
74962	OK	75437	TX	75566	TX	75773	TX
74963	OK	75438	TX	75567	TX	75778	TX
74964	OK	75439	TX	75568	TX	75780	TX
74965	OK	75440	TX	75570	TX	75782	TX
74966	OK	75441	TX	75571	TX	75783	TX
75020	TX	75443	TX	75572	TX	75784	TX
75021	TX	75444	TX	75574	TX	75785	TX
75058	TX	75446	TX	75630	TX	75790	TX
75076	TX	75447	TX	75631	TX	75797	TX
75090	TX	75448	TX	75633	TX	75831	TX
75091	TX	75449	TX	75636	TX	75833	TX
75092	TX	75450	TX	75637	TX	75834	TX
75103	TX	75451	TX	75638	TX	75835	TX
75114	TX	75452	TX	75639	TX	75844	TX
75117	TX	75459	TX	75640	TX	75845	TX
75118	TX	75469	TX	75642	TX	75846	TX
75124	TX	75471	TX	75643	TX	75847	TX
75125	TX	75472	TX	75644	TX	75849	TX
75126	TX	75474	TX	75645	TX	75850	TX
75127	TX	75475	TX	75650	TX	75851	TX
75140	TX	75476	TX	75651	TX	75855	TX
75142	TX	75478	TX	75656	TX	75856	TX
75143	TX	75479	TX	75657	TX	75858	TX
75147	TX	75481	TX	75659	TX	75862	TX
75152	TX	75482	TX	75661	TX	75865	TX
75154	TX	75483	TX	75668	TX	75925	TX
75156	TX	75488	TX	75669	TX	75926	TX
75157	TX	75489	TX	75670	TX	75928	TX
75158	TX	75490	TX	75671	TX	75929	TX
75161	TX	75491	TX	75672	TX	75930	TX
75163	TX	75492	TX	75683	TX	75931	TX
75167	TX	75494	TX	75685	TX	75932	TX
75169	TX	75495	TX	75686	TX	75933	TX
75410	TX	75497	TX	75688	TX	75934	TX
75412	TX	75550	TX	75692	TX	75935	TX
75413	TX	75551	TX	75694	TX	75936	TX
75414	TX	75554	TX	75754	TX	75938	TX
75415	TX	75555	TX	75755	TX	75939	TX
75417	TX	75556	TX	75756	TX	75942	TX
75418	TX	75559	TX	75758	TX	75947	TX
75420	TX	75560	TX	75759	TX	75948	TX
75426	TX	75561	TX	75764	TX	75954	TX
75431	TX	75562	TX	75765	TX	75959	TX
75432	TX	75563	TX	75766	TX	75960	TX
75433	TX	75564	TX	75770	TX	75966	TX
75436	TX	75565	TX	75772	TX	75968	TX

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
75972	TX	76245	TX	76458	TX	76642	TX
75973	TX	76246	TX	76459	TX	76644	TX
75974	TX	76250	TX	76462	TX	76645	TX
75975	TX	76251	TX	76463	TX	76648	TX
75976	TX	76252	TX	76464	TX	76649	TX
75977	TX	76253	TX	76466	TX	76650	TX
75979	TX	76255	TX	76467	TX	76652	TX
75990	TX	76258	TX	76468	TX	76653	TX
76008	TX	76261	TX	76469	TX	76656	TX
76009	TX	76263	TX	76470	TX	76660	TX
76023	TX	76264	TX	76471	TX	76661	TX
76028	TX	76265	TX	76472	TX	76665	TX
76035	TX	76267	TX	76474	TX	76666	TX
76044	TX	76268	TX	76475	TX	76667	TX
76048	TX	76270	TX	76476	TX	76671	TX
76049	TX	76271	TX	76483	TX	76673	TX
76050	TX	76272	TX	76484	TX	76675	TX
76055	TX	76273	TX	76485	TX	76676	TX
76058	TX	76351	TX	76486	TX	76677	TX
76059	TX	76352	TX	76487	TX	76678	TX
76061	TX	76357	TX	76490	TX	76680	TX
76064	TX	76365	TX	76491	TX	76685	TX
76065	TX	76366	TX	76518	TX	76686	TX
76066	TX	76370	TX	76519	TX	76687	TX
76067	TX	76377	TX	76520	TX	76689	TX
76068	TX	76379	TX	76522	TX	76690	TX
76071	TX	76380	TX	76523	TX	76692	TX
76073	TX	76388	TX	76539	TX	76820	TX
76078	TX	76389	TX	76550	TX	76821	TX
76082	TX	76426	TX	76555	TX	76824	TX
76084	TX	76427	TX	76556	TX	76828	TX
76085	TX	76430	TX	76567	TX	76831	TX
76087	TX	76431	TX	76570	TX	76832	TX
76088	TX	76435	TX	76577	TX	76834	TX
76097	TX	76437	TX	76596	TX	76841	TX
76098	TX	76439	TX	76621	TX	76842	TX
76225	TX	76442	TX	76622	TX	76844	TX
76227	TX	76443	TX	76627	TX	76845	TX
76228	TX	76444	TX	76628	TX	76848	TX
76230	TX	76445	TX	76629	TX	76853	TX
76233	TX	76448	TX	76631	TX	76856	TX
76234	TX	76449	TX	76632	TX	76859	TX
76238	TX	76452	TX	76634	TX	76861	TX
76239	TX	76453	TX	76635	TX	76864	TX
76240	TX	76454	TX	76636	TX	76865	TX
76241	TX	76455	TX	76637	TX	76869	TX

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
76870	TX	77473	TX	77850	TX	78026	TX
76871	TX	77474	TX	77852	TX	78039	TX
76873	TX	77484	TX	77853	TX	78050	TX
76875	TX	77485	TX	77855	TX	78052	TX
76877	TX	77514	TX	77856	TX	78053	TX
76878	TX	77519	TX	77857	TX	78055	TX
76880	TX	77533	TX	77859	TX	78056	TX
76882	TX	77535	TX	77861	TX	78059	TX
76883	TX	77538	TX	77863	TX	78060	TX
76884	TX	77560	TX	77865	TX	78062	TX
76885	TX	77561	TX	77867	TX	78063	TX
76888	TX	77564	TX	77868	TX	78064	TX
76930	TX	77575	TX	77869	TX	78065	TX
76933	TX	77580	TX	77870	TX	78066	TX
76936	TX	77582	TX	77871	TX	78067	TX
76941	TX	77585	TX	77873	TX	78070	TX
76943	TX	77597	TX	77875	TX	78071	TX
76945	TX	77611	TX	77876	TX	78072	TX
76949	TX	77614	TX	77878	TX	78075	TX
76951	TX	77616	TX	77879	TX	78076	TX
76953	TX	77624	TX	77880	TX	78107	TX
77326	TX	77625	TX	77882	TX	78108	TX
77327	TX	77626	TX	77950	TX	78111	TX
77328	TX	77630	TX	77957	TX	78113	TX
77331	TX	77631	TX	77960	TX	78114	TX
77332	TX	77632	TX	77961	TX	78116	TX
77335	TX	77639	TX	77962	TX	78117	TX
77350	TX	77656	TX	77963	TX	78118	TX
77351	TX	77657	TX	77969	TX	78119	TX
77359	TX	77659	TX	77970	TX	78121	TX
77360	TX	77660	TX	77971	TX	78122	TX
77363	TX	77661	TX	77990	TX	78124	TX
77364	TX	77662	TX	77991	TX	78133	TX
77368	TX	77663	TX	77993	TX	78140	TX
77369	TX	77664	TX	78001	TX	78143	TX
77371	TX	77665	TX	78003	TX	78144	TX
77374	TX	77670	TX	78007	TX	78147	TX
77376	TX	77830	TX	78008	TX	78151	TX
77399	TX	77831	TX	78009	TX	78154	TX
77418	TX	77833	TX	78011	TX	78159	TX
77423	TX	77834	TX	78012	TX	78160	TX
77426	TX	77835	TX	78014	TX	78161	TX
77445	TX	77836	TX	78016	TX	78163	TX
77446	TX	77837	TX	78019	TX	78266	TX
77452	TX	77838	TX	78021	TX	78335	TX
77466	TX	77839	TX	78022	TX	78336	TX

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
78338	TX	78609	TX	78931	TX	79054	TX
78340	TX	78610	TX	78932	TX	79056	TX
78341	TX	78612	TX	78933	TX	79057	TX
78343	TX	78614	TX	78938	TX	79059	TX
78349	TX	78616	TX	78940	TX	79061	TX
78350	TX	78620	TX	78941	TX	79062	TX
78353	TX	78621	TX	78942	TX	79064	TX
78355	TX	78623	TX	78944	TX	79065	TX
78357	TX	78629	TX	78945	TX	79066	TX
78360	TX	78632	TX	78946	TX	79068	TX
78361	TX	78635	TX	78947	TX	79078	TX
78362	TX	78636	TX	78948	TX	79079	TX
78363	TX	78639	TX	78949	TX	79080	TX
78364	TX	78640	TX	78950	TX	79081	TX
78368	TX	78643	TX	78952	TX	79082	TX
78373	TX	78650	TX	78953	TX	79083	TX
78376	TX	78658	TX	78954	TX	79084	TX
78377	TX	78659	TX	78956	TX	79088	TX
78379	TX	78662	TX	78957	TX	79092	TX
78384	TX	78663	TX	78959	TX	79094	TX
78385	TX	78672	TX	78960	TX	79096	TX
78387	TX	78677	TX	78961	TX	79097	TX
78393	TX	78737	TX	78963	TX	79098	TX
78536	TX	78827	TX	79001	TX	79109	TX
78545	TX	78828	TX	79002	TX	79110	TX
78547	TX	78829	TX	79003	TX	79114	TX
78548	TX	78830	TX	79005	TX	79118	TX
78561	TX	78832	TX	79007	TX	79119	TX
78564	TX	78833	TX	79008	TX	79121	TX
78569	TX	78834	TX	79009	TX	79185	TX
78578	TX	78836	TX	79010	TX	79220	TX
78580	TX	78839	TX	79011	TX	79223	TX
78582	TX	78850	TX	79018	TX	79226	TX
78584	TX	78851	TX	79019	TX	79227	TX
78585	TX	78852	TX	79024	TX	79229	TX
78588	TX	78853	TX	79031	TX	79232	TX
78590	TX	78860	TX	79034	TX	79233	TX
78591	TX	78861	TX	79035	TX	79234	TX
78594	TX	78872	TX	79036	TX	79236	TX
78597	TX	78873	TX	79039	TX	79237	TX
78598	TX	78877	TX	79040	TX	79239	TX
78602	TX	78879	TX	79042	TX	79240	TX
78603	TX	78880	TX	79044	TX	79243	TX
78604	TX	78883	TX	79046	TX	79244	TX
78606	TX	78885	TX	79052	TX	79245	TX
78607	TX	78886	TX	79053	TX	79248	TX

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
79255	TX	79521	TX	79778	TX	80834	CO
79256	TX	79525	TX	79780	TX	80835	CO
79257	TX	79526	TX	79781	TX	80836	CO
79261	TX	79527	TX	79782	TX	80861	CO
79312	TX	79528	TX	79783	TX	81020	CO
79313	TX	79532	TX	79785	TX	81024	CO
79314	TX	79533	TX	79786	TX	81027	CO
79323	TX	79534	TX	79788	TX	81029	CO
79325	TX	79535	TX	79837	TX	81033	CO
79326	TX	79537	TX	79839	TX	81034	CO
79331	TX	79538	TX	79843	TX	81038	CO
79336	TX	79539	TX	79845	TX	81041	CO
79338	TX	79540	TX	79846	TX	81042	CO
79339	TX	79543	TX	79847	TX	81043	CO
79342	TX	79544	TX	79848	TX	81044	CO
79346	TX	79545	TX	79850	TX	81046	CO
79351	TX	79546	TX	79851	TX	81047	CO
79353	TX	79547	TX	79854	TX	81049	CO
79355	TX	79548	TX	79855	TX	81052	CO
79358	TX	79549	TX	80101	CO	81054	CO
79359	TX	79550	TX	80107	CO	81057	CO
79360	TX	79553	TX	80117	CO	81059	CO
79367	TX	79556	TX	80420	CO	81062	CO
79369	TX	79560	TX	80421	CO	81063	CO
79370	TX	79565	TX	80430	CO	81064	CO
79371	TX	79566	TX	80432	CO	81073	CO
79372	TX	79567	TX	80434	CO	81074	CO
79373	TX	79713	TX	80440	CO	81076	CO
79376	TX	79718	TX	80448	CO	81081	CO
79377	TX	79719	TX	80449	CO	81082	CO
79379	TX	79730	TX	80456	CO	81084	CO
79380	TX	79735	TX	80473	CO	81087	CO
79381	TX	79738	TX	80475	CO	81090	CO
79383	TX	79739	TX	80480	CO	81091	CO
79501	TX	79740	TX	80720	CO	81092	CO
79502	TX	79742	TX	80740	CO	81120	CO
79503	TX	79743	TX	80743	CO	81123	CO
79504	TX	79744	TX	80757	CO	81124	CO
79506	TX	79749	TX	80801	CO	81125	CO
79510	TX	79752	TX	80805	CO	81126	CO
79512	TX	79754	TX	80807	CO	81129	CO
79516	TX	79755	TX	80812	CO	81131	CO
79517	TX	79756	TX	80815	CO	81132	CO
79518	TX	79770	TX	80820	CO	81133	CO
79519	TX	79772	TX	80827	CO	81134	CO
79520	TX	79777	TX	80830	CO	81135	CO

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
81138	CO	82053	WY	82844	WY	83420	ID
81140	CO	82054	WY	82845	WY	83421	ID
81141	CO	82060	WY	83203	ID	83423	ID
81143	CO	82082	WY	83210	ID	83425	ID
81144	CO	82222	WY	83211	ID	83429	ID
81148	CO	82225	WY	83212	ID	83431	ID
81149	CO	82227	WY	83215	ID	83433	ID
81151	CO	82242	WY	83217	ID	83434	ID
81152	CO	82301	WY	83218	ID	83435	ID
81153	CO	82321	WY	83221	ID	83436	ID
81154	CO	82323	WY	83226	ID	83438	ID
81155	CO	82324	WY	83227	ID	83442	ID
81201	CO	82325	WY	83228	ID	83443	ID
81211	CO	82327	WY	83229	ID	83444	ID
81212	CO	82329	WY	83232	ID	83445	ID
81215	CO	82331	WY	83235	ID	83446	ID
81220	CO	82332	WY	83236	ID	83447	ID
81221	CO	82334	WY	83237	ID	83450	ID
81222	CO	82335	WY	83241	ID	83451	ID
81223	CO	82410	WY	83251	ID	83462	ID
81226	CO	82411	WY	83253	ID	83463	ID
81227	CO	82412	WY	83256	ID	83464	ID
81228	CO	82420	WY	83262	ID	83465	ID
81232	CO	82421	WY	83263	ID	83466	ID
81233	CO	82422	WY	83271	ID	83467	ID
81236	CO	82426	WY	83274	ID	83468	ID
81240	CO	82428	WY	83276	ID	83469	ID
81242	CO	82431	WY	83277	ID	83523	ID
81244	CO	82432	WY	83278	ID	83536	ID
81246	CO	82434	WY	83283	ID	83543	ID
81248	CO	82441	WY	83285	ID	83548	ID
81252	CO	82638	WY	83286	ID	83555	ID
81253	CO	82701	WY	83314	ID	83602	ID
81290	CO	82715	WY	83322	ID	83604	ID
81320	CO	82723	WY	83324	ID	83610	ID
81324	CO	82730	WY	83327	ID	83612	ID
81332	CO	82801	WY	83330	ID	83617	ID
81401	CO	82831	WY	83332	ID	83620	ID
81402	CO	82832	WY	83336	ID	83622	ID
81411	CO	82833	WY	83337	ID	83624	ID
81422	CO	82835	WY	83343	ID	83628	ID
81424	CO	82836	WY	83347	ID	83629	ID
81425	CO	82837	WY	83349	ID	83631	ID
81429	CO	82838	WY	83350	ID	83632	ID
81431	CO	82839	WY	83352	ID	83636	ID
82050	WY	82842	WY	83355	ID	83637	ID

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
83639	ID	84724	UT	85245	AZ	85609	AZ
83643	ID	84725	UT	85278	AZ	85610	AZ
83645	ID	84729	UT	85320	AZ	85613	AZ
83650	ID	84730	UT	85321	AZ	85614	AZ
83654	ID	84732	UT	85322	AZ	85615	AZ
83657	ID	84733	UT	85324	AZ	85616	AZ
83666	ID	84734	UT	85325	AZ	85617	AZ
83670	ID	84737	UT	85326	AZ	85620	AZ
83672	ID	84738	UT	85328	AZ	85622	AZ
84008	UT	84739	UT	85332	AZ	85625	AZ
84018	UT	84740	UT	85333	AZ	85626	AZ
84023	UT	84741	UT	85334	AZ	85627	AZ
84026	UT	84743	UT	85337	AZ	85629	AZ
84028	UT	84744	UT	85341	AZ	85630	AZ
84030	UT	84745	UT	85342	AZ	85632	AZ
84035	UT	84746	UT	85343	AZ	85633	AZ
84038	UT	84747	UT	85344	AZ	85634	AZ
84039	UT	84749	UT	85346	AZ	85635	AZ
84046	UT	84750	UT	85347	AZ	85636	AZ
84050	UT	84754	UT	85348	AZ	85638	AZ
84063	UT	84755	UT	85354	AZ	85639	AZ
84064	UT	84757	UT	85357	AZ	85643	AZ
84076	UT	84758	UT	85358	AZ	85644	AZ
84078	UT	84762	UT	85359	AZ	85650	AZ
84079	UT	84763	UT	85360	AZ	85655	AZ
84085	UT	84765	UT	85361	AZ	85670	AZ
84086	UT	84766	UT	85362	AZ	85671	AZ
84513	UT	84767	UT	85371	AZ	85736	AZ
84516	UT	84770	UT	85387	AZ	86021	AZ
84518	UT	84771	UT	85390	AZ	86301	AZ
84521	UT	84773	UT	85530	AZ	86302	AZ
84522	UT	84774	UT	85531	AZ	86303	AZ
84523	UT	84775	UT	85535	AZ	86304	AZ
84525	UT	84779	UT	85536	AZ	86305	AZ
84528	UT	84780	UT	85543	AZ	86312	AZ
84537	UT	84781	UT	85546	AZ	86313	AZ
84620	UT	84782	UT	85548	AZ	86314	AZ
84652	UT	84783	UT	85551	AZ	86320	AZ
84654	UT	84784	UT	85552	AZ	86321	AZ
84657	UT	84790	UT	85601	AZ	86322	AZ
84701	UT	84791	UT	85602	AZ	86323	AZ
84710	UT	85070	AZ	85603	AZ	86324	AZ
84711	UT	85217	AZ	85605	AZ	86325	AZ
84715	UT	85218	AZ	85606	AZ	86326	AZ
84722	UT	85219	AZ	85607	AZ	86327	AZ
84723	UT	85220	AZ	85608	AZ	86329	AZ

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
86330	AZ	87009	NM	87735	NM	88121	NM
86331	AZ	87011	NM	87736	NM	88122	NM
86332	AZ	87013	NM	87743	NM	88123	NM
86333	AZ	87016	NM	87746	NM	88124	NM
86334	AZ	87018	NM	87750	NM	88125	NM
86335	AZ	87023	NM	87752	NM	88126	NM
86336	AZ	87024	NM	87753	NM	88130	NM
86337	AZ	87025	NM	87801	NM	88132	NM
86338	AZ	87027	NM	87820	NM	88133	NM
86340	AZ	87028	NM	87821	NM	88134	NM
86341	AZ	87031	NM	87823	NM	88135	NM
86342	AZ	87032	NM	87824	NM	88136	NM
86343	AZ	87034	NM	87825	NM	88201	NM
86351	AZ	87035	NM	87827	NM	88202	NM
86401	AZ	87036	NM	87828	NM	88203	NM
86402	AZ	87041	NM	87829	NM	88230	NM
86403	AZ	87042	NM	87830	NM	88232	NM
86404	AZ	87043	NM	87831	NM	88253	NM
86405	AZ	87044	NM	87832	NM	88301	NM
86406	AZ	87046	NM	87901	NM	88312	NM
86411	AZ	87048	NM	87930	NM	88316	NM
86412	AZ	87052	NM	87931	NM	88318	NM
86413	AZ	87053	NM	87933	NM	88321	NM
86426	AZ	87057	NM	87935	NM	88323	NM
86427	AZ	87060	NM	87939	NM	88324	NM
86429	AZ	87061	NM	87942	NM	88336	NM
86430	AZ	87062	NM	87943	NM	88338	NM
86431	AZ	87063	NM	88009	NM	88341	NM
86432	AZ	87068	NM	88020	NM	88343	NM
86433	AZ	87070	NM	88029	NM	88345	NM
86434	AZ	87072	NM	88030	NM	88346	NM
86436	AZ	87083	NM	88031	NM	88348	NM
86437	AZ	87124	NM	88039	NM	88351	NM
86438	AZ	87144	NM	88042	NM	88353	NM
86439	AZ	87174	NM	88045	NM	88355	NM
86440	AZ	87711	NM	88056	NM	88401	NM
86441	AZ	87712	NM	88101	NM	88410	NM
86442	AZ	87713	NM	88102	NM	88411	NM
86443	AZ	87715	NM	88103	NM	88414	NM
86444	AZ	87722	NM	88112	NM	88415	NM
86445	AZ	87723	NM	88113	NM	88417	NM
86446	AZ	87724	NM	88115	NM	88418	NM
87001	NM	87730	NM	88116	NM	88419	NM
87002	NM	87732	NM	88118	NM	88422	NM
87004	NM	87733	NM	88119	NM	88424	NM
87006	NM	87734	NM	88120	NM	88426	NM

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
88427	NM	89447	NV	92314	CA	93275	CA
88429	NM	89448	NV	92315	CA	93280	CA
88430	NM	89449	NV	92323	CA	93282	CA
88431	NM	89460	NV	92332	CA	93283	CA
88433	NM	89705	NV	92333	CA	93285	CA
88434	NM	90704	CA	92338	CA	93286	CA
88435	NM	92004	CA	92347	CA	93287	CA
88436	NM	92220	CA	92363	CA	93501	CA
88437	NM	92222	CA	92364	CA	93502	CA
89001	NV	92223	CA	92365	CA	93504	CA
89003	NV	92225	CA	92366	CA	93505	CA
89007	NV	92226	CA	92386	CA	93516	CA
89008	NV	92227	CA	92563	CA	93518	CA
89010	NV	92230	CA	92589	CA	93523	CA
89013	NV	92231	CA	92590	CA	93527	CA
89017	NV	92232	CA	92591	CA	93555	CA
89020	NV	92233	CA	92592	CA	93556	CA
89022	NV	92241	CA	92593	CA	93558	CA
89023	NV	92242	CA	93015	CA	93581	CA
89024	NV	92243	CA	93016	CA	93596	CA
89027	NV	92244	CA	93040	CA	93601	CA
89028	NV	92249	CA	93205	CA	93604	CA
89029	NV	92250	CA	93207	CA	93610	CA
89039	NV	92251	CA	93208	CA	93614	CA
89041	NV	92252	CA	93215	CA	93615	CA
89042	NV	92257	CA	93216	CA	93618	CA
89043	NV	92259	CA	93218	CA	93620	CA
89045	NV	92266	CA	93221	CA	93623	CA
89046	NV	92267	CA	93226	CA	93635	CA
89047	NV	92268	CA	93238	CA	93637	CA
89048	NV	92273	CA	93240	CA	93638	CA
89049	NV	92275	CA	93247	CA	93639	CA
89060	NV	92276	CA	93249	CA	93643	CA
89061	NV	92277	CA	93250	CA	93644	CA
89403	NV	92278	CA	93252	CA	93645	CA
89408	NV	92280	CA	93255	CA	93647	CA
89409	NV	92281	CA	93256	CA	93653	CA
89410	NV	92282	CA	93257	CA	93661	CA
89411	NV	92283	CA	93258	CA	93665	CA
89413	NV	92284	CA	93260	CA	93666	CA
89423	NV	92286	CA	93265	CA	93669	CA
89428	NV	92304	CA	93267	CA	93673	CA
89429	NV	92309	CA	93268	CA	94512	CA
89430	NV	92310	CA	93270	CA	94571	CA
89440	NV	92311	CA	93272	CA	95221	CA
89444	NV	92312	CA	93274	CA	95222	CA

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
95223	CA	95464	CA	96063	CA	97366	OR
95224	CA	95485	CA	96074	CA	97367	OR
95225	CA	95493	CA	96075	CA	97368	OR
95226	CA	95527	CA	96078	CA	97369	OR
95228	CA	95552	CA	96080	CA	97372	OR
95229	CA	95563	CA	96090	CA	97376	OR
95232	CA	95595	CA	96091	CA	97380	OR
95233	CA	95620	CA	96092	CA	97388	OR
95245	CA	95646	CA	96093	CA	97390	OR
95246	CA	95903	CA	96101	CA	97391	OR
95247	CA	95910	CA	96104	CA	97394	OR
95248	CA	95913	CA	96108	CA	97406	OR
95249	CA	95919	CA	96110	CA	97407	OR
95250	CA	95920	CA	96112	CA	97410	OR
95251	CA	95922	CA	96115	CA	97411	OR
95252	CA	95925	CA	96116	CA	97414	OR
95254	CA	95935	CA	96118	CA	97415	OR
95255	CA	95936	CA	96120	CA	97416	OR
95257	CA	95939	CA	96124	CA	97417	OR
95301	CA	95943	CA	96125	CA	97420	OR
95306	CA	95944	CA	96126	CA	97423	OR
95311	CA	95948	CA	96799	AS	97424	OR
95312	CA	95951	CA	96862	HI	97427	OR
95318	CA	95954	CA	96970	MH	97428	OR
95322	CA	95963	CA	97016	OR	97429	OR
95324	CA	95967	CA	97018	OR	97432	OR
95325	CA	95969	CA	97029	OR	97434	OR
95334	CA	95972	CA	97033	OR	97435	OR
95338	CA	95978	CA	97039	OR	97436	OR
95342	CA	95981	CA	97048	OR	97439	OR
95345	CA	95988	CA	97050	OR	97441	OR
95369	CA	96006	CA	97051	OR	97442	OR
95374	CA	96010	CA	97053	OR	97443	OR
95388	CA	96015	CA	97054	OR	97444	OR
95389	CA	96021	CA	97056	OR	97447	OR
95422	CA	96024	CA	97064	OR	97449	OR
95423	CA	96029	CA	97065	OR	97450	OR
95424	CA	96035	CA	97111	OR	97457	OR
95426	CA	96041	CA	97115	OR	97458	OR
95435	CA	96046	CA	97127	OR	97459	OR
95443	CA	96048	CA	97148	OR	97462	OR
95451	CA	96052	CA	97341	OR	97463	OR
95453	CA	96054	CA	97343	OR	97464	OR
95457	CA	96055	CA	97357	OR	97465	OR
95458	CA	96059	CA	97364	OR	97466	OR
95461	CA	96061	CA	97365	OR	97467	OR

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
97469	OR	97828	OR	98527	WA	98593	WA
97470	OR	97830	OR	98528	WA	98595	WA
97472	OR	97831	OR	98531	WA	98596	WA
97473	OR	97836	OR	98532	WA	98610	WA
97476	OR	97839	OR	98533	WA	98612	WA
97479	OR	97842	OR	98535	WA	98614	WA
97481	OR	97843	OR	98536	WA	98621	WA
97484	OR	97844	OR	98537	WA	98624	WA
97486	OR	97845	OR	98538	WA	98631	WA
97491	OR	97846	OR	98539	WA	98637	WA
97492	OR	97848	OR	98541	WA	98638	WA
97493	OR	97856	OR	98542	WA	98639	WA
97494	OR	97857	OR	98544	WA	98640	WA
97495	OR	97861	OR	98546	WA	98641	WA
97496	OR	97864	OR	98547	WA	98643	WA
97497	OR	97865	OR	98548	WA	98644	WA
97498	OR	97869	OR	98550	WA	98647	WA
97499	OR	97872	OR	98552	WA	98648	WA
97523	OR	97873	OR	98554	WA	98651	WA
97526	OR	97874	OR	98555	WA	98802	WA
97527	OR	97885	OR	98557	WA	98813	WA
97528	OR	98222	WA	98559	WA	98830	WA
97531	OR	98236	WA	98560	WA	98843	WA
97532	OR	98241	WA	98561	WA	98845	WA
97533	OR	98243	WA	98562	WA	98850	WA
97534	OR	98245	WA	98563	WA	98858	WA
97538	OR	98249	WA	98564	WA	99004	WA
97543	OR	98250	WA	98565	WA	99008	WA
97544	OR	98260	WA	98566	WA	99011	WA
97711	OR	98261	WA	98568	WA	99012	WA
97730	OR	98279	WA	98569	WA	99015	WA
97734	OR	98280	WA	98570	WA	99018	WA
97741	OR	98282	WA	98571	WA	99022	WA
97750	OR	98286	WA	98572	WA	99029	WA
97751	OR	98297	WA	98575	WA	99030	WA
97752	OR	98330	WA	98577	WA	99031	WA
97753	OR	98336	WA	98582	WA	99032	WA
97754	OR	98355	WA	98583	WA	99039	WA
97760	OR	98356	WA	98584	WA	99103	WA
97761	OR	98361	WA	98585	WA	99107	WA
97812	OR	98377	WA	98586	WA	99117	WA
97817	OR	98398	WA	98587	WA	99118	WA
97818	OR	98520	WA	98588	WA	99119	WA
97820	OR	98522	WA	98590	WA	99121	WA
97823	OR	98524	WA	98591	WA	99122	WA
97825	OR	98526	WA	98592	WA	99134	WA

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
99138	WA	99633	AK	99777	AK		
99139	WA	99638	AK	99781	AK		
99140	WA	99640	AK	99788	AK		
99144	WA	99647	AK	99820	AK		
99146	WA	99648	AK	99825	AK		
99147	WA	99649	AK	99826	AK		
99150	WA	99650	AK	99829	AK		
99152	WA	99653	AK	99832	AK		
99153	WA	99657	AK	99840	AK		
99154	WA	99658	AK	99841	AK		
99156	WA	99660	AK				
99159	WA	99661	AK				
99160	WA	99662	AK				
99166	WA	99665	AK				
99180	WA	99666	AK				
99185	WA	99670	AK				
99347	WA	99675	AK				
99401	WA	99685	AK				
99402	WA	99689	AK				
99403	WA	99691	AK				
99546	AK	99692	AK				
99547	AK	99704	AK				
99548	AK	99720	AK				
99549	AK	99722	AK				
99553	AK	99724	AK				
99554	AK	99726	AK				
99558	AK	99729	AK				
99563	AK	99730	AK				
99564	AK	99733	AK				
99565	AK	99740	AK				
99571	AK	99741	AK				
99579	AK	99743	AK				
99581	AK	99744	AK				
99583	AK	99745	AK				
99585	AK	99746	AK				
99590	AK	99748	AK				
99591	AK	99754	AK				
99602	AK	99755	AK				
99604	AK	99756	AK				
99606	AK	99757	AK				
99612	AK	99758	AK				
99613	AK	99760	AK				
99620	AK	99765	AK				
99625	AK	99767	AK				
99627	AK	99768	AK				
99632	AK	99774	AK				

ADDENDUM K- MENTAL HEALTH HPSA ZIP CODES

2005 Mental Health HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
00801	VI	04441	ME	07543	NJ	12173	NY
00802	VI	04442	ME	12015	NY	12174	NY
00803	VI	04443	ME	12017	NY	12175	NY
00804	VI	04451	ME	12025	NY	12176	NY
00805	VI	04455	ME	12029	NY	12184	NY
00820	VI	04462	ME	12031	NY	12187	NY
00821	VI	04464	ME	12032	NY	12192	NY
00822	VI	04478	ME	12035	NY	12194	NY
00823	VI	04479	ME	12036	NY	12195	NY
00824	VI	04481	ME	12037	NY	12197	NY
00830	VI	04485	ME	12042	NY	12405	NY
00831	VI	04490	ME	12043	NY	12406	NY
00840	VI	04497	ME	12050	NY	12407	NY
00841	VI	04628	ME	12051	NY	12413	NY
00850	VI	04637	ME	12058	NY	12414	NY
00851	VI	04648	ME	12060	NY	12418	NY
00936	PR	04654	ME	12062	NY	12421	NY
00956	PR	04657	ME	12064	NY	12422	NY
00957	PR	04666	ME	12071	NY	12423	NY
00958	PR	04668	ME	12073	NY	12424	NY
00959	PR	04671	ME	12075	NY	12427	NY
00960	PR	04686	ME	12076	NY	12430	NY
00961	PR	04691	ME	12078	NY	12431	NY
00965	PR	04732	ME	12083	NY	12434	NY
00966	PR	04733	ME	12087	NY	12436	NY
00969	PR	04737	ME	12092	NY	12438	NY
00970	PR	04747	ME	12093	NY	12439	NY
00971	PR	04759	ME	12095	NY	12442	NY
02801	RI	04764	ME	12106	NY	12444	NY
02826	RI	04765	ME	12115	NY	12450	NY
02835	RI	04768	ME	12116	NY	12451	NY
02837	RI	04772	ME	12117	NY	12452	NY
02838	RI	04775	ME	12122	NY	12454	NY
02840	RI	04776	ME	12124	NY	12455	NY
02841	RI	04777	ME	12125	NY	12459	NY
02842	RI	04780	ME	12130	NY	12460	NY
02858	RI	04781	ME	12131	NY	12463	NY
02871	RI	04787	ME	12134	NY	12468	NY
02878	RI	04920	ME	12136	NY	12470	NY
04226	ME	04923	ME	12149	NY	12473	NY
04257	ME	04950	ME	12155	NY	12474	NY
04276	ME	04958	ME	12157	NY	12482	NY
04278	ME	04979	ME	12160	NY	12485	NY
04406	ME	07108	NJ	12165	NY	12492	NY
04414	ME	07505	NJ	12167	NY	12496	NY
04415	ME	07513	NJ	12172	NY	12502	NY

ADDENDUM K- MENTAL HEALTH HPSA ZIP CODES

2005 Mental Health HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
12503	NY	12957	NY	13364	NY	13667	NY
12513	NY	12960	NY	13367	NY	13668	NY
12516	NY	12961	NY	13368	NY	13669	NY
12517	NY	12964	NY	13404	NY	13670	NY
12521	NY	12965	NY	13411	NY	13672	NY
12523	NY	12966	NY	13415	NY	13676	NY
12526	NY	12967	NY	13433	NY	13677	NY
12529	NY	12969	NY	13439	NY	13678	NY
12530	NY	12970	NY	13450	NY	13680	NY
12534	NY	12973	NY	13457	NY	13681	NY
12541	NY	12974	NY	13459	NY	13683	NY
12544	NY	12976	NY	13460	NY	13684	NY
12565	NY	12977	NY	13464	NY	13687	NY
12851	NY	12980	NY	13468	NY	13690	NY
12852	NY	12983	NY	13470	NY	13694	NY
12855	NY	12986	NY	13473	NY	13695	NY
12857	NY	12987	NY	13482	NY	13696	NY
12858	NY	12989	NY	13485	NY	13697	NY
12870	NY	12993	NY	13488	NY	13699	NY
12872	NY	12995	NY	13489	NY	13730	NY
12879	NY	12996	NY	13613	NY	13731	NY
12883	NY	12997	NY	13614	NY	13733	NY
12913	NY	12998	NY	13617	NY	13739	NY
12914	NY	13065	NY	13620	NY	13740	NY
12915	NY	13124	NY	13621	NY	13747	NY
12916	NY	13136	NY	13623	NY	13750	NY
12917	NY	13143	NY	13625	NY	13751	NY
12920	NY	13146	NY	13626	NY	13752	NY
12922	NY	13148	NY	13630	NY	13753	NY
12926	NY	13154	NY	13633	NY	13755	NY
12927	NY	13155	NY	13635	NY	13756	NY
12928	NY	13165	NY	13639	NY	13757	NY
12930	NY	13305	NY	13642	NY	13758	NY
12932	NY	13312	NY	13645	NY	13775	NY
12936	NY	13315	NY	13646	NY	13776	NY
12937	NY	13325	NY	13647	NY	13778	NY
12939	NY	13326	NY	13648	NY	13780	NY
12941	NY	13327	NY	13649	NY	13782	NY
12942	NY	13332	NY	13652	NY	13783	NY
12943	NY	13333	NY	13654	NY	13786	NY
12945	NY	13335	NY	13655	NY	13788	NY
12946	NY	13337	NY	13658	NY	13796	NY
12949	NY	13342	NY	13660	NY	13801	NY
12950	NY	13343	NY	13662	NY	13804	NY
12953	NY	13345	NY	13664	NY	13806	NY
12956	NY	13348	NY	13666	NY	13807	NY

ADDENDUM K- MENTAL HEALTH HPSA ZIP CODES

2005 Mental Health HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
13808	NY	14423	NY	14703	NY	14755	NY
13809	NY	14433	NY	14704	NY	14756	NY
13810	NY	14435	NY	14706	NY	14757	NY
13814	NY	14437	NY	14707	NY	14758	NY
13815	NY	14449	NY	14708	NY	14760	NY
13820	NY	14454	NY	14709	NY	14766	NY
13825	NY	14462	NY	14710	NY	14767	NY
13830	NY	14466	NY	14711	NY	14769	NY
13832	NY	14480	NY	14712	NY	14770	NY
13834	NY	14481	NY	14714	NY	14772	NY
13838	NY	14485	NY	14715	NY	14774	NY
13839	NY	14486	NY	14716	NY	14775	NY
13841	NY	14487	NY	14717	NY	14777	NY
13842	NY	14488	NY	14718	NY	14778	NY
13843	NY	14489	NY	14719	NY	14779	NY
13844	NY	14502	NY	14720	NY	14781	NY
13846	NY	14505	NY	14721	NY	14782	NY
13847	NY	14510	NY	14722	NY	14783	NY
13849	NY	14513	NY	14723	NY	14784	NY
13856	NY	14516	NY	14724	NY	14785	NY
13859	NY	14517	NY	14726	NY	14786	NY
13860	NY	14519	NY	14727	NY	14787	NY
13861	NY	14520	NY	14728	NY	14788	NY
14029	NY	14521	NY	14729	NY	14801	NY
14041	NY	14522	NY	14730	NY	14802	NY
14042	NY	14529	NY	14731	NY	14803	NY
14048	NY	14533	NY	14732	NY	14804	NY
14060	NY	14538	NY	14733	NY	14805	NY
14061	NY	14539	NY	14735	NY	14806	NY
14062	NY	14541	NY	14736	NY	14807	NY
14063	NY	14542	NY	14737	NY	14808	NY
14065	NY	14545	NY	14738	NY	14809	NY
14070	NY	14551	NY	14739	NY	14810	NY
14081	NY	14555	NY	14740	NY	14812	NY
14101	NY	14556	NY	14741	NY	14813	NY
14129	NY	14558	NY	14742	NY	14815	NY
14133	NY	14560	NY	14743	NY	14818	NY
14135	NY	14563	NY	14744	NY	14819	NY
14136	NY	14568	NY	14745	NY	14820	NY
14138	NY	14572	NY	14747	NY	14821	NY
14166	NY	14588	NY	14748	NY	14822	NY
14168	NY	14589	NY	14750	NY	14823	NY
14171	NY	14590	NY	14751	NY	14824	NY
14173	NY	14592	NY	14752	NY	14826	NY
14413	NY	14701	NY	14753	NY	14827	NY
14414	NY	14702	NY	14754	NY	14830	NY

ADDENDUM K- MENTAL HEALTH HPSA ZIP CODES

2005 Mental Health HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
14831	NY	15351	PA	15461	PA	15752	PA
14836	NY	15352	PA	15462	PA	15754	PA
14839	NY	15353	PA	15463	PA	15758	PA
14840	NY	15354	PA	15464	PA	15759	PA
14841	NY	15357	PA	15465	PA	15763	PA
14843	NY	15359	PA	15466	PA	15764	PA
14846	NY	15362	PA	15467	PA	15765	PA
14847	NY	15364	PA	15468	PA	15770	PA
14855	NY	15370	PA	15469	PA	15771	PA
14856	NY	15380	PA	15470	PA	15772	PA
14858	NY	15401	PA	15472	PA	15776	PA
14860	NY	15410	PA	15473	PA	15777	PA
14865	NY	15413	PA	15474	PA	15780	PA
14869	NY	15415	PA	15475	PA	15784	PA
14870	NY	15416	PA	15476	PA	15828	PA
14873	NY	15417	PA	15478	PA	15920	PA
14874	NY	15420	PA	15480	PA	15929	PA
14876	NY	15421	PA	15482	PA	16049	PA
14877	NY	15422	PA	15484	PA	16201	PA
14878	NY	15425	PA	15486	PA	16210	PA
14879	NY	15428	PA	15488	PA	16212	PA
14880	NY	15429	PA	15489	PA	16215	PA
14884	NY	15430	PA	15490	PA	16217	PA
14885	NY	15431	PA	15492	PA	16218	PA
14891	NY	15433	PA	15631	PA	16222	PA
14895	NY	15435	PA	15656	PA	16226	PA
14897	NY	15436	PA	15682	PA	16228	PA
14898	NY	15437	PA	15686	PA	16229	PA
15012	PA	15438	PA	15701	PA	16236	PA
15072	PA	15439	PA	15705	PA	16238	PA
15087	PA	15440	PA	15711	PA	16239	PA
15310	PA	15442	PA	15713	PA	16244	PA
15315	PA	15443	PA	15716	PA	16249	PA
15316	PA	15444	PA	15720	PA	16250	PA
15320	PA	15445	PA	15723	PA	16259	PA
15322	PA	15446	PA	15727	PA	16261	PA
15325	PA	15447	PA	15728	PA	16262	PA
15327	PA	15449	PA	15729	PA	16263	PA
15334	PA	15450	PA	15730	PA	16301	PA
15337	PA	15451	PA	15731	PA	16312	PA
15338	PA	15454	PA	15734	PA	16313	PA
15341	PA	15455	PA	15739	PA	16317	PA
15344	PA	15456	PA	15744	PA	16319	PA
15346	PA	15458	PA	15745	PA	16321	PA
15348	PA	15459	PA	15746	PA	16322	PA
15349	PA	15460	PA	15748	PA	16323	PA

ADDENDUM K- MENTAL HEALTH HPSA ZIP CODES

2005 Mental Health HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
16329	PA	16923	PA	17261	PA	17948	PA
16340	PA	16925	PA	17262	PA	17949	PA
16341	PA	16926	PA	17263	PA	17951	PA
16342	PA	16927	PA	17265	PA	17952	PA
16343	PA	16928	PA	17268	PA	17953	PA
16344	PA	16929	PA	17270	PA	17954	PA
16345	PA	16930	PA	17271	PA	17957	PA
16346	PA	16932	PA	17272	PA	17959	PA
16347	PA	16933	PA	17721	PA	17960	PA
16350	PA	16935	PA	17724	PA	17961	PA
16351	PA	16936	PA	17726	PA	17963	PA
16352	PA	16937	PA	17729	PA	17964	PA
16353	PA	16938	PA	17735	PA	17965	PA
16362	PA	16939	PA	17738	PA	17966	PA
16364	PA	16940	PA	17745	PA	17967	PA
16365	PA	16941	PA	17747	PA	17968	PA
16366	PA	16942	PA	17748	PA	17970	PA
16367	PA	16943	PA	17750	PA	17972	PA
16368	PA	16945	PA	17751	PA	17974	PA
16369	PA	16946	PA	17760	PA	17976	PA
16370	PA	16947	PA	17764	PA	17978	PA
16371	PA	16948	PA	17765	PA	17979	PA
16372	PA	16950	PA	17767	PA	17980	PA
16373	PA	17201	PA	17773	PA	17981	PA
16374	PA	17210	PA	17778	PA	17982	PA
16402	PA	17214	PA	17779	PA	17983	PA
16405	PA	17217	PA	17901	PA	17985	PA
16416	PA	17219	PA	17921	PA	18012	PA
16420	PA	17220	PA	17922	PA	18030	PA
16436	PA	17221	PA	17923	PA	18058	PA
16720	PA	17222	PA	17925	PA	18071	PA
16746	PA	17224	PA	17929	PA	18210	PA
16748	PA	17225	PA	17930	PA	18211	PA
16822	PA	17231	PA	17931	PA	18212	PA
16848	PA	17232	PA	17932	PA	18214	PA
16901	PA	17235	PA	17933	PA	18216	PA
16910	PA	17236	PA	17934	PA	18218	PA
16911	PA	17237	PA	17935	PA	18220	PA
16912	PA	17244	PA	17936	PA	18229	PA
16914	PA	17246	PA	17938	PA	18230	PA
16915	PA	17247	PA	17941	PA	18231	PA
16917	PA	17250	PA	17942	PA	18232	PA
16918	PA	17251	PA	17943	PA	18235	PA
16920	PA	17252	PA	17944	PA	18237	PA
16921	PA	17254	PA	17945	PA	18240	PA
16922	PA	17256	PA	17946	PA	18241	PA

ADDENDUM K- MENTAL HEALTH HPSA ZIP CODES

2005 Mental Health HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
18242	PA	18413	PA	18629	PA	21536	MD
18244	PA	18415	PA	18630	PA	21538	MD
18245	PA	18417	PA	18636	PA	21541	MD
18248	PA	18419	PA	18657	PA	21550	MD
18250	PA	18420	PA	18801	PA	21561	MD
18252	PA	18421	PA	18810	PA	21610	MD
18254	PA	18424	PA	18812	PA	21620	MD
18255	PA	18425	PA	18813	PA	21635	MD
18301	PA	18426	PA	18814	PA	21645	MD
18320	PA	18427	PA	18815	PA	21650	MD
18321	PA	18428	PA	18816	PA	21651	MD
18322	PA	18430	PA	18817	PA	21661	MD
18323	PA	18431	PA	18818	PA	21667	MD
18324	PA	18435	PA	18820	PA	21678	MD
18325	PA	18436	PA	18821	PA	21690	MD
18326	PA	18437	PA	18822	PA	22650	VA
18327	PA	18438	PA	18823	PA	22835	VA
18328	PA	18439	PA	18824	PA	22849	VA
18330	PA	18441	PA	18825	PA	22851	VA
18331	PA	18443	PA	18826	PA	22920	VA
18332	PA	18445	PA	18827	PA	22922	VA
18333	PA	18446	PA	18828	PA	22938	VA
18334	PA	18449	PA	18829	PA	22949	VA
18335	PA	18451	PA	18830	PA	22954	VA
18336	PA	18453	PA	18831	PA	22958	VA
18337	PA	18454	PA	18832	PA	22964	VA
18340	PA	18455	PA	18833	PA	22967	VA
18341	PA	18456	PA	18834	PA	22969	VA
18342	PA	18457	PA	18837	PA	22971	VA
18344	PA	18458	PA	18840	PA	22976	VA
18346	PA	18459	PA	18842	PA	24464	VA
18347	PA	18460	PA	18843	PA	24553	VA
18348	PA	18461	PA	18844	PA	28420	NC
18349	PA	18462	PA	18845	PA	28422	NC
18350	PA	18463	PA	18846	PA	28451	NC
18352	PA	18464	PA	18847	PA	28452	NC
18353	PA	18465	PA	18848	PA	28459	NC
18354	PA	18466	PA	18850	PA	28461	NC
18355	PA	18469	PA	18851	PA	28462	NC
18356	PA	18470	PA	18853	PA	28465	NC
18357	PA	18472	PA	18854	PA	28467	NC
18360	PA	18473	PA	19549	PA	28468	NC
18370	PA	18610	PA	21520	MD	28469	NC
18371	PA	18615	PA	21522	MD	28470	NC
18372	PA	18623	PA	21523	MD	28479	NC
18405	PA	18624	PA	21531	MD	28611	NC

ADDENDUM K- MENTAL HEALTH HPSA ZIP CODES

2005 Mental Health HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
28630	NC	32425	FL	33070	FL	44492	OH
28633	NC	32426	FL	43301	OH	44493	OH
28638	NC	32427	FL	43302	OH	44607	OH
28645	NC	32428	FL	43306	OH	44619	OH
28661	NC	32431	FL	43314	OH	44625	OH
28667	NC	32432	FL	43322	OH	44634	OH
29015	SC	32433	FL	43325	OH	44820	OH
29065	SC	32434	FL	43332	OH	44827	OH
29106	SC	32435	FL	43335	OH	44833	OH
29130	SC	32437	FL	43337	OH	44854	OH
29132	SC	32439	FL	43341	OH	44856	OH
29176	SC	32440	FL	43342	OH	44881	OH
29180	SC	32442	FL	43356	OH	44887	OH
32004	FL	32443	FL	43920	OH	45101	OH
32007	FL	32445	FL	43945	OH	45105	OH
32033	FL	32446	FL	43962	OH	45110	OH
32080	FL	32447	FL	43968	OH	45115	OH
32082	FL	32448	FL	44003	OH	45118	OH
32084	FL	32452	FL	44004	OH	45119	OH
32085	FL	32454	FL	44005	OH	45121	OH
32086	FL	32455	FL	44010	OH	45123	OH
32092	FL	32459	FL	44030	OH	45130	OH
32095	FL	32460	FL	44032	OH	45131	OH
32112	FL	32462	FL	44041	OH	45132	OH
32131	FL	32463	FL	44047	OH	45133	OH
32138	FL	32464	FL	44048	OH	45135	OH
32139	FL	32550	FL	44068	OH	45142	OH
32140	FL	32619	FL	44076	OH	45144	OH
32145	FL	32628	FL	44082	OH	45154	OH
32147	FL	32648	FL	44084	OH	45155	OH
32148	FL	32666	FL	44085	OH	45167	OH
32149	FL	32680	FL	44088	OH	45168	OH
32157	FL	32692	FL	44093	OH	45171	OH
32160	FL	32693	FL	44099	OH	45172	OH
32177	FL	33001	FL	44408	OH	45616	OH
32178	FL	33036	FL	44413	OH	45618	OH
32181	FL	33037	FL	44415	OH	45629	OH
32185	FL	33040	FL	44423	OH	45630	OH
32187	FL	33041	FL	44427	OH	45636	OH
32189	FL	33042	FL	44431	OH	45648	OH
32193	FL	33043	FL	44432	OH	45650	OH
32259	FL	33044	FL	44441	OH	45652	OH
32260	FL	33045	FL	44445	OH	45653	OH
32420	FL	33050	FL	44455	OH	45657	OH
32422	FL	33051	FL	44460	OH	45660	OH
32423	FL	33052	FL	44490	OH	45662	OH

ADDENDUM K- MENTAL HEALTH HPSA ZIP CODES

2005 Mental Health HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
45663	OH	47039	IN	48060	MI	48754	MI
45671	OH	47040	IN	48061	MI	48755	MI
45677	OH	47041	IN	48063	MI	48757	MI
45679	OH	47042	IN	48064	MI	48758	MI
45682	OH	47043	IN	48074	MI	48759	MI
45684	OH	47060	IN	48079	MI	48767	MI
45687	OH	47424	IN	48097	MI	48768	MI
45693	OH	47438	IN	48401	MI	48769	MI
45694	OH	47439	IN	48410	MI	48809	MI
45697	OH	47441	IN	48413	MI	48811	MI
45699	OH	47443	IN	48416	MI	48812	MI
46928	IN	47445	IN	48419	MI	48815	MI
46930	IN	47449	IN	48422	MI	48818	MI
46933	IN	47453	IN	48426	MI	48829	MI
46938	IN	47457	IN	48427	MI	48834	MI
46952	IN	47459	IN	48432	MI	48838	MI
46953	IN	47465	IN	48434	MI	48845	MI
46957	IN	47471	IN	48435	MI	48846	MI
46986	IN	47838	IN	48441	MI	48849	MI
46987	IN	47845	IN	48445	MI	48850	MI
46989	IN	47848	IN	48450	MI	48851	MI
46991	IN	47849	IN	48453	MI	48852	MI
47001	IN	47850	IN	48454	MI	48860	MI
47006	IN	47852	IN	48456	MI	48865	MI
47010	IN	47855	IN	48465	MI	48870	MI
47011	IN	47861	IN	48466	MI	48873	MI
47012	IN	47864	IN	48467	MI	48875	MI
47016	IN	47865	IN	48468	MI	48881	MI
47017	IN	47879	IN	48469	MI	48884	MI
47018	IN	47882	IN	48470	MI	48885	MI
47019	IN	48001	MI	48471	MI	48886	MI
47020	IN	48002	MI	48472	MI	48887	MI
47021	IN	48004	MI	48475	MI	48888	MI
47022	IN	48006	MI	48701	MI	48891	MI
47023	IN	48014	MI	48720	MI	49028	MI
47024	IN	48022	MI	48723	MI	49030	MI
47025	IN	48023	MI	48725	MI	49031	MI
47030	IN	48027	MI	48726	MI	49032	MI
47031	IN	48028	MI	48729	MI	49036	MI
47032	IN	48032	MI	48731	MI	49040	MI
47033	IN	48039	MI	48733	MI	49042	MI
47034	IN	48040	MI	48735	MI	49047	MI
47035	IN	48041	MI	48736	MI	49061	MI
47036	IN	48049	MI	48741	MI	49066	MI
47037	IN	48054	MI	48744	MI	49067	MI
47038	IN	48059	MI	48746	MI	49072	MI

ADDENDUM K- MENTAL HEALTH HPSA ZIP CODES

2005 Mental Health HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
49075	MI	49289	MI	49812	MI	53137	WI
49082	MI	49309	MI	49816	MI	53156	WI
49089	MI	49312	MI	49817	MI	53178	WI
49091	MI	49322	MI	49818	MI	53206	WI
49093	MI	49327	MI	49821	MI	53503	WI
49094	MI	49329	MI	49822	MI	53504	WI
49095	MI	49337	MI	49825	MI	53506	WI
49099	MI	49339	MI	49826	MI	53507	WI
49112	MI	49347	MI	49829	MI	53510	WI
49130	MI	49349	MI	49835	MI	53516	WI
49220	MI	49401	MI	49836	MI	53518	WI
49221	MI	49403	MI	49837	MI	53526	WI
49227	MI	49404	MI	49839	MI	53530	WI
49228	MI	49409	MI	49840	MI	53533	WI
49229	MI	49412	MI	49845	MI	53535	WI
49232	MI	49413	MI	49847	MI	53538	WI
49233	MI	49417	MI	49848	MI	53540	WI
49235	MI	49422	MI	49854	MI	53541	WI
49236	MI	49423	MI	49858	MI	53543	WI
49238	MI	49424	MI	49862	MI	53544	WI
49239	MI	49426	MI	49863	MI	53549	WI
49242	MI	49427	MI	49864	MI	53551	WI
49247	MI	49428	MI	49872	MI	53553	WI
49248	MI	49429	MI	49873	MI	53554	WI
49249	MI	49430	MI	49874	MI	53555	WI
49250	MI	49434	MI	49878	MI	53556	WI
49252	MI	49435	MI	49880	MI	53561	WI
49253	MI	49448	MI	49883	MI	53565	WI
49255	MI	49456	MI	49884	MI	53569	WI
49256	MI	49460	MI	49886	MI	53573	WI
49257	MI	49464	MI	49887	MI	53577	WI
49258	MI	49711	MI	49891	MI	53578	WI
49262	MI	49712	MI	49893	MI	53580	WI
49265	MI	49713	MI	49894	MI	53581	WI
49266	MI	49720	MI	49895	MI	53582	WI
49268	MI	49727	MI	49896	MI	53583	WI
49271	MI	49730	MI	49911	MI	53584	WI
49274	MI	49734	MI	49938	MI	53586	WI
49275	MI	49735	MI	49947	MI	53587	WI
49276	MI	49751	MI	49959	MI	53588	WI
49279	MI	49782	MI	49968	MI	53594	WI
49281	MI	49795	MI	49969	MI	53595	WI
49282	MI	49796	MI	53036	WI	53599	WI
49286	MI	49797	MI	53038	WI	53801	WI
49287	MI	49806	MI	53047	WI	53802	WI
49288	MI	49807	MI	53094	WI	53803	WI

ADDENDUM K- MENTAL HEALTH HPSA ZIP CODES

2005 Mental Health HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
53804	WI	53953	WI	54120	WI	54424	WI
53805	WI	53954	WI	54121	WI	54425	WI
53806	WI	53955	WI	54124	WI	54428	WI
53807	WI	53958	WI	54125	WI	54429	WI
53808	WI	53959	WI	54127	WI	54430	WI
53809	WI	53960	WI	54128	WI	54432	WI
53810	WI	53961	WI	54135	WI	54433	WI
53811	WI	53962	WI	54137	WI	54434	WI
53812	WI	53964	WI	54138	WI	54435	WI
53813	WI	53965	WI	54139	WI	54436	WI
53816	WI	53968	WI	54141	WI	54437	WI
53817	WI	53969	WI	54143	WI	54439	WI
53818	WI	54001	WI	54149	WI	54442	WI
53820	WI	54002	WI	54150	WI	54446	WI
53821	WI	54003	WI	54151	WI	54447	WI
53824	WI	54004	WI	54153	WI	54450	WI
53825	WI	54005	WI	54154	WI	54451	WI
53826	WI	54006	WI	54156	WI	54452	WI
53827	WI	54007	WI	54157	WI	54456	WI
53901	WI	54009	WI	54159	WI	54459	WI
53910	WI	54010	WI	54161	WI	54460	WI
53911	WI	54011	WI	54166	WI	54462	WI
53913	WI	54013	WI	54171	WI	54464	WI
53920	WI	54014	WI	54174	WI	54465	WI
53923	WI	54015	WI	54175	WI	54470	WI
53924	WI	54016	WI	54177	WI	54480	WI
53925	WI	54017	WI	54182	WI	54485	WI
53927	WI	54020	WI	54202	WI	54486	WI
53928	WI	54021	WI	54204	WI	54487	WI
53929	WI	54022	WI	54209	WI	54490	WI
53930	WI	54023	WI	54210	WI	54491	WI
53932	WI	54024	WI	54211	WI	54493	WI
53934	WI	54025	WI	54212	WI	54498	WI
53935	WI	54026	WI	54213	WI	54499	WI
53936	WI	54027	WI	54226	WI	54511	WI
53937	WI	54028	WI	54234	WI	54512	WI
53940	WI	54082	WI	54235	WI	54513	WI
53941	WI	54101	WI	54246	WI	54514	WI
53942	WI	54102	WI	54405	WI	54515	WI
53943	WI	54103	WI	54409	WI	54517	WI
53944	WI	54104	WI	54414	WI	54519	WI
53948	WI	54107	WI	54416	WI	54520	WI
53949	WI	54111	WI	54418	WI	54521	WI
53950	WI	54112	WI	54420	WI	54524	WI
53951	WI	54114	WI	54421	WI	54525	WI
53952	WI	54119	WI	54422	WI	54526	WI

ADDENDUM K- MENTAL HEALTH HPSA ZIP CODES

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
54527	WI	54632	WI	54747	WI	54840	WI
54530	WI	54634	WI	54749	WI	54841	WI
54532	WI	54635	WI	54750	WI	54843	WI
54534	WI	54637	WI	54751	WI	54844	WI
54536	WI	54638	WI	54754	WI	54845	WI
54537	WI	54639	WI	54755	WI	54846	WI
54538	WI	54640	WI	54756	WI	54847	WI
54540	WI	54641	WI	54758	WI	54848	WI
54541	WI	54642	WI	54759	WI	54850	WI
54542	WI	54643	WI	54760	WI	54853	WI
54545	WI	54645	WI	54761	WI	54855	WI
54546	WI	54646	WI	54762	WI	54856	WI
54547	WI	54648	WI	54763	WI	54857	WI
54550	WI	54649	WI	54764	WI	54858	WI
54552	WI	54651	WI	54765	WI	54859	WI
54554	WI	54652	WI	54766	WI	54861	WI
54555	WI	54654	WI	54767	WI	54862	WI
54556	WI	54655	WI	54769	WI	54865	WI
54557	WI	54656	WI	54770	WI	54867	WI
54558	WI	54657	WI	54771	WI	54868	WI
54559	WI	54658	WI	54772	WI	54870	WI
54560	WI	54659	WI	54773	WI	54871	WI
54561	WI	54660	WI	54801	WI	54872	WI
54563	WI	54661	WI	54805	WI	54875	WI
54565	WI	54662	WI	54806	WI	54876	WI
54566	WI	54664	WI	54810	WI	54888	WI
54610	WI	54665	WI	54812	WI	54889	WI
54611	WI	54666	WI	54813	WI	54890	WI
54612	WI	54667	WI	54814	WI	54891	WI
54613	WI	54670	WI	54816	WI	54893	WI
54615	WI	54721	WI	54817	WI	54895	WI
54616	WI	54723	WI	54818	WI	54896	WI
54618	WI	54725	WI	54819	WI	54926	WI
54619	WI	54728	WI	54821	WI	54928	WI
54620	WI	54730	WI	54822	WI	54929	WI
54621	WI	54731	WI	54824	WI	54930	WI
54622	WI	54733	WI	54826	WI	54933	WI
54623	WI	54734	WI	54827	WI	54940	WI
54624	WI	54735	WI	54828	WI	54943	WI
54625	WI	54736	WI	54829	WI	54945	WI
54626	WI	54737	WI	54830	WI	54946	WI
54627	WI	54738	WI	54832	WI	54948	WI
54628	WI	54739	WI	54834	WI	54949	WI
54629	WI	54740	WI	54835	WI	54950	WI
54630	WI	54743	WI	54837	WI	54960	WI
54631	WI	54746	WI	54839	WI	54961	WI

ADDENDUM K- MENTAL HEALTH HPSA ZIP CODES

2005 Mental Health HPSA Zip Code List

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
54962	WI	57446	SD	58043	ND	58265	ND
54965	WI	57448	SD	58045	ND	58270	ND
54966	WI	57449	SD	58046	ND	58271	ND
54967	WI	57450	SD	58053	ND	58272	ND
54969	WI	57451	SD	58054	ND	58273	ND
54970	WI	57452	SD	58056	ND	58274	ND
54975	WI	57454	SD	58057	ND	58276	ND
54976	WI	57455	SD	58058	ND	58277	ND
54977	WI	57456	SD	58060	ND	58282	ND
54978	WI	57457	SD	58061	ND	58313	ND
54981	WI	57460	SD	58065	ND	58318	ND
54982	WI	57461	SD	58067	ND	58344	ND
54983	WI	57465	SD	58068	ND	58359	ND
54984	WI	57466	SD	58069	ND	58361	ND
54990	WI	57468	SD	58074	ND	58368	ND
57219	SD	57469	SD	58075	ND	58380	ND
57232	SD	57470	SD	58076	ND	58384	ND
57239	SD	57471	SD	58077	ND	58385	ND
57247	SD	57472	SD	58081	ND	58428	ND
57261	SD	57473	SD	58210	ND	58430	ND
57270	SD	57474	SD	58212	ND	58444	ND
57273	SD	57475	SD	58216	ND	58463	ND
57274	SD	57476	SD	58218	ND	58475	ND
57401	SD	57477	SD	58219	ND	58478	ND
57402	SD	57479	SD	58220	ND	58482	ND
57420	SD	57481	SD	58222	ND	58487	ND
57421	SD	57601	SD	58223	ND	58488	ND
57422	SD	57631	SD	58224	ND	58523	ND
57424	SD	57632	SD	58225	ND	58524	ND
57426	SD	57646	SD	58227	ND	58528	ND
57427	SD	57648	SD	58229	ND	58529	ND
57428	SD	58001	ND	58230	ND	58530	ND
57429	SD	58008	ND	58231	ND	58531	ND
57430	SD	58009	ND	58233	ND	58533	ND
57432	SD	58013	ND	58236	ND	58538	ND
57433	SD	58015	ND	58237	ND	58540	ND
57434	SD	58016	ND	58238	ND	58541	ND
57435	SD	58017	ND	58240	ND	58542	ND
57436	SD	58018	ND	58241	ND	58544	ND
57437	SD	58027	ND	58243	ND	58545	ND
57438	SD	58030	ND	58250	ND	58549	ND
57439	SD	58032	ND	58254	ND	58552	ND
57440	SD	58033	ND	58257	ND	58559	ND
57441	SD	58035	ND	58259	ND	58562	ND
57442	SD	58040	ND	58261	ND	58564	ND
57445	SD	58041	ND	58262	ND	58565	ND

ADDENDUM K- MENTAL HEALTH HPSA ZIP CODES

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
58568	ND	58833	ND	59073	MT	59827	MT
58569	ND	58835	ND	59074	MT	59828	MT
58570	ND	58838	ND	59075	MT	59829	MT
58571	ND	58844	ND	59081	MT	59830	MT
58573	ND	58847	ND	59082	MT	59831	MT
58575	ND	58854	ND	59086	MT	59832	MT
58576	ND	59001	MT	59089	MT	59833	MT
58577	ND	59007	MT	59631	MT	59835	MT
58579	ND	59008	MT	59632	MT	59837	MT
58580	ND	59011	MT	59634	MT	59840	MT
58634	ND	59013	MT	59638	MT	59841	MT
58711	ND	59014	MT	59641	MT	59842	MT
58716	ND	59016	MT	59642	MT	59843	MT
58721	ND	59018	MT	59643	MT	59844	MT
58723	ND	59019	MT	59644	MT	59845	MT
58727	ND	59020	MT	59645	MT	59848	MT
58730	ND	59022	MT	59647	MT	59853	MT
58737	ND	59025	MT	59710	MT	59854	MT
58740	ND	59026	MT	59713	MT	59855	MT
58747	ND	59027	MT	59720	MT	59856	MT
58748	ND	59028	MT	59721	MT	59858	MT
58750	ND	59029	MT	59722	MT	59859	MT
58752	ND	59030	MT	59724	MT	59860	MT
58757	ND	59031	MT	59725	MT	59863	MT
58758	ND	59033	MT	59728	MT	59864	MT
58759	ND	59034	MT	59729	MT	59865	MT
58760	ND	59035	MT	59731	MT	59866	MT
58761	ND	59041	MT	59732	MT	59867	MT
58762	ND	59046	MT	59733	MT	59870	MT
58763	ND	59047	MT	59735	MT	59871	MT
58765	ND	59050	MT	59736	MT	59872	MT
58769	ND	59052	MT	59739	MT	59873	MT
58770	ND	59053	MT	59740	MT	59874	MT
58771	ND	59054	MT	59745	MT	59875	MT
58772	ND	59055	MT	59746	MT	59910	MT
58773	ND	59059	MT	59747	MT	59914	MT
58775	ND	59061	MT	59749	MT	59915	MT
58776	ND	59063	MT	59751	MT	59917	MT
58778	ND	59065	MT	59754	MT	59918	MT
58782	ND	59066	MT	59755	MT	59923	MT
58783	ND	59067	MT	59759	MT	59929	MT
58784	ND	59068	MT	59761	MT	59930	MT
58787	ND	59069	MT	59762	MT	59931	MT
58793	ND	59070	MT	59820	MT	59933	MT
58794	ND	59071	MT	59821	MT	59934	MT
58831	ND	59072	MT	59824	MT	59935	MT

ADDENDUM K- MENTAL HEALTH HPSA ZIP CODES

2005 Mental Health HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
60111	IL	66840	KS	67438	KS	75114	TX
60112	IL	66842	KS	67443	KS	75118	TX
60115	IL	66851	KS	67456	KS	75126	TX
60129	IL	66858	KS	67460	KS	75142	TX
60135	IL	66859	KS	67464	KS	75143	TX
60145	IL	66861	KS	67475	KS	75147	TX
60146	IL	66866	KS	67476	KS	75157	TX
60150	IL	67002	KS	67483	KS	75158	TX
60178	IL	67004	KS	67491	KS	75160	TX
60520	IL	67005	KS	67546	KS	75161	TX
60548	IL	67008	KS	70340	LA	76055	TX
60550	IL	67010	KS	70342	LA	76363	TX
60552	IL	67012	KS	70380	LA	76364	TX
60556	IL	67013	KS	70381	LA	76371	TX
60619	IL	67017	KS	70392	LA	76373	TX
66042	KS	67019	KS	70510	LA	76380	TX
66067	KS	67022	KS	70511	LA	76384	TX
66076	KS	67023	KS	70514	LA	76385	TX
66078	KS	67031	KS	70522	LA	76436	TX
66079	KS	67038	KS	70528	LA	76457	TX
66080	KS	67039	KS	70533	LA	76531	TX
66092	KS	67042	KS	70538	LA	76565	TX
66095	KS	67051	KS	70540	LA	76621	TX
66711	KS	67053	KS	70542	LA	76622	TX
66712	KS	67063	KS	70548	LA	76627	TX
66713	KS	67072	KS	70555	LA	76628	TX
66724	KS	67073	KS	70575	LA	76631	TX
66725	KS	67074	KS	70634	LA	76636	TX
66728	KS	67102	KS	70637	LA	76645	TX
66734	KS	67103	KS	70638	LA	76648	TX
66735	KS	67105	KS	70640	LA	76650	TX
66739	KS	67106	KS	70644	LA	76660	TX
66741	KS	67107	KS	70648	LA	76666	TX
66743	KS	67119	KS	70651	LA	76673	TX
66746	KS	67120	KS	70652	LA	76676	TX
66753	KS	67123	KS	70653	LA	76692	TX
66756	KS	67131	KS	70654	LA	76821	TX
66760	KS	67132	KS	70655	LA	76837	TX
66762	KS	67133	KS	70657	LA	76841	TX
66763	KS	67140	KS	70658	LA	76848	TX
66770	KS	67144	KS	70660	LA	76855	TX
66773	KS	67146	KS	70662	LA	76859	TX
66778	KS	67152	KS	71357	LA	76861	TX
66780	KS	67154	KS	71366	LA	76862	TX
66781	KS	67156	KS	71375	LA	76865	TX
66782	KS	67428	KS	71463	LA	76866	TX

ADDENDUM K- MENTAL HEALTH HPSA ZIP CODES

2005 Mental Health HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
76875	TX	79373	TX	82301	WY	82944	WY
76930	TX	79381	TX	82310	WY	82945	WY
76932	TX	79383	TX	82321	WY	83001	WY
76933	TX	79505	TX	82322	WY	83002	WY
76937	TX	79511	TX	82323	WY	83011	WY
76941	TX	79516	TX	82324	WY	83012	WY
76945	TX	79517	TX	82325	WY	83013	WY
76949	TX	79526	TX	82327	WY	83014	WY
76953	TX	79527	TX	82329	WY	83025	WY
77422	TX	79529	TX	82331	WY	83101	WY
77430	TX	79549	TX	82332	WY	83110	WY
77431	TX	79550	TX	82334	WY	83111	WY
77463	TX	79566	TX	82335	WY	83112	WY
77480	TX	79567	TX	82336	WY	83113	WY
77486	TX	79720	TX	82501	WY	83114	WY
77511	TX	79721	TX	82510	WY	83115	WY
77512	TX	79733	TX	82512	WY	83116	WY
77515	TX	79748	TX	82513	WY	83118	WY
77516	TX	79902	TX	82514	WY	83119	WY
77531	TX	79903	TX	82515	WY	83120	WY
77534	TX	79904	TX	82516	WY	83121	WY
77541	TX	79906	TX	82520	WY	83122	WY
77542	TX	79908	TX	82523	WY	83123	WY
77566	TX	79911	TX	82524	WY	83124	WY
77577	TX	79912	TX	82638	WY	83126	WY
77578	TX	79913	TX	82642	WY	83127	WY
77581	TX	79914	TX	82649	WY	83128	WY
77583	TX	79918	TX	82901	WY	83414	WY
77584	TX	79920	TX	82902	WY	84003	UT
77588	TX	79923	TX	82922	WY	84004	UT
78801	TX	79924	TX	82923	WY	84013	UT
78802	TX	79925	TX	82925	WY	84017	UT
78838	TX	79928	TX	82929	WY	84022	UT
78870	TX	79930	TX	82930	WY	84024	UT
78881	TX	79931	TX	82931	WY	84029	UT
78884	TX	79935	TX	82932	WY	84032	UT
79201	TX	79936	TX	82933	WY	84033	UT
79223	TX	79937	TX	82934	WY	84034	UT
79225	TX	79961	TX	82935	WY	84036	UT
79227	TX	79966	TX	82936	WY	84042	UT
79236	TX	79968	TX	82937	WY	84043	UT
79247	TX	79973	TX	82938	WY	84049	UT
79248	TX	79974	TX	82939	WY	84055	UT
79252	TX	79976	TX	82941	WY	84057	UT
79259	TX	79977	TX	82942	WY	84058	UT
79351	TX	79996	TX	82943	WY	84059	UT

ADDENDUM K- MENTAL HEALTH HPSA ZIP CODES

2005 Mental Health HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
84060	UT	87022	NM	87528	NM	88033	NM
84061	UT	87023	NM	87529	NM	88044	NM
84062	UT	87024	NM	87530	NM	88046	NM
84068	UT	87025	NM	87531	NM	88047	NM
84069	UT	87026	NM	87532	NM	88048	NM
84071	UT	87027	NM	87533	NM	88052	NM
84074	UT	87029	NM	87537	NM	88054	NM
84080	UT	87031	NM	87539	NM	88058	NM
84082	UT	87032	NM	87543	NM	88063	NM
84083	UT	87034	NM	87548	NM	88072	NM
84097	UT	87035	NM	87549	NM	88081	NM
84098	UT	87036	NM	87551	NM	88321	NM
84510	UT	87038	NM	87553	NM	88510	TX
84511	UT	87040	NM	87554	NM	88511	TX
84512	UT	87041	NM	87556	NM	88512	TX
84530	UT	87042	NM	87557	NM	88513	TX
84531	UT	87044	NM	87558	NM	88514	TX
84533	UT	87049	NM	87564	NM	88515	TX
84534	UT	87051	NM	87566	NM	88516	TX
84535	UT	87060	NM	87571	NM	88517	TX
84536	UT	87061	NM	87575	NM	88518	TX
84601	UT	87063	NM	87576	NM	88519	TX
84602	UT	87064	NM	87577	NM	88520	TX
84603	UT	87068	NM	87578	NM	88521	TX
84604	UT	87070	NM	87579	NM	88523	TX
84605	UT	87072	NM	87580	NM	88524	TX
84606	UT	87083	NM	87581	NM	88525	TX
84626	UT	87315	NM	87582	NM	88526	TX
84633	UT	87357	NM	87936	NM	88527	TX
84651	UT	87510	NM	87937	NM	88528	TX
84653	UT	87511	NM	87940	NM	88529	TX
84655	UT	87512	NM	87941	NM	88530	TX
84660	UT	87513	NM	88001	NM	88531	TX
84663	UT	87514	NM	88002	NM	88532	TX
84664	UT	87515	NM	88003	NM	88533	TX
87002	NM	87516	NM	88004	NM	88534	TX
87005	NM	87517	NM	88005	NM	88535	TX
87006	NM	87518	NM	88006	NM	88536	TX
87007	NM	87519	NM	88007	NM	88538	TX
87009	NM	87520	NM	88008	NM	88539	TX
87012	NM	87521	NM	88011	NM	88540	TX
87014	NM	87522	NM	88012	NM	88541	TX
87016	NM	87523	NM	88021	NM	88542	TX
87017	NM	87524	NM	88024	NM	88543	TX
87020	NM	87525	NM	88027	NM	88544	TX
87021	NM	87527	NM	88032	NM	88545	TX

ADDENDUM K- MENTAL HEALTH HPSA ZIP CODES

2005 Mental Health HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
88546	TX	89013	NV	89446	NV	92258	CA
88547	TX	89017	NV	89447	NV	92259	CA
88548	TX	89020	NV	89496	NV	92260	CA
88549	TX	89022	NV	89801	NV	92261	CA
88550	TX	89023	NV	89802	NV	92262	CA
88553	TX	89041	NV	89803	NV	92263	CA
88554	TX	89042	NV	89815	NV	92264	CA
88555	TX	89043	NV	89820	NV	92266	CA
88556	TX	89045	NV	89821	NV	92270	CA
88557	TX	89047	NV	89822	NV	92273	CA
88558	TX	89048	NV	89823	NV	92276	CA
88559	TX	89049	NV	89824	NV	92281	CA
88560	TX	89060	NV	89825	NV	92283	CA
88561	TX	89061	NV	89826	NV	92292	CA
88562	TX	89135	NV	89828	NV	92305	CA
88563	TX	89148	NV	89830	NV	92385	CA
88565	TX	89301	NV	89831	NV	93202	CA
88566	TX	89310	NV	89832	NV	93203	CA
88567	TX	89311	NV	89833	NV	93204	CA
88568	TX	89314	NV	89834	NV	93205	CA
88569	TX	89315	NV	89835	NV	93206	CA
88570	TX	89316	NV	89883	NV	93207	CA
88571	TX	89317	NV	92201	CA	93208	CA
88572	TX	89318	NV	92202	CA	93212	CA
88573	TX	89319	NV	92203	CA	93215	CA
88574	TX	89403	NV	92210	CA	93216	CA
88575	TX	89404	NV	92211	CA	93218	CA
88576	TX	89406	NV	92222	CA	93220	CA
88577	TX	89407	NV	92227	CA	93221	CA
88578	TX	89408	NV	92230	CA	93223	CA
88579	TX	89409	NV	92231	CA	93226	CA
88580	TX	89414	NV	92232	CA	93230	CA
88581	TX	89415	NV	92233	CA	93232	CA
88582	TX	89418	NV	92234	CA	93235	CA
88583	TX	89419	NV	92235	CA	93237	CA
88584	TX	89420	NV	92236	CA	93238	CA
88585	TX	89421	NV	92240	CA	93239	CA
88586	TX	89422	NV	92241	CA	93240	CA
88587	TX	89425	NV	92243	CA	93241	CA
88588	TX	89426	NV	92244	CA	93244	CA
88589	TX	89427	NV	92249	CA	93245	CA
88590	TX	89429	NV	92250	CA	93246	CA
89001	NV	89430	NV	92251	CA	93247	CA
89003	NV	89438	NV	92253	CA	93250	CA
89008	NV	89444	NV	92255	CA	93255	CA
89010	NV	89445	NV	92257	CA	93256	CA

ADDENDUM K- MENTAL HEALTH HPSA ZIP CODES

2005 Mental Health HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
93257	CA	93516	CA	95334	CA	95988	CA
93258	CA	93517	CA	95340	CA	96009	CA
93260	CA	93518	CA	95341	CA	96010	CA
93262	CA	93519	CA	95344	CA	96014	CA
93263	CA	93528	CA	95348	CA	96021	CA
93265	CA	93529	CA	95351	CA	96023	CA
93266	CA	93531	CA	95353	CA	96024	CA
93267	CA	93541	CA	95354	CA	96025	CA
93270	CA	93546	CA	95355	CA	96027	CA
93271	CA	93554	CA	95357	CA	96029	CA
93272	CA	93561	CA	95365	CA	96031	CA
93276	CA	93581	CA	95368	CA	96032	CA
93280	CA	93596	CA	95369	CA	96034	CA
93282	CA	93601	CA	95374	CA	96035	CA
93283	CA	93604	CA	95376	CA	96037	CA
93285	CA	93608	CA	95378	CA	96038	CA
93286	CA	93610	CA	95382	CA	96039	CA
93287	CA	93614	CA	95385	CA	96041	CA
93292	CA	93615	CA	95386	CA	96044	CA
93301	CA	93620	CA	95388	CA	96046	CA
93302	CA	93627	CA	95422	CA	96048	CA
93303	CA	93635	CA	95423	CA	96050	CA
93304	CA	93637	CA	95424	CA	96052	CA
93305	CA	93638	CA	95426	CA	96055	CA
93306	CA	93639	CA	95435	CA	96056	CA
93307	CA	93643	CA	95443	CA	96057	CA
93308	CA	93644	CA	95451	CA	96058	CA
93309	CA	93645	CA	95453	CA	96059	CA
93311	CA	93653	CA	95457	CA	96061	CA
93312	CA	93661	CA	95458	CA	96063	CA
93313	CA	93665	CA	95461	CA	96064	CA
93314	CA	93668	CA	95464	CA	96067	CA
93380	CA	93669	CA	95485	CA	96068	CA
93383	CA	93670	CA	95493	CA	96074	CA
93384	CA	95301	CA	95527	CA	96075	CA
93385	CA	95303	CA	95552	CA	96078	CA
93386	CA	95307	CA	95560	CA	96080	CA
93387	CA	95312	CA	95563	CA	96085	CA
93388	CA	95315	CA	95568	CA	96086	CA
93389	CA	95317	CA	95595	CA	96090	CA
93390	CA	95319	CA	95913	CA	96091	CA
93501	CA	95322	CA	95920	CA	96092	CA
93502	CA	95324	CA	95939	CA	96093	CA
93504	CA	95326	CA	95943	CA	96094	CA
93505	CA	95328	CA	95951	CA	96097	CA
93512	CA	95333	CA	95963	CA	96107	CA

ADDENDUM K- MENTAL HEALTH HPSA ZIP CODES

2005 Mental Health HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
96109	CA	97366	OR	97525	OR	98552	WA
96113	CA	97367	OR	97526	OR	98554	WA
96114	CA	97368	OR	97527	OR	98557	WA
96117	CA	97369	OR	97528	OR	98559	WA
96119	CA	97372	OR	97530	OR	98561	WA
96121	CA	97376	OR	97531	OR	98562	WA
96123	CA	97380	OR	97532	OR	98563	WA
96127	CA	97388	OR	97533	OR	98566	WA
96128	CA	97390	OR	97534	OR	98568	WA
96130	CA	97391	OR	97535	OR	98569	WA
96132	CA	97394	OR	97536	OR	98571	WA
96133	CA	97410	OR	97537	OR	98575	WA
96134	CA	97416	OR	97538	OR	98577	WA
96136	CA	97417	OR	97539	OR	98583	WA
96747	HI	97429	OR	97540	OR	98586	WA
96757	HI	97432	OR	97541	OR	98587	WA
96760	HI	97435	OR	97543	OR	98590	WA
96771	HI	97436	OR	97544	OR	98595	WA
96858	HI	97441	OR	98068	WA	98602	WA
96940	PW	97442	OR	98305	WA	98605	WA
97102	OR	97443	OR	98320	WA	98612	WA
97103	OR	97447	OR	98324	WA	98613	WA
97107	OR	97457	OR	98325	WA	98614	WA
97108	OR	97462	OR	98326	WA	98617	WA
97110	OR	97467	OR	98331	WA	98619	WA
97112	OR	97469	OR	98339	WA	98620	WA
97118	OR	97470	OR	98343	WA	98621	WA
97121	OR	97473	OR	98350	WA	98623	WA
97122	OR	97479	OR	98357	WA	98624	WA
97130	OR	97481	OR	98358	WA	98628	WA
97131	OR	97484	OR	98362	WA	98631	WA
97134	OR	97486	OR	98363	WA	98635	WA
97135	OR	97494	OR	98365	WA	98637	WA
97136	OR	97495	OR	98368	WA	98638	WA
97138	OR	97496	OR	98376	WA	98640	WA
97141	OR	97497	OR	98381	WA	98641	WA
97143	OR	97498	OR	98382	WA	98643	WA
97145	OR	97499	OR	98520	WA	98644	WA
97146	OR	97501	OR	98526	WA	98647	WA
97147	OR	97502	OR	98527	WA	98650	WA
97149	OR	97503	OR	98535	WA	98670	WA
97341	OR	97504	OR	98536	WA	98672	WA
97343	OR	97520	OR	98537	WA	98673	WA
97357	OR	97522	OR	98541	WA	98812	WA
97364	OR	97523	OR	98547	WA	98814	WA
97365	OR	97524	OR	98550	WA	98819	WA

ADDENDUM K- MENTAL HEALTH HPSA ZIP CODES

2005 Mental Health HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
98823	WA	99117	WA	99371	WA	99622	AK
98824	WA	99118	WA	99546	AK	99625	AK
98827	WA	99119	WA	99547	AK	99626	AK
98829	WA	99121	WA	99548	AK	99627	AK
98832	WA	99122	WA	99549	AK	99628	AK
98833	WA	99123	WA	99551	AK	99629	AK
98834	WA	99124	WA	99552	AK	99630	AK
98837	WA	99126	WA	99553	AK	99632	AK
98840	WA	99129	WA	99554	AK	99633	AK
98841	WA	99131	WA	99555	AK	99634	AK
98844	WA	99133	WA	99557	AK	99636	AK
98846	WA	99134	WA	99558	AK	99637	AK
98848	WA	99135	WA	99559	AK	99638	AK
98849	WA	99137	WA	99561	AK	99640	AK
98851	WA	99138	WA	99563	AK	99641	AK
98853	WA	99139	WA	99564	AK	99645	AK
98855	WA	99140	WA	99565	AK	99647	AK
98856	WA	99141	WA	99566	AK	99648	AK
98857	WA	99144	WA	99569	AK	99649	AK
98859	WA	99146	WA	99571	AK	99650	AK
98860	WA	99147	WA	99573	AK	99651	AK
98862	WA	99148	WA	99574	AK	99652	AK
98922	WA	99150	WA	99575	AK	99653	AK
98925	WA	99151	WA	99576	AK	99654	AK
98926	WA	99152	WA	99578	AK	99655	AK
98934	WA	99153	WA	99579	AK	99656	AK
98940	WA	99154	WA	99580	AK	99657	AK
98941	WA	99155	WA	99581	AK	99658	AK
98943	WA	99156	WA	99583	AK	99660	AK
98946	WA	99157	WA	99584	AK	99661	AK
98950	WA	99159	WA	99585	AK	99662	AK
99008	WA	99160	WA	99586	AK	99665	AK
99013	WA	99166	WA	99588	AK	99666	AK
99029	WA	99167	WA	99589	AK	99667	AK
99032	WA	99169	WA	99590	AK	99668	AK
99034	WA	99173	WA	99591	AK	99670	AK
99040	WA	99180	WA	99602	AK	99674	AK
99101	WA	99181	WA	99604	AK	99675	AK
99103	WA	99185	WA	99606	AK	99676	AK
99105	WA	99321	WA	99607	AK	99677	AK
99107	WA	99322	WA	99609	AK	99678	AK
99109	WA	99341	WA	99612	AK	99679	AK
99110	WA	99344	WA	99613	AK	99680	AK
99114	WA	99349	WA	99614	AK	99681	AK
99115	WA	99356	WA	99620	AK	99683	AK
99116	WA	99357	WA	99621	AK	99685	AK

ADDENDUM K- MENTAL HEALTH HPSA ZIP CODES

2005 Mental Health HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
99686	AK	99748	AK	99919	AK		
99687	AK	99749	AK	99921	AK		
99688	AK	99750	AK	99922	AK		
99689	AK	99751	AK	99923	AK		
99690	AK	99752	AK	99925	AK		
99691	AK	99754	AK	99926	AK		
99692	AK	99755	AK	99927	AK		
99693	AK	99756	AK	99928	AK		
99694	AK	99757	AK	99929	AK		
99701	AK	99758	AK				
99702	AK	99759	AK				
99703	AK	99760	AK				
99704	AK	99761	AK				
99705	AK	99763	AK				
99706	AK	99764	AK				
99707	AK	99765	AK				
99708	AK	99766	AK				
99709	AK	99767	AK				
99710	AK	99768	AK				
99711	AK	99770	AK				
99712	AK	99773	AK				
99714	AK	99774	AK				
99716	AK	99775	AK				
99720	AK	99776	AK				
99721	AK	99777	AK				
99722	AK	99779	AK				
99723	AK	99780	AK				
99724	AK	99781	AK				
99725	AK	99782	AK				
99726	AK	99786	AK				
99727	AK	99788	AK				
99729	AK	99789	AK				
99730	AK	99791	AK				
99732	AK	99820	AK				
99733	AK	99825	AK				
99734	AK	99826	AK				
99736	AK	99827	AK				
99737	AK	99829	AK				
99738	AK	99830	AK				
99740	AK	99832	AK				
99741	AK	99833	AK				
99743	AK	99840	AK				
99744	AK	99841	AK				
99745	AK	99901	AK				
99746	AK	99903	AK				
99747	AK	99918	AK				

ADDENUM L

LIST OF CPT[1]/HCPCS CODES USED TO DESCRIBE CERTAIN DESIGNATED HEALTH SERVICE CATEGORIES[2] UNDER SECTION 1877 OF THE SOCIAL SECURITY ACT—Effective January 1, 2005

CLINICAL LABORATORY SERVICES

INCLUDE CPT codes for all clinical laboratory services in the 80000 series, except EXCLUDE CPT codes for the following blood component collection services:

86890	Autologous blood process
86891	Autologous blood, op salvage
86927	Plasma, fresh frozen
86930	Frozen blood prep
86931	Frozen blood thaw
86932	Frozen blood freeze/thaw
86945	Blood product/irradiation
86950	Leukacyte transfusion
86965	Pooling blood platelets
86985	Split blood or products

INCLUDE the following CPT and HCPCS level 2 codes for other clinical laboratory services:

0010T	TB test, gamma interferon
0023T	Phenotype drug test, hiv 1
0026T	Measure remnant lipoproteins
0030T	Antiprothrombin antibody

1CPT codes and descriptions only are copyright 2004 American Medical Association. All rights are reserved and applicable FARS/DFARS clauses apply.

[2] This list does not include codes for the following designated health service categories: durable medical equipment and supplies; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services. For the full definition of designated health services, refer to 42 CFR 411.351. For more information, refer to http://cms.hhs.gov/medlearn/refphys.asp.

0041T	Detect ur infect agnt w/cpas
0043T	Co expired gas analysis
0058T	Cryopreservation, ovary tiss
0059T	Cryopreservation, oocyte
0064T	Spectroscop eval expired gas
0085T	Breath test heart reject
0087T	Sperm eval hyaluronan
36415	Routine venipuncture
G0027	Semen analysis
G0103	Psa, total screening
G0107	CA screen; fecal blood test
G0123	Screen cerv/vag thin layer
G0124	Screen c/v thin layer by MD
G0141	Scr c/v cyto,autosys and md
G0143	Scr c/v cyto,thinlayer,rescr
G0144	Scr c/v cyto,thinlayer,rescr
G0145	Scr c/v cyto,thinlayer,rescr
G0147	Scr c/v cyto, automated sys
G0148	Scr c/v cyto, autosys, rescr
G0306	CBC/diffwbc w/o platelet
G0307	CBC without platelet
G0328	Fecal blood scrn immunoassay
P2028	Cephalin floculation test
P2029	Congo red blood test
P2033	Blood thymol turbidity
P2038	Blood mucoprotein
P3000	Screen pap by tech w md supv
P3001	Screening pap smear by phys
P9612	Catheterize for urine spec
P9615	Urine specimen collect mult
Q0111	Wet mounts/ w preparations
Q0112	Potassium hydroxide preps
Q0113	Pinworm examinations
Q0114	Fern test
Q0115	Post-coital mucous exam

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH-LANGUAGE PATHOLOGY

INCLUDE the following CPT codes for the physical therapy/occupational therapy/speech-language pathology services in the 97000 series:

97001	Pt evaluation

97002	Pt re-evaluation
97003	Ot evaluation
97004	Ot re-evaluation
97010	Hot or cold packs therapy
97012	Mechanical traction therapy
97016	Vasopneumatic device therapy
97018	Paraffin bath therapy
97020	Microwave therapy
97022	Whirlpool therapy
97024	Diathermy treatment
97026	Infrared therapy
97028	Ultraviolet therapy
97032	Electrical stimulation
97033	Electric current therapy
97034	Contrast bath therapy
97035	Ultrasound therapy
97036	Hydrotherapy
97039	Physical therapy treatment
97110	Therapeutic exercises
97112	Neuromuscular reeducation
97113	Aquatic therapy/exercises
97116	Gait training therapy
97124	Massage therapy
97139	Physical medicine procedure
97140	Manual therapy
97150	Group therapeutic procedures
97504	Orthotic training
97520	Prosthetic training
97530	Therapeutic activities
97532	Cognitive skills development
97533	Sensory integration
97535	Self care mngment training
97537	Community/work reintegration
97542	Wheelchair mngment training
97545	Work hardening
97546	Work hardening add-on
97597	Active wound care/20cm or <
97598	Active wound care > 20cm
97602	Wound(s) care nonselective
97605	Neg press wound tx, < 50 cm
97606	Neg press wound tx, > 50 cm
97703	Prosthetic checkout
97750	Physical performance test
97755	Assistive technology assess
97799	Physical medicine procedure

INCLUDE CPT codes for physical therapy/occupational therapy/speech-language pathology services not in the 97000 series:

64550	Apply neurostimulator
90901	Biofeedback train, any meth
90911	Biofeedback peri/uro/rectal
92507	Speech/hearing therapy
92508	Speech/hearing therapy
92526	Oral function therapy
92597	Oral speech device eval
92607	Ex for speech device rx, 1hr
92608	Ex for speech device rx addl
92609	Use of speech device service
92610	Evaluate swallowing function
92611	Motion fluoroscopy/swallow
92612	Endoscopy swallow tst (fees)
92614	Laryngoscopic sensory test
92616	Fees w/laryngeal sense test
93797	Cardiac rehab
93798	Cardiac rehab/monitor
94667	Chest wall manipulation
94668	Chest wall manipulation
95831	Limb muscle testing, manual
95832	Hand muscle testing, manual
95833	Body muscle testing, manual
95834	Body muscle testing, manual
95851	Range of motion measurements
95852	Range of motion measurements
96000	Motion analysis, video/3d
96001	Motion test w/ft press meas
96002	Dynamic surface emg
96003	Dynamic fine wire emg
96105	Assessment of aphasia
96110	Developmental test, lim
96111	Developmental test, extend
96115	Neurobehavior status exam
0029T	Magnetic tx for incontinence

INCLUDE HCPCS level 2 codes for the following physical therapy/occupational therapy/speech-language pathology services:

G0279	Excorp shock tx, elbow epi

G0280	Excorp shock tx other than
G0281	Elec stim unattend for press
G0283	Elec stim other than wound
G0329	Electromagntic tx for ulcers

RADIOLOGY AND CERTAIN OTHER IMAGING SERVICES

INCLUDE the following codes in the CPT 70000 series:

70100	X-ray exam of jaw
70110	X-ray exam of jaw
70120	X-ray exam of mastoids
70130	X-ray exam of mastoids
70134	X-ray exam of middle ear
70140	X-ray exam of facial bones
70150	X-ray exam of facial bones
70160	X-ray exam of nasal bones
70190	X-ray exam of eye sockets
70200	X-ray exam of eye sockets
70210	X-ray exam of sinuses
70220	X-ray exam of sinuses
70240	X-ray exam, pituitary saddle
70250	X-ray exam of skull
70260	X-ray exam of skull
70300	X-ray exam of teeth
70310	X-ray exam of teeth
70320	Full mouth x-ray of teeth
70328	X-ray exam of jaw joint
70330	X-ray exam of jaw joints
70336	Magnetic image, jaw joint
70350	X-ray head for orthodontia
70355	Panoramic x-ray of jaws
70360	X-ray exam of neck
70370	Throat x-ray & fluoroscopy
70371	Speech evaluation, complex
70380	X-ray exam of salivary gland
70450	Ct head/brain w/o dye
70460	Ct head/brain w/dye
70470	Ct head/brain w/o & w/dye
70480	Ct orbit/ear/fossa w/o dye
70481	Ct orbit/ear/fossa w/dye
70482	Ct orbit/ear/fossa w/o&w/dye
70486	Ct maxillofacial w/o dye
70487	Ct maxillofacial w/dye

70488	Ct maxillofacial w/o & w/dye
70490	Ct soft tissue neck w/o dye
70491	Ct soft tissue neck w/dye
70492	Ct sft tsue nck w/o & w/dye
70496	Ct angiography, head
70498	Ct angiography, neck
70540	Mri orbit/face/neck w/o dye
70542	Mri orbit/face/neck w/dye
70543	Mri orbt/fac/nck w/o & w/dye
70544	Mr angiography head w/o dye
70545	Mr angiography head w/dye
70546	Mr angiograph head w/o&w/dye
70547	Mr angiography neck w/o dye
70548	Mr angiography neck w/dye
70549	Mr angiograph neck w/o&w/dye
70551	Mri brain w/o dye
70552	Mri brain w/dye
70553	Mri brain w/o & w/dye
71010	Chest x-ray
71015	Chest x-ray
71020	Chest x-ray
71021	Chest x-ray
71022	Chest x-ray
71023	Chest x-ray and fluoroscopy
71030	Chest x-ray
71034	Chest x-ray and fluoroscopy
71035	Chest x-ray
71100	X-ray exam of ribs
71101	X-ray exam of ribs/chest
71110	X-ray exam of ribs
71111	X-ray exam of ribs/chest
71120	X-ray exam of breastbone
71130	X-ray exam of breastbone
71250	Ct thorax w/o dye
71260	Ct thorax w/dye
71270	Ct thorax w/o & w/dye
71275	Ct angiography, chest
71550	Mri chest w/o dye
71551	Mri chest w/dye
71552	Mri chest w/o & w/dye
71555	Mri angio chest w or w/o dye
72010	X-ray exam of spine
72020	X-ray exam of spine
72040	X-ray exam of neck spine
72050	X-ray exam of neck spine

72052	X-ray exam of neck spine
72069	X-ray exam of trunk spine
72070	X-ray exam of thoracic spine
72072	X-ray exam of thoracic spine
72074	X-ray exam of thoracic spine
72080	X-ray exam of trunk spine
72090	X-ray exam of trunk spine
72100	X-ray exam of lower spine
72110	X-ray exam of lower spine
72114	X-ray exam of lower spine
72120	X-ray exam of lower spine
72125	Ct neck spine w/o dye
72126	Ct neck spine w/dye
72127	Ct neck spine w/o & w/dye
72128	Ct chest spine w/o dye
72129	Ct chest spine w/dye
72130	Ct chest spine w/o & w/dye
72131	Ct lumbar spine w/o dye
72132	Ct lumbar spine w/dye
72133	Ct lumbar spine w/o & w/dye
72141	Mri neck spine w/o dye
72142	Mri neck spine w/dye
72146	Mri chest spine w/o dye
72147	Mri chest spine w/dye
72148	Mri lumbar spine w/o dye
72149	Mri lumbar spine w/dye
72156	Mri neck spine w/o & w/dye
72157	Mri chest spine w/o & w/dye
72158	Mri lumbar spine w/o & w/dye
72170	X-ray exam of pelvis
72190	X-ray exam of pelvis
72191	Ct angiograph pelv w/o&w/dye
72192	Ct pelvis w/o dye
72193	Ct pelvis w/dye
72194	Ct pelvis w/o & w/dye
72195	Mri pelvis w/o dye
72196	Mri pelvis w/dye
72197	Mri pelvis w/o & w/dye
72198	Mr angio pelvis w/o & w/dye
72200	X-ray exam sacroiliac joints
72202	X-ray exam sacroiliac joints
72220	X-ray exam of tailbone
73000	X-ray exam of collar bone
73010	X-ray exam of shoulder blade
73020	X-ray exam of shoulder

73030	X-ray exam of shoulder
73050	X-ray exam of shoulders
73060	X-ray exam of humerus
73070	X-ray exam of elbow
73080	X-ray exam of elbow
73090	X-ray exam of forearm
73092	X-ray exam of arm, infant
73100	X-ray exam of wrist
73110	X-ray exam of wrist
73120	X-ray exam of hand
73130	X-ray exam of hand
73140	X-ray exam of finger(s)
73200	Ct upper extremity w/o dye
73201	Ct upper extremity w/dye
73202	Ct uppr extremity w/o&w/dye
73206	Ct angio upr extrm w/o&w/dye
73218	Mri upper extremity w/o dye
73219	Mri upper extremity w/dye
73220	Mri uppr extremity w/o&w/dye
73221	Mri joint upr extrem w/o dye
73222	Mri joint upr extrem w/dye
73223	Mri joint upr extr w/o&w/dye
73500	X-ray exam of hip
73510	X-ray exam of hip
73520	X-ray exam of hips
73540	X-ray exam of pelvis & hips
73550	X-ray exam of thigh
73560	X-ray exam of knee, 1 or 2
73562	X-ray exam of knee, 3
73564	X-ray exam, knee, 4 or more
73565	X-ray exam of knees
73590	X-ray exam of lower leg
73592	X-ray exam of leg, infant
73600	X-ray exam of ankle
73610	X-ray exam of ankle
73620	X-ray exam of foot
73630	X-ray exam of foot
73650	X-ray exam of heel
73660	X-ray exam of toe(s)
73700	Ct lower extremity w/o dye
73701	Ct lower extremity w/dye
73702	Ct lwr extremity w/o&w/dye
73706	Ct angio lwr extr w/o&w/dye
73718	Mri lower extremity w/o dye
73719	Mri lower extremity w/dye

73720	Mri lwr extremity w/o&w/dye
73721	Mri jnt of lwr extre w/o dye
73722	Mri joint of lwr extr w/dye
73723	Mri joint lwr extr w/o&w/dye
73725	Mr ang lwr ext w or w/o dye
74000	X-ray exam of abdomen
74010	X-ray exam of abdomen
74020	X-ray exam of abdomen
74022	X-ray exam series, abdomen
74150	Ct abdomen w/o dye
74160	Ct abdomen w/dye
74170	Ct abdomen w/o &w/dye
74175	Ct angio abdom w/o & w/dye
74181	Mri abdomen w/o dye
74182	Mri abdomen w/dye
74183	Mri abdomen w/o & w/dye
74185	Mri angio, abdom w orw/o dye
74210	Contrst x-ray exam of throat
74220	Contrast x-ray, esophagus
74230	Cine/vid x-ray, throat/esoph
74240	X-ray exam, upper gi tract
74241	X-ray exam, upper gi tract
74245	X-ray exam, upper gi tract
74246	Contrst x-ray uppr gi tract
74247	Contrst x-ray uppr gi tract
74249	Contrst x-ray uppr gi tract
74250	X-ray exam of small bowel
74290	Contrast x-ray, gallbladder
74291	Contrast x-rays, gallbladder
74710	X-ray measurement of pelvis
75552	Heart mri for morph w/o dye
75553	Heart mri for morph w/dye
75554	Cardiac MRI/function
75555	Cardiac MRI/limited study
75635	Ct angio abdominal arteries
76000	Fluoroscope examination
76006	X-ray stress view
76010	X-ray, nose to rectum
76020	X-rays for bone age
76040	X-rays, bone evaluation
76061	X-rays, bone survey
76062	X-rays, bone survey
76065	X-rays, bone evaluation
76066	Joint survey, single view
76070	Ct bone density, axial

76071	Ct bone density, peripheral
76075	Dxa bone density, axial
76076	Dxa bone density/peripheral
76077	Dxa bone density/v-fracture
76078	Radiographic absorptiometry
76082	Computer mammogram add-on
76083	Computer mammogram add-on
76090	Mammogram, one breast
76091	Mammogram, both breasts
76092	Mammogram, screening
76093	Magnetic image, breast
76094	Magnetic image, both breasts
76100	X-ray exam of body section
76101	Complex body section x-ray
76102	Complex body section x-rays
76120	Cine/video x-rays
76125	Cine/video x-rays add-on
76150	X-ray exam, dry process
76370	Ct scan for therapy guide
76375	3d/holograph reconstr add-on
76380	CAT scan follow-up study
76400	Magnetic image, bone marrow
76499	Radiographic procedure
76506	Echo exam of head
76510	Ophth us, b & quant a
76511	Ophth us, quant a only
76512	Ophth us, b w/non-quant a
76513	Echo exam of eye, water bath
76514	Echo exam of eye, thickness
76516	Echo exam of eye
76519	Echo exam of eye
76536	Us exam of head and neck
76604	Us exam, chest, b-scan
76645	Us exam, breast(s)
76700	Us exam, abdom, complete
76705	Echo exam of abdomen
76770	Us exam abdo back wall, comp
76775	Us exam abdo back wall, lim
76778	Us exam kidney transplant
76800	Us exam, spinal canal
76801	Ob us < 14 wks, single fetus
76802	Ob us < 14 wks, add'l fetus
76805	Ob us >/= 14 wks, sngl fetus
76810	Ob us >/= 14 wks, addl fetus
76811	Ob us, detailed, sngl fetus

76812	Ob us, detailed, addl fetus
76815	Ob us, limited, fetus(s)
76816	Ob us, follow-up, per fetus
76818	Fetal biophys profile w/nst
76819	Fetal biophys profil w/o nst
76820	Umbilical artery echo
76821	Middle cerebral artery echo
76825	Echo exam of fetal heart
76826	Echo exam of fetal heart
76827	Echo exam of fetal heart
76828	Echo exam of fetal heart
76856	Us exam, pelvic, complete
76857	Us exam, pelvic, limited
76870	Us exam, scrotum
76880	Us exam, extremity
76885	Us exam infant hips, dynamic
76886	Us exam infant hips, static
76970	Ultrasound exam follow-up
76977	Us bone density measure
76999	Echo examination procedure

INCLUDE the following CPT codes for echocardiography and vascular ultrasound:

93303	Echo transthoracic
93304	Echo transthoracic
93307	Echo exam of heart
93308	Echo exam of heart
93320	Doppler echo exam, heart [if used in conjunction with 93303-93308]
93321	Doppler echo exam, heart [if used in conjunction with 93303-93308]
93325	Doppler color flow add-on [if used in conjunction with 93303-93308]
93875	Extracranial study
93880	Extracranial study
93882	Extracranial study
93886	Intracranial study
93888	Intracranial study
93890	Tcd, vasoreactivity study
93892	Tcd, emboli detect w/o inj
93922	Extremity study
93923	Extremity study
93924	Extremity study
93925	Lower extremity study

93926	Lower extremity study
93930	Upper extremity study
93931	Upper extremity study
93965	Extremity study
93970	Extremity study
93971	Extremity study
93975	Vascular study
93976	Vascular study
93978	Vascular study
93979	Vascular study
93980	Penile vascular study
93981	Penile vascular study
93990	Doppler flow testing

INCLUDE the following CPT and HCPCS level 2 codes:

51798	Us urine capacity measure
78350	Bone mineral, single photon
91110	Gi tract capsule endoscopy
0028T	Dexa body composition study
0042T	Ct perfusion w/contrast, cbf
0067T	Ct colonography;dx
G0130	Single energy x-ray study
G0202	Screeningmammographydigital
G0204	Diagnosticmammographydigital
G0206	Diagnosticmammographydigital
G0288	Recon, CTA for surg plan
Q0092	Set up port xray equipment
R0070	Transport portable x-ray
R0075	Transport port x-ray multipl

RADIATION THERAPY SERVICES AND SUPPLIES

INCLUDE the following codes in the CPT 70000 series:

77261	Radiation therapy planning
77262	Radiation therapy planning
77263	Radiation therapy planning
77280	Set radiation therapy field
77285	Set radiation therapy field
77290	Set radiation therapy field
77295	Set radiation therapy field
77299	Radiation therapy planning
77300	Radiation therapy dose plan
77301	Radiotherapy dose plan, imrt
77305	Teletx isodose plan simple

77310	Teletx isodose plan intermed
77315	Teletx isodose plan complex
77321	Special teletx port plan
77326	Brachytx isodose calc simp
77327	Brachytx isodose calc interm
77328	Brachytx isodose plan compl
77331	Special radiation dosimetry
77332	Radiation treatment aid(s)
77333	Radiation treatment aid(s)
77334	Radiation treatment aid(s)
77336	Radiation physics consult
77370	Radiation physics consult
77399	External radiation dosimetry
77401	Radiation treatment delivery
77402	Radiation treatment delivery
77403	Radiation treatment delivery
77404	Radiation treatment delivery
77406	Radiation treatment delivery
77407	Radiation treatment delivery
77408	Radiation treatment delivery
77409	Radiation treatment delivery
77411	Radiation treatment delivery
77412	Radiation treatment delivery
77413	Radiation treatment delivery
77414	Radiation treatment delivery
77416	Radiation treatment delivery
77417	Radiology port film(s)
77418	Radiation tx delivery, imrt
77427	Radiation tx management, x5
77431	Radiation therapy management
77432	Stereotactic radiation trmt
77470	Special radiation treatment
77499	Radiation therapy management
77520	Proton trmt, simple w/o comp
77522	Proton trmt, simple w/comp
77523	Proton trmt, intermediate
77525	Proton treatment, complex
77600	Hyperthermia treatment
77605	Hyperthermia treatment
77610	Hyperthermia treatment
77615	Hyperthermia treatment
77620	Hyperthermia treatment
77750	Infuse radioactive materials
77761	Apply intrcav radiat simple
77762	Apply intrcav radiat interm

77763	Apply intrcav radiat compl
77776	Apply interstit radiat simpl
77777	Apply interstit radiat inter
77778	Apply interstit radiat compl
77781	High intensity brachytherapy
77782	High intensity brachytherapy
77783	High intensity brachytherapy
77784	High intensity brachytherapy
77789	Apply surface radiation
77790	Radiation handling
77799	Radium/radioisotope therapy

INCLUDE the following CPT and HCPCS level 2 codes classified elsewhere:

19296	Place po breast cath for rad
19297	Place breast cath for rad
19298	Place breast rad tube/caths
31643	Diag bronchoscope/catheter
55859	Percut/needle insert, pros
57155	Insert uteri tandems/ovoids
58346	Insert heyman uteri capsule
61770	Incise skull for treatment
61793	Focus radiation beam
92974	Cath place, cardio brachytx
0073T	Delivery, comp imrt
0082T	Stereotactic rad delivery
0083T	Stereotactic rad tx mngmt
G0173	Stereo radiosurgery,complete
G0242	Multisource photon ster plan
G0243	Multisour photon stero treat
G0251	Linear acc based stero radio
G0338	Linear accelerator stero pln
G0339	Robot lin-radsurg com, first
G0340	Robt lin-radsurg fractx 2-5

EPO AND OTHER DIALYSIS-RELATED DRUGS

The physician self-referral prohibition does not apply to the following codes for EPO and other dialysis-related drugs furnished in or by an ESRD facility if the conditions in §411.355(g) are satisfied:

J0630	Calcitonin salmon injection
J0636	Inj calcitriol per 0.1 mcg

J0895	Deferoxamine mesylate inj
J1270	Injection, doxercalciferol
J1750	Iron dextran
J1756	Iron sucrose injection
J1955	Inj levocarnitine per 1 gm
J2501	Paricalcitol
J2916	Na ferric gluconate complex
J2993	Reteplase injection
J2995	Inj streptokinase /250000 IU
J2997	Alteplase recombinant
J3364	Urokinase 5000 IU injection
P9041	Albumin (human),5%, 50ml
P9045	Albumin (human), 5%, 250ml
P9046	Albumin (human), 25%, 20ml
P9047	Albumin (human), 25%, 50ml
Q4054	Darbepoetin alfa, esrd use
Q4055	Epoetin alfa, esrd use

PREVENTIVE SCREENING TESTS, IMMUNIZATIONS AND VACCINES

The physician self-referral prohibition does not apply to the following tests if they are performed for screening purposes and satisfy the conditions in §411.355(h):

76083	Computer mammogram add-on
76092	Mammogram, screening
80061	Lipid panel [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V.81.2]
82465	Assay, bld/serum cholesterol [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V.81.2]
82947	Assay, glucose, blood quant [only when billed with ICD-9-CM code V77.1]
82950	Glucose test [only when billed with ICD-9-CM code V77.1]
82951	Glucose tolerance test (GTT) [only when billed with ICD-9-CM code V77.1]
83718	Assay of lipoprotein [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V.81.2]
84478	Assay of triglycerides [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V.81.2]
G0103	Psa, total screening

G0107	CA screen; fecal blood test
G0123	Screen cerv/vag thin layer
G0124	Screen c/v thin layer by MD
G0141	Scr c/v cyto,autosys and md
G0143	Scr c/v cyto,thinlayer,rescr
G0144	Scr c/v cyto,thinlayer,rescr
G0145	Scr c/v cyto,thinlayer,rescr
G0147	Scr c/v cyto, automated sys
G0148	Scr c/v cyto, autosys, rescr
G0202	Screening mammographydigital
G0328	Fecal blood scrn immunoassay
P3000	Screen pap by tech w md supv
P3001	Screening pap smear by phys

The physician self-referral prohibition does not apply to the following immunization and vaccine codes if they satisfy the conditions in §411.355(h):

90655	Flu vaccine no preserv 6-35m
90656	Flu vaccine no preserv 3 & >
90657	Flu vaccine, 3 yrs, im
90658	Flu vaccine, 3 yrs & >, im
90732	Pneumococcal vaccine
90740	Hepb vacc, ill pat 3 dose im
90743	Hep b vacc, adol, 2 dose im
90744	Hepb vacc ped/adol 3 dose im
90746	Hep b vaccine, adult, im
90747	Hepb vacc, ill pat 4 dose im

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Part IV

Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicare Program; Coverage and Payment of Ambulance Services; Recalibration of Conversion Factor; Inflation Update for CY 2005; Notice

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1267–N]

RIN 0938–AN20

Medicare Program; Coverage and Payment of Ambulance Services; Recalibration of Conversion Factor; Inflation Update for CY 2005

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice.

SUMMARY: This notice sets forth: (1) A discussion of the annual review of the conversion factor (CF) used to calculate the Medicare program ambulance fee schedule; and (2) the annual ambulance inflation factor for ambulance services for calendar year 2005.

EFFECTIVE DATE: The revised CF is effective for services furnished on or after January 1, 2005.

FOR FURTHER INFORMATION CONTACT: Anne E. Tayloe, (410) 786–4546.

SUPPLEMENTARY INFORMATION:

I. Background

A. Legislative and Regulatory History

The Secretary will annually review the conversion factor (CF) and will adjust the CF if actual experience under the fee schedule is significantly different from the assumptions used to determine the initial CF, as stated in § 414.610(g). Additionally, the ambulance inflation factor (AIF) must be adjusted annually, as stated in section 1834(l)(3)(B) of the Social Security Act (the Act) and in § 414.610(f).

Under section 1861(s)(7) of the Act, Medicare Part B (Supplementary Medical Insurance) covers and pays for ambulance services, to the extent prescribed in regulations at 42 CFR parts 410 and 414, when the use of other methods of transportation would be contraindicated for the beneficiary. The House Ways and Means Committee and Senate Finance Committee Reports that accompanied the 1965 legislation creating the Act suggest that the Congress intended that: (1) The ambulance benefit cover transportation services only if other means of transportation are contraindicated by the beneficiary's medical condition; and (2) only ambulance service to local facilities be covered unless necessary services are not available locally, in which case, transportation to the nearest facility furnishing those services is covered (H.R. Rep. No. 213, 89th Cong., 1st Sess. 37 and S. Rep. No. 404, 89th Cong., 1st Sess., Pt I, 43 (1965)). The reports indicate that transportation may also be provided from one hospital to another, to the beneficiary's home, or to an extended care facility.

Our regulations relating to ambulance services are located at 42 CFR part 410, subpart B, and 42 CFR part 414, subpart H. Section 410.10(i) lists ambulance services as one of the covered medical and other health services under Medicare Part B. Ambulance services are subject to basic conditions and limitations set forth at § 410.12 and to specific conditions and limitations included at § 410.40. Part 414, subpart H describes how payment is made for ambulance services covered by Medicare.

Ambulance services (air and ground) are divided into different levels of services based on the medically necessary treatment provided during transport. These services include the levels of service as follows:

For Ground:

- Basic Life Support (BLS)
- Advanced Life Support, Level 1 (ALS1)
- Advanced Life Support, Level 2 (ALS2)
- Specialty Care Transport (SCT)
- Paramedic ALS Intercept (PI)

For Air:

- Fixed Wing Air Ambulance (FW)
- Rotary Wing Air Ambulance (RW)

Historically, payment levels for ambulance services depended, in part, upon the entity that furnished the services. Prior to implementation of the ambulance fee schedule on April 1, 2002, providers (hospitals, including critical access hospitals, skilled nursing facilities, and home health agencies) were paid on a retrospective reasonable cost basis. Suppliers, which are entities that are independent of any provider, were paid on a reasonable charge basis.

The Balanced Budget Act of 1997 (BBA) (establishing section 1834(l) of the Act) mandated the development of an ambulance fee schedule (AFS) through negotiated rulemaking. On February 27, 2002, we published a final rule in the **Federal Register** (Fee Schedule for Payment of Ambulance Services and Revisions to the Physician Certification Requirements for Coverage of Nonemergency Ambulance Services, 67 FR 9100) that established a fee schedule for the payment of ambulance services under the Medicare program, effective for services furnished on or after April 1, 2002. The fee schedule replaced the retrospective reasonable cost payment system for providers and the reasonable charge system for suppliers of ambulance services. Additionally, the final rule: (1) Implemented a statutory requirement that ambulance suppliers accept Medicare assignment; (2) codified the establishment of new HealthCare Common Procedure Coding System (HCPCS) codes to be reported on claims for ambulance services; (3) established increased payment under the fee schedule for ambulance services furnished in rural areas based on the location of the beneficiary at the time the beneficiary is placed on board the ambulance; (4) revised the certification requirements for coverage of non-emergency ambulance services; and (5) provided for a 5-year transition period during which program payment for Medicare covered ambulance services would be based upon a blended rate comprised of a fee schedule portion and a reasonable cost (providers) or reasonable charge (suppliers) portion. We are now in the third year of that transition over to full payment based solely on the fee schedule amount.

B. Ambulance CF Review

The February 27, 2002 final rule also provided that we would annually review rates and adjust the CF and air ambulance rates if actual experience under the fee schedule is significantly different from the assumptions used to determine the initial CF and air ambulance rates. The CF and air ambulance rates would not be adjusted solely because of changes in the total number of ambulance transports (§ 414.610(g)). This notice describes the claims data for the first 9 months of the AFS (April 1, 2002 through December 31, 2002) and explains the calculations used to determine whether the existing CF has resulted in a significant discrepancy between assumptions and actual experience under the AFS. These 2002 claims data were used because they were the most recent complete period of claims data under the AFS that were available for this analysis.

C. Ambulance Inflation Factor for CY 2005

Section 1834(l)(3)(B) of the Act (implemented by regulation at § 414.610(f)) provides the basis for updating payment amounts for ambulance services. This provision requires that the AFS be updated by the AIF annually, based on the percentage increase in the consumer price index (CPI) for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year (§ 414.610(f)).

II. Data and Methodology for Recalibration

As stated in section I.B. of this notice, we used claims data from the period April 1, 2002 through December 31, 2002 because this was the latest complete period for which we had claims data during which the AFS was in effect. We used a similar methodology to set the original CF as described in the February 27, 2002 final rule. We counted the number of trips at each level and determined the percentage of utilization of each to the total number of trips, then we compared these percentages to the same percentages from the original data used to set the CF. This method provided a means to evaluate the accuracy of the assumptions that were used to set the original CF. We also examined the degree to which ambulance billers' charges were less than the AFS amounts. This gave the actual amount of ''low billing.'' We then determined the conversion factor for ground services based on the actual claims data and compared that amount to the CF that has been in use based on the assumptions. The resulting CF was only eight-tenths of 1 percent (0.8 percent) lower than the CF that was in use. We then performed a similar analysis using the 9-month 2002 claims data to evaluate the payment rates for air ambulance services. This resulted in payment rates that were 2.8 percent lower than the rates currently in use. We have determined that this is not a significant difference. Therefore, in accordance with § 414.610(g), we have determined that no adjustment to the existing payment rate structure is warranted.

The February 27, 2002 final rule also stated that we would review the basis for the bonus amounts paid for ambulance transports that originate in a rural area. Given that the Congress, through enactment of section 414 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, has provided for significant additional spending for these services, we have determined that no further adjustment in the payment amounts for these rural ambulance services is warranted.

III. Provisions of the Notice

A. AFS CF Update

In accordance with § 414.610(g), we have reviewed actual claims data and determined that actual experience under the AFS is not significantly different than the assumptions used to set the CF. Therefore, we are not revising the existing CF as a consequence of actual experience.

B. AIF for 2005

Section 1834(l)(3)(B) of the Act, as specified in § 414.610(f), provides for an update in payments for CY 2005 that is equal to the percentage increase in the CPI for all urban consumers (CPI–U) for the 12-month period ending with June of the previous year (that is, June 2004). We will use the actual percentage increase and not an estimate or projection. The AIF for 2005 is 3.3 percent.

During the transition period (see § 414.615), the AIF is applied to both the fee schedule portion of the blended payment amount and to the reasonable charge or cost portion of the blended payment amount separately for each ambulance provider or supplier. Then, these two amounts are added together to determine the total payment amount for each provider or supplier.

IV. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide a period of public comment before the provisions of a notice such as this take effect. We can waive this procedure, however, if we find good cause that a notice and comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporate a statement of finding and its reasons in the notice issued.

We find it unnecessary to undertake notice and comment rulemaking because the statute and regulation specify the methods of computation of annual updates, and we have no discretion in this matter. Further, this notice does not change substantive policy, but merely applies the update methods specified in statute and regulation. Therefore, for good cause, we waive notice and comment procedures.

V. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

VI. Regulatory Impact Analysis

We have examined the impact of this notice as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). As stated above, the AIF (equal to the percentage increase in the CPI–U of June 30, 2004 as compared to June 30, 2003) for 2005 is 3.3 percent. We estimate that the application of the AIF will result in this notice being considered a major rule because it will result in an additional total program expenditure of approximately $100 million in CY 2005.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any 1 year. For purposes of the RFA, all ambulance providers or suppliers are considered to be small entities. Individuals and States are not included in the definition of a small entity.

We consider that a substantial number of entities are affected if the rule impacts more than 5 percent of the total number of small entities as it does in this notice. This notice will impact every ambulance provider and supplier in the same way because all ambulance payment rates for all ambulance services furnished by all types of ambulance suppliers and providers are increased by the same ambulance inflation factor. We estimate the impact of this notice will be an approximate 3 percent increase in Medicare revenues for all ambulance suppliers and providers that furnish services to Medicare beneficiaries. This will be a somewhat less than 2 percent increase in total revenues (that is, Medicare plus non-Medicare revenues). This estimated impact does not meet the threshold established by HHS to be considered a significant impact. Nonetheless, we have prepared the analysis below to describe the impact of this notice.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of

a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. This notice applies to small rural hospitals that furnish at least one Medicare covered ambulance service to at least one Medicare beneficiary.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This notice does not result in an expenditure in any 1 year by State, local, or tribal governments of $110 million.

Executive Order 13132 establishes certain requirements that an agency must meet when it publishes a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. This notice will not have a substantial effect on State or local governments.

We estimate that the total program expenditure for CY 2005 for ambulance services covered by the Medicare program is approximately $3.7 billion. This estimate of program spending includes application of an AIF assumed to be approximately 3 percent. This assumption results in an additional total program expenditure of approximately $100 million distributed over 16,000 suppliers and providers that furnish ambulance services to Medicare beneficiaries.

For recalibrating the AFS, there are two alternatives: (1) To make an adjustment to the AFS, if actual experience is significantly different from our initial assumptions; or (2) to make no adjustment to the AFS because actual experience is not significantly different from our initial assumptions. As discussed in section II.A. of this notice, we have decided not to make an adjustment to the AFS because actual experience is not significantly different from our initial assumptions; however, we note that making the adjustment would have lowered payments to suppliers and providers of ambulance services. Therefore, payments to suppliers and providers of ambulance services are slightly higher than would otherwise be made if we were to make these adjustments to the AFS. We estimate the impact of this action will be an approximate 0.8 percent increase in Medicare revenues for all ambulance suppliers and providers that furnish ground ambulance services to Medicare beneficiaries and an approximate 2.8 percent increase in Medicare revenues for all ambulance suppliers and providers that furnish air ambulance services to Medicare beneficiaries. This will be a 0.5 percent and 1.5 percent increase in total revenues for ground and air ambulance services respectively (that is, Medicare plus non-Medicare revenues). The estimated impact of this action is, therefore, not significant.

In accordance with the provisions of Executive Order 12866, this notice was reviewed by the Office of Management and Budget.

Authority: Section 1834(l) of the Social Security Act (42 U.S.C. 1395m(l)).

(Catalog of Federal Domestic Assistance Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: July 29, 2004.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Approved: September 21, 2004.

Tommy G. Thompson,

Secretary.

[FR Doc. 04–24757 Filed 11–2–04; 4:45 pm]

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Federal Register

Monday,
November 15, 2004

Part V

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 412 and 413

Medicare Program; Prospective Payment System for Inpatient Psychiatric Facilities; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 412 and 413

[CMS–1213–F]

RIN 0938–AL50

Medicare Program; Prospective Payment System for Inpatient Psychiatric Facilities

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule establishes a prospective payment system for Medicare payment of inpatient hospital services furnished in psychiatric hospitals and psychiatric units of acute care hospitals and critical access hospitals. It implements section 124 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA). The prospective payment system described in this final rule will replace the reasonable cost-based payment system under which psychiatric hospitals and psychiatric units are paid under Medicare.

DATES: This rule is effective for cost reporting periods beginning on or after January 1, 2005.

FOR FURTHER INFORMATION CONTACT: Janet Samen, (410) 786–9161 (General information.) Phillip Cotterill, (410) 786–6598 and Fred Thomas (410) 786–6675, (For information regarding the regression analysis).

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To assist readers in referencing sections contained in this document, we are providing he following table of contents.

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Acronyms

Because of the many terms to which we refer by acronym in this final rule, we are listing the acronyms used and their corresponding terms in alphabetical order below:

BBA Balanced Budget Act of 1997 (Pub. L. 105–33)
BBRA Medicare, Medicaid and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999 (Pub. L. 106–113)
BIPA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Benefits Improvement and Protection Act of 2000 (Pub. L. 106–554)
CMS Centers for Medicare & Medicaid Services
DSM–IV–TR Diagnostic and Statistical Manual of Mental Disorders Fourth Edition—Text Revision
DRGs Diagnosis-related groups
FY Federal fiscal year
HCRIS Hospital Cost Report Information System
ICD–9–CM International Classification of Diseases, 9th Revision, Clinical Modification
IPFs Inpatient psychiatric facilities
IPPS Hospital Inpatient Prospective Payment System
IRFs Inpatient rehabilitation facilities
LTCHs Long-term care hospitals
MedPAR Medicare provider analysis and review file

MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–173)
PIP Periodic interim payments
PPS Prospective Payment System
TEFRA Tax Equity and Fiscal Responsibility Act of 1982, (Pub. L. 97–248)

I. Background

A. General and Legislative History

When the Medicare statute was originally enacted in 1965, Medicare payment for inpatient hospital services was based on the reasonable costs incurred in furnishing services to Medicare beneficiaries. Section 223 of the Social Security Act Amendments of 1972 (Pub. L. 92–603) amended section 1861(v)(1) of the Social Security Act (the Act) to set forth limits on reasonable costs for inpatient hospital services. The statute was later amended by section 101(a) of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (Pub. L. 97–248) to limit payment by placing a limit on allowable costs per discharge.

The Congress directed implementation of a prospective payment system (PPS) for acute care hospitals in 1983, with the enactment of Public Law 98–21. Section 601 of the Social Security Amendments of 1983 (Pub. L. 98–21) added a new section 1886(d) to the Act that replaced the reasonable cost-based payment system for most inpatient hospital services with a PPS.

Although most inpatient hospital services became subject to the PPS, certain specialty hospitals were excluded from the PPS and continued to be paid reasonable costs subject to limits imposed by TEFRA. These hospitals included psychiatric hospitals and psychiatric units in acute care hospitals, long-term care hospitals (LTCH), children's hospitals, and rehabilitation hospitals and rehabilitation units in acute care hospitals. Cancer hospitals were added to the list of excluded hospitals by section 6004(a) of the Omnibus Budget Reconciliation Act of 1989 (Pub. L. 101–239).

The Congress enacted various provisions in the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33), the Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act (BBRA) (Pub. L. 106–113), and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106–554) to replace the cost-based methods of reimbursement with a PPS for the following excluded hospitals:

- Rehabilitation hospitals and rehabilitation units in acute care hospitals.
- Psychiatric hospitals and psychiatric units in acute care hospitals.
- Long term care hospitals.

The BBA also imposed national limits (or caps) on hospital-specific target amounts (that is, annual per discharge limits) for these hospitals until cost reporting periods beginning on or after October 1, 2002. A detailed description of the TEFRA payment methodology is provided in section B.1. of this final rule.

Section 124 of the BBRA mandated that the Secretary—(1) develop a per diem PPS for inpatient hospital services furnished in psychiatric hospitals and psychiatric units (hereinafter referred to as inpatient psychiatric facilities (IPFs)); (2) include in the PPS an adequate patient classification system that reflects the differences in patient resource use and costs among psychiatric hospitals and psychiatric units; (3) maintain budget neutrality; (4) permit the Secretary to require psychiatric hospitals and psychiatric units to submit information necessary for the development of the PPS; and (5) submit a report to the Congress describing the development of the PPS.

Section 124 of the BBRA also required that the PPS for IPFs be implemented for cost reporting periods beginning on or after October 1, 2002. In general, the creation of a prospective payment system requires an extraordinary amount of lead-time in order to conduct the research that is required to create a completely new payment system. For example, we must create data files, develop models to test individual variables and those variables' ability to explain costs, as well as perform extensive empirical analysis of the collected data.

With respect to the creation of the IPF PPS, more lead time than usual was necessary. This is because the research we had conducted before the passage of the BBRA dated back to the 1980s and was focused on developing a per discharge IPF PPS. The research efforts to develop a discharged-based IPF PPS, however, failed to adequately explain cost variation among psychiatric cases. Because diagnosis in psychiatry is complicated and the criteria for diagnosis and treatment are less well defined in psychiatry than in general medicine and surgery, developing an IPF PPS was more elusive. Moreover, there have been significant changes in mental health treatment, for example, new medications and outpatient treatment options. Thus, to develop an adequate patient classification system that reflects the differences in patient resource use and costs, we had to embark on numerous courses of research that could be used as a possible foundation for the proposed IPF PPS.

When we began the process of developing a proposed IPF PPS, we believed pursuing an assessment instrument, incorporating key indicators of functional status, was the most logical place to begin. This approach is consistent with the approach we followed in developing patient classification systems for other Medicare prospective payment systems (for example., home health agencies, skilled nursing facilities, and inpatient rehabilitation facilities). Our administrative data was inadequate to develop other patient classification systems because, although it provides useful information on diagnoses, services, and procedures, it does not include many patient and clinical characteristics and functional status indicators, which have been established as key components of a patient classification system. Therefore, to obtain the patient-level data we needed to develop an assessment-based patient classification system, we contracted with the University of Michigan's Public Health Institute in September 2002. We selected this contractor because it had developed a protocol assessment instrument, precursors of which had shown promise in explaining variation in resource utilization among psychiatric patients. Although there continues to be progress in completing the initial phase of this research, that is, adoption of an initial assessment instrument for pilot testing, we are unable to delay implementation of the IPF PPS until the draft assessment instrument is completed.

Also, in our effort to meet the requirements of section 124 of the BBRA, we also pursued a second research project with the Health, Economics, Research, Inc. (now known as RTI International®). RTI International® embarked on a research project to identify patient characteristics and modes of practice believed to account for variation in per diem cost. It became apparent that, despite everyone's best efforts, the ongoing research projects being conducted by the University of Michigan and RTI International®, could not be completed in time for us to engage in notice and comment rulemaking and achieve implementation of the IPF PPS by October 1, 2002.

In addition, shortly before October 1, 2002, the American Psychiatric Association (APA) informed us that The Health Economics and Outcomes

Research Institute (THEORI) of the Greater New York Hospital Association had developed a potential IPF PPS classification model that was based on our currently available administrative data. Based on the model presented to us by the APA, we immediately began our own vigorous review of the ''APA'' model. We note, however, that although the information shared with us by the APA was extremely valuable in our formulation of a proposed IPF PPS, it came too late for us to be able to do the following: (1) Perform the analysis required to ensure that a system based on our administrative data would fulfill the statutory mandate of section 124 of the BBRA; and (2) engage in notice-and-comment rulemaking and implement the IPF PPS by October 1, 2002. As soon as we completed an analysis of the information presented by the APA and of our administrative data, we published the proposed IPF PPS regulation.

Initially, the proposed rule provided for a 60-day comment period. However, due to the complexity and scope of the proposed rule and because the public requested additional time to examine the rule so that it could provide meaningful comments, we extended the public comment period. The intricacy and complexity of the issues presented in the public comments required us to perform further substantial analysis to adequately address the issues raised by commenters, as well as our duty to satisfy section 124 of the BBRA. We have made every effort to complete this final rule as quickly as possible.

(We note that, even though the IPF PPS described in this final rule is effective for cost reporting periods beginning on or after January 1, 2005 and compliance with the IPF PPS requirements is required for cost reporting periods beginning on or after January 1, 2005, we will not have computer system changes in place that are necessary to accommodate claims processing under the IPF PPS until April 4, 2005 (claims processing updates will occur on the first Monday following April 1, 2005). Therefore, claims submitted after January 1, 2005, but before April 4, 2005, will be paid as if the TEFRA rate was still in effect. Payments will be reconciled with the appropriate IPF PPS amount. We have instructed the fiscal intermediaries (FIs) to reconcile the payments that are made to IPFs for covered inpatient hospital services furnished to Medicare beneficiaries for cost reporting periods beginning on or after January 1, 2005, until the date of the systems implementation on April 4, 2005, with the amounts that are payable under the IPF PPS system by May 1, 2005.

Since IPFs will receive payment under the IPF PPS starting with their first cost reporting period beginning on or after January 1, 2005, only those IPFs with cost reporting periods beginning on or after January 1, 2005 but before April 1, 2005 will experience payment reconciliation.

Requirements for Issuance of Regulations

Section 902 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) amended section 1871(a) of the Act and requires the Secretary, in consultation with the Director of the Office of Management and Budget, to establish and publish timelines for the publication of Medicare final regulations based on the previous publication of a Medicare proposed or interim final regulation. Section 902 of the MMA also states that the timelines for these regulations may vary but will not exceed 3 years after publication of the preceding proposed or interim final regulation except under exceptional circumstances.

This rule finalizes provisions set forth in the November 28, 2003 proposed rule (68 FR 66920). In addition, this final rule has been published within the 3-year time limit imposed by section 902 of the MMA. Therefore, we believe that the final rule is in accordance with the Congress' intent to ensure timely publication of final regulations.

B. Overview of the Payment System for Inpatient Psychiatric Hospitals and Psychiatric Units Before the BBRA

1. Description of the TEFRA Payment Methodology

Hospitals and units that are excluded from the hospital inpatient prospective payment system (IPPS) under section 1886(d)(1)(B) of the Act are paid for their inpatient operating costs under the provisions of the TEFRA (Pub. L. 97–248).

The TEFRA provisions are found in section 1886(b) of the Act and implemented in regulations at 42 CFR 413. TEFRA established payments based on hospital-specific limits for inpatient operating costs. As specified in § 413.40, TEFRA established a ceiling on payments for hospitals excluded from the IPPS. The ceiling on payments is determined by calculating the product of a facility's base year costs (the year in which its target reimbursement limit is based) per discharge, updated to the current year by a rate-of-increase percentage, and multiplied by the number of total current year discharges. A detailed discussion of target amount payment limits under TEFRA can be found in the final rule concerning the IPPS published in the **Federal Register** on September 1, 1983 (48 FR 39746).

The base year for a facility varied, depending on when the facility was initially determined to be an IPPS excluded provider. The base year for facilities that were established before the implementation of the TEFRA provision was 1982. For facilities established after the implementation of the TEFRA provision, facilities were allowed to choose which of their first 3 cost reporting years would be used in the future to determine their target limit. In 1992, the ''new provider'' period was shortened to 2 full years of cost reporting periods (§ 413.40(f)(1)).

Excluded facilities whose costs were below their target amounts would receive bonus payments equal to the lesser of half of the difference between costs and the target amount, up to a maximum of 5 percent of the target amount, or the hospital's costs. For excluded hospitals whose costs exceeded their target amounts, Medicare provided relief payments equal to half of the amount by which the hospital's costs exceeded the target amount up to 10 percent of the target amount. Excluded facilities that experienced a more significant increase in patient acuity could also apply for an additional amount as specified in § 413.40(d) for Medicare exception payments.

2. BBA Amendments to TEFRA

The BBA amendments to section 1886 of the Act significantly altered the payment provisions for hospitals and units paid under the TEFRA provisions and added other qualifying criteria for certain hospitals excluded from the IPPS. A complete explanation of these amendments can be found in the final rule concerning the IPPS we published in the **Federal Register** on August 29, 1997 (62 FR 45966).

The BBA made the following changes to section 1886 of the Act for TEFRA hospitals:

- Section 4411 of the BBA amended section 1886(b)(3)(B) of the Act and restricted the rate-of-increase percentages that are applied to each provider's target amount so that excluded hospitals and units experiencing lower inpatient operating costs relative to their target amounts receive lower rates of increase.
- Section 4412 of the BBA amended section 1886(g) of the Act to establish a 15-percent reduction in capital payments for excluded psychiatric and rehabilitation hospitals and units and LTCHs, for portions of cost reporting periods occurring during the period of

October 1, 1997, through September 30, 2002.

• Section 4414 of the BBA amended section 1886(b)(3) of the Act to establish caps on the target amounts for excluded hospitals and units at the 75th percentile of target amounts for similar facilities for cost reporting periods beginning on or after October 1, 1997, through September 30, 2002. The caps on these target amounts apply only to psychiatric hospitals and rehabilitation hospital units and LTCHs. Payments for these excluded hospitals and units are based on the lesser of a provider's cost per discharge or its hospital-specific cost per discharge, subject to this cap.

• Section 4415 of the BBA amended section 1886(b)(1) of the Act by revising the percentage factors used to determine the amount of bonus and relief payments and establishing continuous improvement bonus payments for excluded hospitals and units for cost reporting periods beginning on or after October 1, 1997. If a hospital is eligible for the continuous improvement bonus, the bonus payment is equal to the lesser of: (1) 50 percent of the amount by which operating costs are less than expected costs; or (2) 1 percent of the target amount.

• Sections 4416 and 4419 of the BBA amended sections 1886(b) of the Act to establish a new framework for payments for new excluded providers. Section 4416 of the BBA added a new section 1886(b)(7) to the Act that established a new statutory methodology for new psychiatric and rehabilitation hospitals and units, and LTCHs. Under section 4416 of the BBA, payment to these providers for their first two cost reporting periods is limited to the lesser of the operating costs per case, or 110 percent of the national median of target amounts. This is adjusted for differences in wage levels, for the same class of hospital for cost reporting periods ending during FY 1996, updated to the applicable period.

3. BBRA Amendments to TEFRA

The BBRA of 1999 refined some of the policies mandated by the BBA for hospitals and units paid under the TEFRA provisions. The provisions of the BBRA, amending section 1886(b)(3)(H) of the Act, were explained in detail and implemented in the IPPS interim final rule published in the **Federal Register** on August 1, 2000 (65 FR 47026) and in the IPPS final rule also published on August 1, 2000 (65 FR 47054).

With respect to the TEFRA payment methodology, section 4414 of the BBA had provided for caps on target amounts for excluded hospitals and units for cost reporting periods beginning on or after October 1, 1997. Section 121 of the BBRA amended section 1886(b)(3)(H) of the Act to provide for an appropriate wage adjustment to these caps on the target amounts for certain hospitals and units paid under the TEFRA provisions, effective for cost reporting periods beginning on or after October 1, 1999 through September 30, 2002.

4. BIPA Amendments to TEFRA

Section 306 of BIPA amended section 1886 of the Act by increasing the incentive payments for psychiatric hospitals and psychiatric units to 3 percent for cost reporting periods beginning on or after October 1, 2000 and before October 1, 2001.

II. Provisions of the Proposed Regulations

On November 28, 2003, we published a proposed rule in the **Federal Register** (68 FR 66920) as required by section 124 of the BBRA that proposed a PPS for Medicare payment of inpatient hospital services furnished in IPFs. The IPF PPS would replace the current reasonable cost-based payment system under the TEFRA provisions.

We proposed to base the IPF PPS on data from the fiscal year (FY) 1999 Medicare Provider Analysis and Review (MedPAR) file, which includes patient characteristics (for example, patients' diagnoses and age), and data from the FY 1999 Hospital Cost Report Information System (HCRIS), which includes facility characteristics (for example, location and teaching status). We proposed the following policies and methodology for the IPF PPS. We proposed to:

• Add a new subpart N in 42 CFR 412 for the IPF PPS, and make conforming changes to parts 412 and 413 regarding the implementation of the IPF PPS.

• Compute a standardized Federal per diem payment to be paid to all IPFs based on the sum of the national average routine operating, ancillary, and capital costs for each patient day of psychiatric care in an IPF adjusted for budget neutrality.

• Adjust the Federal per diem payment to reflect certain patient and facility characteristics that were found in the regression analysis to be associated with statistically significant cost differences.

• Provide patient-level adjustments for age, specified diagnosis-related groups (DRGs), and selected comorbidity categories.

• Provide facility adjustments that include a wage index adjustment, rural location adjustment, and a teaching status adjustment.

• Recognize variable per diem adjustments to account for the higher costs incurred in the early days of a psychiatric stay.

• Adopt an outlier policy to target greater payment to the high cost cases.

• Provide an interrupted stay policy for the purpose of applying the variable per diem adjustment and the outlier policy.

• Implement the IPF PPS for IPF cost reporting periods beginning on or after April 1, 2004, with a 3-year transition period. We proposed that the first update would occur on July 1, 2005.

• Include a coding policy that would require IPFs to report patient diagnoses using the International Classification of Diseases-9th Revision, Clinical Modification (ICD–9–CM) code set.

• Update a regulatory reference to the Diagnostic and Statistical Manual of Mental Disorders (DSM) from the Third Edition to the Fourth Edition, Text Revision (DSM–IV–TR).

• Use the 1997-based excluded hospital with capital market basket to establish the labor-related share of the Federal per diem base rate, to calculate the budget neutrality adjustment, and to update the Federal per diem base rate.

• Provide the annual update strategy for the IPF PPS.

• Include research information for future refinement of the patient classification system.

III. Analysis of and Responses to Public Comments

In the November 28, 2003 **Federal Register** (68 FR 66920), we published the proposed IPF PPS and provided for a 60-day comment period. On January 30, 2004, we published a notice in the **Federal Register** (68 FR 4464) extending the comment period for an additional 30 days in response to public requests. The comment period that would have closed on January 27, 2004, was extended 30 days. Thus, the comment period for the proposed rule closed on February 26, 2004.

We received 273 comments from hospital associations, psychiatric hospitals, providers, acute care hospitals, health research organizations, patient advocacy organizations, State associations, and physicians. We reviewed each commenter's letter and grouped related comments. Some comments were identical. After associating like comments, we placed them in categories based on subject matter or based on the section(s) of the regulation affected. Summaries of the public comments received and our responses to those comments are set forth below.

IV. Overview of the IPF PPS Proposed Payment Methodology

In the November 2003 proposed rule, we proposed to establish a Federal payment for each patient day in an IPF derived from the national average daily routine operating, ancillary, and capital costs in IPFs. The Federal per diem payment would comprise a Federal per diem base rate adjusted by factors for patient and facility characteristics that account for variation in patient resource use. The Federal per diem base rate would be updated to the midpoint of the first year under the IPF PPS, standardized to account for the overall positive effects of the IPF PPS payment adjustments, and adjusted for budget neutrality.

We proposed that psychiatric hospitals and psychiatric units paid under section 1886(b) of the Act would be paid under the IPF PPS for cost reporting periods beginning on or after April 1, 2004. We proposed that the IPF PPS would apply to inpatient hospital services furnished by Medicare participating entities in the United States that are classified as psychiatric hospitals or psychiatric units as specified in § 412.22, § 412.23, § 412.25, and § 412.27. As specified in § 400.200, the United States means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

However, the following hospitals are paid under special payment provisions specified in § 412.22(c) and, therefore, would not be paid under the IPF PPS:

- Veterans Administration hospitals.
- Hospitals that are reimbursed under State cost control systems approved under 42 CFR part 403.
- Hospitals that are reimbursed in accordance with demonstration projects specified in section 402(a) of Public Law 90–248 (42 U.S.C. 1395b–1) or section 222(a) of Public Law 92–603 (42 U.S.C. 1395b–1(note)).
- Non-participating hospitals furnishing emergency services to Medicare beneficiaries.

We received a variety of comments on the proposed applicability requirements of the IPF PPS. In this final rule, we are adopting the proposed policies regarding applicability of the IPF PPS.

Comment: One commenter recommended that CMS develop a separate payment system for government-operated IPFs. The commenter believes that these hospitals provide a different service than other psychiatric hospitals and psychiatric units.

Several commenters requested that psychiatric units be excluded from the IPF PPS until a more equitable system can be created.

Response: Section 124 of Public Law 106–113 requires the Secretary to implement a prospective payment system for psychiatric hospitals described in clause (i) of section 1886(d)(1)(B) of the Act and psychiatric units described in clause (v) of this section. Government-operated psychiatric hospitals and psychiatric units fall within the definition of a psychiatric hospital and unit outlined in section 124 of the BBRA to which this IPF PPS applies. Consequently, these entities, like all other psychiatric hospitals and units, must be paid under this system effective with the start of the implementation of the IPF PPS.

With regard to the equity of the payment system, we believe that we are implementing an equitable prospective payment system based on the best data available.

We also believe it is important to note that a per diem approach explains a significant percentage of the cost variation among inpatient psychiatric patients. We estimate that the final IPF PPS explains the 33 percent variation in per diem cost among IPF cases. A commenter indicated that the combination of the explanatory power of a per diem system and the proposed adjustments on case level costs is approximately 80 percent. Our analysis confirmed the commenter's findings, however, we found the explanatory power of a per diem system and the final adjustment factors to be approximately 85 percent, solidifying our belief that the payment model combination we are using, a per diem system with adjustments based on case level costs, is equitable.

Comment: One commenter questioned whether psychiatric units that are currently paid under the IPPS and do not meet the requirements of § 412.22, § 412.25, and § 412.27 would be excluded from the IPF PPS. The commenter also asked whether these providers would be paid under the IPF PPS if they would meet the requirements of § 412.22, § 412.25, and § 412.27. A few commenters asked if ''DRG-exempt status'' for psychiatric units would continue to be an option after the effective date of the IPF PPS.

Response: If a hospital has a psychiatric unit that meets the requirements specified in § 412.22, § 412.25, and § 412.27, the psychiatric unit is excluded from the IPPS (that is, DRG-exempt). The IPF PPS will replace the reasonable cost-based payments currently paid to excluded psychiatric hospitals and units for cost reporting periods beginning on or after January 1, 2005. Once the IPF PPS is implemented, hospitals will be paid under the IPF PPS for all patients admitted to the excluded psychiatric unit.

Comment: One commenter recommended that critical access hospitals (CAHs) be allowed cost-based reimbursement for services in their psychiatric units. If a hospital or unit treats psychiatric patients but it does not meet the statutory definition of a psychiatric hospital or unit, then the IPF PPS would not apply.

Response: Section 405(g)(2) of the MMA specifies that the amount of payment for services in psychiatric units of a CAH described in section 1820(c)(2)(E) of the Act shall be equal to the amount that would otherwise be made if the services were inpatient hospital services provided in a distinct part psychiatric unit. Therefore, we have amended § 413.70(e) to clarify that, effective for cost reporting periods beginning on or after January 1, 2005, certified psychiatric units in CAHs will be paid under the IPF PPS. We believe the statute is very clear concerning methodology.

Comment: Several commenters requested an exceptions process through which an IPF could seek additional payment.

Response: We believe that the final IPF PPS explains a sufficient amount of the cost variation among IPF patients and that an exceptions process is not necessary.

More importantly, when we become aware of patient or facility characteristics that lead to higher per diem costs, we would propose to establish an adjustment factor to the IPF PPS so that all IPFs that qualify could benefit from the adjustment as part of routine claims processing rather than through an exceptions process through which an individual IPF could request additional payment. Therefore, we will be accounting for their differences in costs.

V. Development of the Budget-Neutral Federal Per Diem Base Rate

In the proposed rule, we proposed that the IPF PPS be based on a standardized Federal per diem base rate calculated from IPF average per diem costs and adjusted for budget-neutrality. We proposed that the Federal per diem base rate would be used as the standard payment per day for the IPF PPS. In addition, the Federal per diem base rate would be adjusted by the applicable wage index factor and the patient-level and facility-level adjustments that are applicable to the stay.

A. Calculation of the Average Per Diem Cost

To calculate the proposed Federal per diem base rate, we estimated the cost per day for—(1) routine services from FY 1999 cost reports (supplemented with FY 1998 cost reports if the FY 1999 cost report is missing); and (2) ancillary costs per day using data from the FY 1999 Medicare claims and corresponding data from facility cost reports.

For routine services, the per diem operating and capital costs were used to develop the base for the psychiatric per diem amount. The per diem routine costs were obtained from each facility's Medicare cost report. To estimate the costs for routine services included in the proposed Federal per diem base rate calculation, we added the total routine costs (including costs for capital) submitted on the cost report for each provider and divided it by the total Medicare days.

Some average routine costs per day were determined to be aberrant, that is, the costs were extraordinarily high or low and most likely contained data errors. The following method was used to trim extraordinarily high or low cost values in order to improve the accuracy of our results.

First, the average and standard deviations of the total per diem cost (routine and ancillary costs) were computed separately for cases from psychiatric hospitals and psychiatric units. Separate statistics were computed because we did not want to systematically exclude a larger proportion of cases from the higher cost psychiatric units. Before calculating the means, we trimmed cases from the file when covered days were zero or routine costs were less than $100 or greater than $3,000. We selected these amounts because we believe this range captured the grossly aberrant cases. Elimination of the grossly aberrant cases would prevent the means from being distorted.

Second, we trimmed cases when the provider's total cost per day was outside the generally-accepted statistical trim points of plus or minus 3.00 standard deviations from the respective means for each facility type (psychiatric hospitals and psychiatric units). If the total cost per day was outside the trim value, we deleted the data for that provider from the per diem rate development file because it helped eliminate skewing of the data. After trimming the data, the average routine cost per day in FY 1999 was calculated to be $495.

For ancillary services, we calculated the costs by converting charges from the FY 1999 Medicare claims into costs using facility-specific, cost-center specific cost-to-charge ratios obtained from each provider's applicable cost reports. We matched each provider's departmental cost-to-charge ratios from their Medicare cost report to each charge on their claims reported in the MedPAR file. Multiplying the total charges for each type of ancillary service by the corresponding cost-to-charge ratio provided an estimate of the costs for all ancillary services received by the patient during the stay.

For those departmental cost-to-charge ratios that we considered to be aberrant because they were outside the generally-accepted statistical trim points of plus or minus 3.00 standard deviations from the facility-type mean, we replaced the individual cost-to-charge ratios for each department with the median department cost-to-charge ratio by facility type (psychiatric hospital or psychiatric unit). We considered using the mean of the cost to-charge ratio as the substitution value, but because the distribution of ratios of cost-to-charges is not normally distributed and there is no limit to the upper ceiling of the ratio, the mean ratio would be overstated due to the higher values on the upper tail of the bell curve. Therefore, we chose the median by facility type as a better measure for the substitution value when the facility's actual cost-to-charge ratio was outside the trim values.

After computing the estimated costs of applying the applicable cost-to-charge ratios, and, when appropriate, the median cost-to charge ratio, to the total ancillary charges for each patient stay, we determined the average ancillary amount per day by dividing the total ancillary costs for all stays by the total number of covered Medicare days. Using this methodology, the average ancillary cost per day in FY 1999 was calculated to be $67.

Adding the average ancillary costs per day ($67) and the average routine costs per day including capital costs ($495) provides the estimated average per diem cost for each patient day of inpatient psychiatric care in FY 1999 ($562). We used the above described procedures to calculate the average per diem cost in this final rule as well.

Comment: Several commenters recommended that CMS use more current data for the final IPF PPS. The commenters suggested that CMS use the FY 2002 MedPAR data and the FY 2002 HCRIS data, supplemented with FY 2001 cost report data when necessary.

A few commenters indicated it would be preferable to use the most current cost report data, with an appropriate audit adjustment factor, if necessary.

Response: We used the best available data when we developed the proposed rule. We are continuing to use the best data available for this final rule. Specifically, we calculated the average cost per day using FY 2002 claims and cost report data supplemented with FY 2001 cost report data if the FY 2002 cost report was missing. Using FY 2002 data and the methodology described above, we calculated the per diem cost for each patient day of inpatient psychiatric care in an IPF in FY 2002. We note that currently, less than 50 percent of the hospitals have filed their FY 2003 cost reports. Therefore, we believe that FY 2002 cost report data provides the best available information for this final rule.

B. Determining the Update Factors for the Budget-Neutrality Calculation

Section 124(a)(1) of the BBRA requires that the IPF PPS be budget neutral. In other words, the amount of total payments under the IPF PPS, including any payment adjustments, must be projected to be equal to the amount of total payments that would have been made if the IPF PPS were not implemented. Therefore, in the proposed rule as well as in this final rule, we have calculated the budget-neutrality factor by setting the total estimated PPS payments to be equal to the total estimated payments that would have been made under the TEFRA methodology had the IPF PPS not been implemented.

In the proposed rule, we based the rate setting calculations and estimated impacts on an April 1, 2004 implementation date. However, in order to create a more efficient process of updates for the various Medicare payment systems, we proposed to establish a July 1 annual update cycle for the IPF PPS. We also indicated we would not update the rates on July 1, 2004 because we believed there would be an insufficient time under the new IPF PPS to generate data that would be useful in updating the IPF PPS. As a result, we calculated the proposed Federal per diem base rate to be budget neutral for the 15-month period April 1, 2004 through June 30, 2005.

In this final rule, we calculated the final Federal per diem base rate to be budget neutral during the implementation period under the IPF PPS. As in the proposed rule, we will use a July 1 update cycle. Similar to the proposed rule, we will not update the IPF PPS during the first year of implementation because we believe there would be an insufficient amount of time under the IPF PPS to generate data useful in updating the system. Thus, the implementation period for the

final IPF PPS is the 18-month period January 1, 2005 through June 30, 2006. As a result, we updated the Federal per diem base rate to the midpoint of the January 1, 2005 through June 30, 2006, implementation period (that is, October 1, 2005).

1. The 1997-Based Excluded Hospital with Capital Market Basket

Since FY 2003, the 1997-based excluded hospital with capital market basket has been used to establish the rates-of-increase for excluded hospitals and units paid under TEFRA. As a result, in the proposed rule, we proposed to use the 1997-based excluded hospital capital market basket to update the Federal per diem base rate to the midpoint of the implementation period under the IPF PPS, to establish the labor-related share for applying the wage index (see section V. of this final rule), and to update the Federal per diem base rate after the implementation period (see section V. of this final rule).

In the proposed rule, we explained that we periodically rebase (moving the base year for the structure of costs), and revise (changing data sources, cost categories, or price proxies used) the market basket to reflect more current cost data. We provided a detailed comparison of the 1992-based excluded hospital with capital market basket that had been in effect prior to October 1, 2002 to the rebased and revised 1997-based excluded hospital with capital market basket.

In the proposed rule, we explained that the operating portion of the 1997-based excluded hospital with capital market basket is derived from the 1997-based excluded hospital market basket. The methodology used to develop the operating portion was described in the IPPS final rule published in the **Federal Register** on August 1, 2002 (67 FR 50042 through 50044). In brief, the operating cost category weights in the 1997-based excluded hospital market basket were determined from the 1997 Medicare cost reports, the 1997 Business Expenditure Survey from the Bureau of the Census and the 1997 Annual Input-Output data from the Bureau of Economic Analysis. As was discussed in the IPPS final rule, we made two methodological revisions in developing the 1997-based excluded hospital market basket: (1) Changing the wage and benefit price proxies to use the Employment Cost Index (ECI) wage and benefit data for hospital workers; and (2) adding a cost category for blood and blood products.

As we indicated in the proposed rule (68 FR 66926), when we add the weight for capital costs to the excluded hospital market basket, the sum of the operating and capital weights must still equal 100.0. Because capital costs account for 8.968 percent of total costs for excluded hospitals in 1997, operating costs must account for 91.032 percent. Each operating cost category weight in the 1997-based excluded hospital market basket was multiplied by 0.91032 to determine its weight in the 1997-based excluded hospital with capital market basket.

The aggregate capital component of the 1997-based excluded hospital market basket (8.968 percent) was determined from the same set of Medicare cost reports used to derive the operating component. The detailed capital cost categories of depreciation, interest, and other capital expenses were also determined using the Medicare cost reports. There are two sets of weights for the capital portion of the market basket. The first set of weights identifies the proportion of capital expenditures attributable to each capital cost category, while the second set represents relative vintage weights for depreciation and interest. The vintage weights identify the proportion of capital expenditures that is attributable to each year over the useful life of capital assets within a cost category (see the IPPS final rule on August 1, 2002 (67 FR 50045 through 50047), for a discussion on how vintage weights are determined).

The cost categories, price proxies, and base-year FY 1997 weights for the excluded hospital with capital market basket are presented in Table 1 below. The vintage weights for the 1997-based excluded hospital with capital market basket are presented in Table 1(A) below.

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TABLE 1— Excluded Hospital With Capital Input Price Index (FY 1992 and FY 1997) Structure and Weights from the IPF PPS proposed rule published in the Federal Register on November 28, 2003 (68 FR 66927).

Cost Category	Price Wage Variable	Weights (%) Base-Year 1992	Weights (%) Base-Year 1997
TOTAL		100.000	100.000
Compensation		57.935	57.579
Wages and Salaries	ECI-Wages and Salaries, Civilian Hospital Workers	47.417	47.355
Employee Benefits	ECI-Benefits, Civilian Hospital Workers	10.519	10.244
Professional fees: Non-Medical	ECI – Compensation: Prof. & Technical	1.908	4.423
Utilities		1.524	1.180
Electricity	WPI – Commercial Electric Power	0.916	0.726
Fuel Oil, Coal, etc.	WPI – Commercial Natural Gas	0.365	0.248
Water and Sewerage	CPI-U - Water & Sewage	0.243	0.206
Professional Liability Insurance	HCFA - Professional Liability Premiums	0.983	0.733
All Other Products and Services		28.571	27.117
All Other Products		22.027	17.914
Pharmaceuticals	WPI – Prescription Drugs	2.791	6.318
Food: Direct Purchase	WPI – Processed Foods	2.155	1.122
Food: Contract Service	CPI-U - Food Away from Home	0.998	1.043
Chemicals	WPI – Industrial Chemicals	3.413	2.133
Blood and Blood Products	WPI – Blood and Derivatives		0.748
Medical Instruments	WPI - Med. Inst. & Equipment	2.868	1.795
Photographic Supplies	WPI – Photo Supplies	0.364	0.167
Rubber and Plastics	WPI - Rubber & Plastic Products	4.423	1.366
Paper Products	WPI - Convert. Paper and Paperboard	1.984	1.110
Apparel	WPI – Apparel	0.809	0.478
Machinery and Equipment	WPI - Machinery & Equipment	0.193	0.852
Miscellaneous Products	WPI - Finished Goods excluding Food and Energy	2.029	0.783
All Other Services		6.544	9.203
Telephone	CPI-U – Telephone Services	0.574	0.348
Postage	CPI-U – Postage	0.268	0.702
All Other: Labor	ECI – Compensation: Service Workers	4.945	4.453
All Other: Non-Labor Intensive	CPI-U - All Items (Urban)	0.757	3.700
Capital-Related Costs		9.080	8.968
Depreciation		5.611	5.586
Fixed Assets	Boeckh-Institutional Construction: 23 Year Useful Life	3.570	3.503
Movable Equipment	WPI – Machinery & Equipment: 11 Year Useful life	2.041	2.083
Interest Costs		3.212	2.682
Non-profit	Avg. Yield Municipal Bonds: 23 Year Useful Life	2.730	2.280
For-profit	Avg. Yield AAA Bonds: 23 Year Useful Life	0.482	0.402
Other Capital-Related Costs	CPI-U – Residential Rent	0.257	0.699

Note: Weights may not sum to 100.0 due to rounding.

TABLE 1(A)—Excluded Hospital with Capital Input Price Index (FY 1997) Vintage Weights from the IPF PPS proposed rule published in the Federal Register on November 28, 2003 (68 FR 66928).

Year from Farthest to Most Recent	Fixed Assets (23-Year Weights)	Movable Assets (11-Year Weights)	Interest: Capital-Related (23-Year Weights)
1	0.018	0.063	0.007
2	0.021	0.068	0.009
3	0.023	0.074	0.011
4	0.025	0.080	0.012
5	0.026	0.085	0.014
6	0.028	0.091	0.016
7	0.030	0.096	0.019
8	0.032	0.101	0.022
9	0.035	0.108	0.026
10	0.039	0.114	0.030
11	0.042	0.119	0.035
12	0.044		0.039
13	0.047		0.045
14	0.049		0.049
15	0.051		0.053
16	0.053		0.059
17	0.057		0.065
18	0.060		0.072
19	0.062		0.077
20	0.063		0.081
21	0.065		0.085
22	0.064		0.087
23	0.065		0.090
Total	1.0000	1.0000	1.0000

Note: Weights may not sum to 1.000 due to rounding.

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In the proposed rule (68 FR 66928) we described an analysis we conducted to ensure that the excluded hospital with capital market basket provides a reasonable measure of the price changes facing IPFs. We conducted an analysis of annual percent changes in the market basket when the weights for wages, pharmaceuticals, and capital in IPFs were substituted into the 1997-based excluded hospital with capital market basket. Other cost categories were recalibrated using ratios available from the IPPS market basket. Our analysis found that on average between 1995 and 2002, the excluded hospital with capital market basket increased at nearly the same average annual rate (3.4 percent) as the market basket with IPF weights for wages, pharmaceuticals, and capital (3.5 percent). This difference is less than the 0.25 percentage point criterion that determines whether a forecast error adjustment is warranted under the IPPS update framework.

Based on this analysis, we believe that the excluded hospital with capital market basket is doing an adequate job of reflecting the price changes facing IPFs. For this reason, in this final rule we are adopting the 1997-based excluded hospital with capital market basket to update the Federal per diem base rate to the midpoint of the IPF PPS implementation period, to establish the labor-related share of the Federal per diem base rate, and to update the IPF PPS after the implementation period.

2. Calculating the Budget-Neutrality Adjustment Factor

Many commenters stated that they were concerned that the data used in the proposed rule were not current and did not reflect an accurate view of the services provided to Medicare psychiatric patients. The data sources we used to calculate the proposed budget-neutrality factor were the best data available for IPFs at that time and included FY 1999 cost report data and FY 1999 Medicare claims data from the June 2001 update of the MedPAR files. We updated the data for each IPF to the midpoint of the proposed 15-month implementation period (April 1, 2004 through June 30, 2005) and used the projected market basket update factors for each applicable year. For this final rule, we used FY 2002 data, the best data available.

a. Cost Report Data for January 1, 2005 Through June 30, 2006

In the proposed rule, we proposed to update each IPF's cost to the midpoint of the proposed implementation period April 1, 2004 through June 30, 2005. We explained that to calculate the operating costs, we would use the applicable percentage increases to the TEFRA target amounts for FY 1999 through FY 2002 in accordance with § 413.40(c)(3)(vii) and the full excluded hospital market-basket percentage increase for FY 2003 and later in accordance with § 413.40(c)(3)(viii).

In this final rule, in order to determine each provider's projected operating cost for the IPF PPS implementation period adopted in this final rule, we updated each IPF's per diem cost in FY 2002 to the midpoint of the implementation period January 1, 2005 through June 30, 2006. We used the most recent projection of the full percentage increase in the 1997-based excluded hospital market basket index for FY 2003 and later in accordance with § 413.40(c)(3)(viii).

Comment: A few commenters recommended that CMS project IPF

operating and capital costs using the full TEFRA market basket indexes.

Response: We used FY 1999 data in the proposed rule. In order to update the data to the midpoint of the proposed implementation period, we applied the cap imposed by section 4414 of the BBA in accordance with § 413.40(c)(3)(vii). The BBA caps sunset after FY 2002. Since we used the FY 2002 cost reports to project TEFRA costs and payments in this final rule, we used the full excluded hospital market basket indexes to project the costs and payments to the midpoint of the IPF PPS implementation period in accordance with § 413.40(c)(3)(viii).

Since the IPF PPS includes both the operating and capital-related costs, we projected the capital-related cost under the TEFRA system as well. We used the excluded capital market basket to project the capital-related costs under the TEFRA system. Table 2 below summarizes the excluded hospital market basket (without capital) and the excluded capital market basket indexes.

Table 2--Excluded Hospital Market Basket Without Capital and Excluded Capital Market Basket

Fiscal Year	Excluded Hospital Market Basket Without Capital Percent	Excluded Capital Market Basket Percent
FY 2003	4.0%	0.7%
FY 2004	3.8%	0.7%
FY 2005*	3.7%	1.0%
FY 2006*	3.2%	1.2%

*Projected Percentage

Source: Global Insight, Inc., 3rd quarter 2004, USMACRO.CONTROL0804@CISSIM/TRENDLONG0804.SIM Historical data through 2nd quarter 2004.

b. Estimate of Total Payments Under the TEFRA Payment System

Consistent with the proposed rule, in this final rule, we estimated payments for inpatient operating and capital costs under the current TEFRA system using the following methodology:

Step 1: IPF's Facility-Specific Target Amount

The facility-specific target amount for an IPF was calculated based on the IPF's allowable inpatient operating cost per discharge for the base period, excluding capital-related, non-physician anesthetist, and graduate medical education costs. We updated the target amount using the rate-of-increase percentages specified in § 413.40(c)(3)(viii).

Step 2: Calculating Each IPF's TEFRA Payments for Inpatient Operating Services

Under the TEFRA system, an IPF's payment amount for inpatient operating services is the lower of—

- The hospital-specific target amount multiplied by the number of Medicare discharges (the ceiling); or
- The hospital's average inpatient operating cost per case multiplied by the number of Medicare discharges.

In addition, under the TEFRA system, payments may include a bonus or relief payment, as follows:

- IPFs whose net inpatient operating costs are lower than or equal to the ceiling would receive the lower payment of—(1) the net inpatient operating costs plus 15 percent of the difference between the inpatient operating costs and the ceiling; or (2) the net inpatient operating costs plus 2 percent of the ceiling.
- IPFs whose net inpatient operating costs are greater than the ceiling, but less than 110 percent of the ceiling, would receive the ceiling payment.
- IPFs whose net inpatient operating costs are greater than 110 percent of the ceiling would receive the ceiling payment plus the lower of—(1) 50 percent of the difference between the 110 percent of the ceiling and the net inpatient operating costs; or (2) 10 percent of the ceiling payment.

Step 3: IPF Payments for Capital-Related Costs

Under the TEFRA system, in accordance with section 1886(g) of the Act, Medicare allowable capital-related costs are paid on a reasonable cost basis. Each IPF's payment for capital-related costs is taken directly from the cost report and updated for inflation using the excluded capital market basket.

Step 4: IPF Total Operating and Capital-Related Costs Under the TEFRA Payment System

Once estimated payments for inpatient operating costs were determined (including bonus and relief payments, as appropriate), we added the TEFRA adjusted operating payments and capital-related cost payments together to determine each IPF's total payments under the TEFRA payment system.

c. Payments Under the IPF PPS Without a Budget-Neutrality Adjustment

Consistent with the proposed rule, in this final rule, we used the 1997-based excluded hospital with capital market basket to trend the FY 2002 base year data to the midpoint of the IPF PPS implementation period and, for the purpose of applying a wage index adjustment, to establish the labor-related portion of the Federal per diem base rate.

In this final rule, by trending the cost using the applicable market basket increase factors, we updated the average per diem cost to the midpoint of the January 1, 2005 through June 30, 2006 implementation period. The updated average cost per day of $724.43 was then used in the payment model to project future payments under the IPF PPS.

The next step is to apply the associated wage index and all applicable patient-level and facility-level adjustments to determine the appropriate IPF PPS payment amount for each stay in the final payment model file.

C. Standardization of the Federal Per Diem Base Rate

We must standardize the IPF PPS payments in order to account for the overall positive effects of the final IPF PPS payment adjustment factors. The proposed standardization factor was calculated to be 17 percent. However, in the proposed rule, we included a 19-percent budget-neutrality adjustment and a 2-percent outlier adjustment, and

did not identify the percentage of the overall budget-neutrality adjustment that was attributable to standardization.

As was done in the proposed rule and in this final rule, to standardize the IPF PPS payments, we compared the IPF PPS payment amounts calculated from the psychiatric stays in the FY 2002 MedPAR file to the projected TEFRA payments from the FY 2002 cost report file updated to the midpoint of the IPF PPS implementation period. The standardization factor was calculated by dividing total estimated payments under the TEFRA payment system by estimated payments under the IPF PPS. The standardization factor was calculated to be 0.8367. As a result, the $724.43 Federal per diem base rate was reduced by 16.33 percent.

D. Calculation of the Budget Neutrality Adjustment

As we noted above, in the proposed rule we identified a 19-percent budget-neutrality factor, but did not break it out into separate components. In this final rule, we are identifying each component of the budget neutrality adjustment, that is, the outlier adjustment, stop-loss adjustment, and behavioral offset.

1. Outlier Adjustment

Since the IPF PPS payment amount for each IPF includes applicable outlier amounts, using an approach consistent with the proposed rule, we reduced the standardized Federal per diem base rate to account for aggregate IPF PPS payments estimated to be made as outlier payments. The appropriate outlier amount was determined by comparing the adjusted prospective payment for the entire stay to the computed cost per case. If costs were above the prospective payment plus the adjusted fixed dollar loss threshold, an outlier payment was computed using the applicable risk-sharing percentages, as explained in greater detail in section VI.D.1. of this final rule. The outlier amount was computed for all stays, and the total outlier amount was added to the final IPF PPS payment. The outlier adjustment was calculated to be 2 percent. As a result, the Federal per diem base rate includes a reduction of 2 percent.

2. Stop-Loss Provision Adjustment

As explained in detail in section VI.D.3. of this final rule, we will provide stop-loss payments to ensure that an IPF's total PPS payments are no less than a minimum percentage of their TEFRA payment, had the IPF PPS not been implemented. As with outlier payments, in this final rule, we reduced the standardized Federal per diem base rate by the percentage of aggregate IPF PPS payments estimated to be made for stop-loss payments.

The stop-loss payment amount was determined by comparing aggregate prospective payments that the provider would receive under the IPF PPS to aggregate TEFRA payments that the provider would have otherwise received without implementation of the IPF PPS. If an IPF's aggregate IPF PPS payments are less than 70 percent of its aggregate payments under TEFRA, a stop-loss payment was computed for that IPF. The stop-loss payment amounts were computed for those IPFs that were projected to receive the payments, and the total amount was added to the final IPF PPS payment amount. In our calculation, we needed to include a reduction of 0.39 percent in the standardized Federal per diem base rate to maintain budget neutrality in the final IPF PPS.

We note that the 0.39 percent adjustment due to the stop-loss provision is temporary in nature. This adjustment will be removed after the transition because, as explained in section IV.D.3. of this final rule, the stop-loss provision is applicable only during the transition period.

3. Behavioral Offset

As explained in the proposed rule, we expect that once the IPF PPS is implemented, IPFs may experience usage patterns that are significantly different from those they currently experience. For example, since the IPF PPS is a per diem system, IPFs might have an incentive to keep patients in the facility longer to maximize their use of beds or to receive outlier payments. In addition, the current TEFRA payment system does not depend on coding a principal diagnosis; however, payment will depend on properly coding the principal diagnosis under the IPF PPS. Therefore, we expect that IPFs will have an incentive to comprehensively code for the presence of comorbidities and ultimately the coding practice of IPFs should improve once the IPF PPS is implemented.

As a result of these behavioral changes, Medicare may incur higher payments than assumed in our calculations. These effects were taken into account when we calculated the proposed budget-neutral Federal per diem base rate. Accounting for these effects through an adjustment is commonly known as a behavioral offset.

Based on accepted actuarial practices and consistent with the assumptions made under the Inpatient Rehabilitation Facility PPS, we assumed in determining the behavioral offset, that IPFs would regain 15 percent of potential ''losses'' and augment payment increases by 5 percent. We applied this actuarial assumption, which is based on our historical experience with new payment systems, to the estimated ''losses'' and ''gains'' among the IPFs.

Comment: A few commenters disagreed with CMS's concern that the IPF PPS would provide an incentive for IPFs to increase length of stay. They stated that the incentive to increase length of stay already exists under the current TEFRA payment system. The commenters stated that under TEFRA, the longer the stay, the higher the payment as long as the hospital stays under its TEFRA limit.

Commenters stated that despite this incentive, length of stay has continuously declined over the last decade. One commenter mentioned that IPFs use clinical practice guidelines used by Quality Improvement Organizations, rather than Medicare reimbursement standards, to determine when a patient is ready for discharge.

Several commenters stated that they do not foresee any significant increase in length of stay for psychiatric admissions and recommended that CMS adopt a smaller behavioral offset initially. They suggested that the length of stay could easily be monitored by CMS and adjusted in the future, if necessary.

Response: Since per diem payment systems pay on a per day basis rather than a per discharge basis, there is an incentive to keep patients more days. Therefore, we believe that including a behavioral offset will make our calculations and impact analysis more accurate. We will monitor the extent to which current practice in IPFs changes such as how the average length of stay is affected by implementation of a per diem payment system and may propose adjustments to the behavioral assumptions, accordingly.

In addition to the length of stay, the final IPF PPS payment model depends on the accurate coding of diagnoses for the DRG and comorbidity adjustments. We expect that IPFs will try to code diagnoses for each stay more accurately after the implementation of the IPF PPS in order to receive payment adjustments. This behavior change could result in significantly higher Medicare payments to IPFs than we assumed when we calculated the final Federal per diem base amount.

The behavioral offset for the final IPF PPS was calculated to be 2.66 percent. As a result, we reduced the standardized Federal per diem base rate

by 2.66 percent to maintain budget neutrality.

To summarize, the proposed Federal per diem base rate with an outlier adjustment and budget neutrality with a behavioral offset was calculated to be $530. This amount included a 2-percent reduction to account for proposed outlier payments and a 19 percent reduction to account for budget neutrality and the behavioral offset to the Federal per diem base rate otherwise calculated under the methodology as described above. Of that 19-percent reduction, 17 percent is attributable to standardization, and 2 percent is attributable to the behavioral offset (see section V.C. of this final rule for an explanation of standardization).

Using the FY 2002 data for this final rule, the final budget-neutral Federal per diem base rate with an outlier adjustment, a stop loss provision with a behavioral offset is calculated to be $575.95. This amount includes a 16.33-percent reduction from $724.43 to account for standardization to the projected TEFRA per diem payment for the implementation period, a 2-percent reduction to account for outlier payments, a 0.39-percent reduction to account for stop-loss payments and a 2.66-percent reduction to account for the behavioral offset.

VI. Cost Regression Used To Develop Payment Adjustment Factors

In the proposed rule, we provided a detailed description of the data file used for the regression analysis, our trimming methods, and the limitations associated with IPFs reporting routine per diem costs as an average. As a result of the regression analysis, we proposed patient-level payment adjustments for age, DRG assignment based on patients' principal diagnoses, selected comorbidities, and a day of stay adjustment (the variable per diem adjustments) to reflect higher resource use in the early days of an IPF stay. We also proposed facility-level payment adjustments for wage area and rural location, and a teaching status adjustment.

Comment: One commenter stated that the regression models used in the proposed rule may not have appropriately modeled the data. The commenter believes that data entered into the regression model(s) are of a hierarchical nature, namely patients within facilities. Therefore, within a facility they cannot be considered independent observations, a requirement of simple regression models. To account for the fact that patients are nested within hospitals, hierarchical linear models need to be used. This will allow the covariance structure to be modeled. The commenter also believes that this will allow facility level variables to be modeled in the appropriate place. The commenter stated that although this would have to be explored, a model might estimate average facility costs while individual variability attributable to the patients and their covariates would be estimated separately.

Response: There are two parts to our response to this comment. The first part addresses why our data are not well-suited for the use of hierarchical linear models. The second part addresses the potential consequences for the payment adjustment factors of using ordinary least squares to estimate the cost regression instead of a method applicable for hierarchical linear models. We use ordinary least squares in the proposed rule as well as in this final rule.

First, the commenter is correct that, in principle, multi-level or hierarchical linear models would be appropriate for cost data that varied among patients within psychiatric facilities (commonly referred to as within group variation) and among psychiatric facilities (commonly called between group variation). However, in our cost data, each facility assigns the same per diem routine cost to all of its patients. As a result, there is no per diem routine cost variation among patients within the same facility, and, since routine costs are a large proportion of total cost, our measure of routine cost contains relatively little within group variation. In our data, ancillary cost differences are the only source of within group variation in per diem cost. This constraint substantially limits our ability to model patient effects within facilities. We concluded that under these circumstances, we are not able to meaningfully estimate a hierarchical linear model and that the data could be appropriately modeled using ordinary least squares.

Second, there are two potential consequences of using ordinary least squares to estimate the cost regression rather than a statistical method applicable for hierarchical models. According to statistical theory, the first consequence is that the standard errors of the regression coefficients may differ in the 2 cases. These differences could influence the conclusions drawn from tests of statistical inference about the role of the regression's independent variables (for example, patient age and length of stay) in explaining variation in per diem costs. The significance of this problem is that, potentially, we might develop a payment adjustment based on a variable that we believe to be a significant determinant of per diem cost, when we would not have developed a payment adjustment for that variable if we had estimated the cost regression using a statistical technique that would yield more accurate standard errors. To test whether this problem applies to our cost regression, we estimated the regression using a method applicable to hierarchical models.

As noted by the commenter, the advantage of hierarchical linear models is that they allow modeling of the covariance structure. The method we used (the SAS procedure named Proc Mixed) allows the user to select among alternative models of the data's covariance structure. Among the options in Proc Mixed, we used a random effects model with ''compound symmetry'' as a compromise between the assumptions of ordinary least squares and the completely unstructured case, which imposes no assumptions on the covariance structure. The results of this test were, as predicted by statistical theory, that the standard errors from Proc Mixed often differed from those estimated using ordinary least squares. However, there was no change in the conclusions drawn from statistical inference tests because the variables that were significant using ordinary least squares remained highly significant using Proc Mixed. As a result, both statistical techniques imply that the same variables are important determinants of per diem cost and, hence, potential candidates for payment adjustment factors.

The second potential statistical consequence of using ordinary least squares rather than a hierarchical model method to estimate the cost regression is that the size of the regression coefficients of the independent variables may be different. In turn, differences in regression coefficients will produce differences in sizes of the payment adjustment factors. However, statistical theory does not predict that the ordinary least squares estimates are subject to statistical bias. Furthermore, statistical theory implies that very large sample sizes such as ours will improve the accuracy of ordinary least squares estimates. Therefore, statistical theory does not imply that the regression coefficients estimated using ordinary least squares are necessarily less accurate than those estimated with Proc Mixed or a similar method.

Based on the three considerations just described, we believe that the statistical methods we used in the proposed and final rule enabled us to model the data appropriately. That is, although in principle our data is hierarchical, in

practice, it does not contain the full extent of variation at the patient and facility levels that would yield meaningful hierarchical modeling. In addition, our conclusions about which variables are important in explaining cost variation are not affected by our use of ordinary least squares. Finally, statistical theory of hierarchical modeling does not imply that there is necessarily a problem with the size of the regression coefficients obtained from ordinary least squares.

Comment: A commenter stated that CMS estimated a ''structural model'' rather than a ''payment model'' by including variables in the regression that were not used as payment adjustors (size and the occupancy rate). The commenter acknowledged that there is some debate about which type of model is most appropriate in constructing payment systems, but expressed the opinion that the ''research and policy community'' believes that payment models are preferred to structural models.

Response: This commenter is referring to two different approaches in using cost regressions to develop payment adjustments. In the ''payment model'' approach, the only independent variables included in the cost regression are those variables that are used as payment adjustments. In the ''structural model'' approach, all variables that are hypothesized to be important determinants of cost are included in the cost regression, whether or not they are going to be used as payment adjustments. Omitting ''structural'' variables from the cost regression will affect the sizes of the regression coefficients for ''payment'' variables if the omitted variables are correlated with some or all of the payment variables, which will in turn affect the magnitude of the payment adjustment factors. If omitted structural variables are completely uncorrelated with any of the payment variables, omission of the structural variables from the cost regression will lower the overall explanatory power of the regression, but will not affect the sizes of the regression coefficients for the payment variables. Debate over whether the payment or the structural approach is preferred generally centers on the case when one or more structural variables are positively correlated with one or more payment variables. In this case, the payment approach will result in paying for some of the effects of the omitted structural variable(s) via the payment adjustments of some of the payment variables. That is, the payment adjustment factors for some payment variables will be greater than they would have been had the structural model been used. The structural approach will result in smaller payment adjustment factors for some payment variables because the effects of the omitted structural variables are not reflected in the regression coefficients of those payment variables, but rather are captured by the regression coefficients of the structural variables included in the cost regression.

We believe the commenter is questioning whether CMS included variables in the cost regression that were not used as payment adjustors. The two variables cited in the comment are measures of facility size and occupancy. In fact, in neither the proposed nor the final rule did we include facility size in our cost regression. We followed the payment model approach with respect to the size variable because facility size has never been regarded as an acceptable payment variable in any of our prospective payment systems since it is a variable over which a facility has a substantial degree of control. However, in adopting the payment model approach for the size variable, we are allowing the effects of size to increase payment adjustment factors to the extent that facility size is positively correlated with acceptable payment variables. For example, small facilities that are small because of other factors such as rural location will be compensated for their higher costs due to those factors. Therefore, adopting a structural payment model approach would have adversely penalized small facilities and we recognize that small facilities may be important providers of psychiatric services in many circumstances. In the case of the occupancy rate, we adopted the structural approach and included the variable in the regression. Whether a facility is large or small, we think that it is appropriate to control for variations in the occupancy rate in estimating the effects of the payment variables on per diem cost to avoid compensating facilities for inefficiency associated with underutilized fixed costs.

Comment: A commenter asked whether the age and comorbidity variables identified the same groups of patients, and as a result, whether by including both variables in our regression, we were making the same adjustment twice.

Response: Although the presence of comorbidities is more common among the elderly, the age and comorbidity variables do not identify exactly the same groups of patients. In the proposed rule, the age variable grouped all patients over age 65 in the same category and the comorbidity variables identified 17 different conditions. Comorbidities were present for patients under age 65 as well as those over age 65. Further, since we identified 17 separate comorbid categories, some elderly patients have no comorbidities, others have a single comorbidity, and still others may have multiple comorbidities. Including the age and comorbidity variables in the regression does not measure the same adjustment twice, but rather utilizes the fact that the variables are not perfectly correlated to measure separate effects for age and comorbidities.

Comment: One commenter recommended that CMS compare the relationship between costs per day among the various types of IPFs to the same relationship among types of SNFs.

The commenter stated that hospital-based SNFs have higher per diem costs than freestanding SNFs, but the shorter lengths of stay for hospital-based SNFs result in approximately equal per case costs for freestanding and hospital-based SNFs.

Response: The government-operated psychiatric hospitals have relatively low per diem costs, relatively long lengths of stay, and relatively high per case costs. However, among the other main types of psychiatric facilities (non-profit hospitals, for-profit hospitals, and psychiatric units), there is a direct relationship between per diem and per case costs because lengths of stay are very similar for these types of facilities. Psychiatric units have the highest per diem and per case costs, followed by non-profit hospitals, and last by for-profit hospitals.

Comment: A few commenters suggested that CMS adopt the DRG methodology used under the IPPS instead of utilizing adjustment factors for age, comorbidities, and DRG assignment. The commenters believe that by using this method, the DRGs would be established for cases with and without the presence of comorbidities and for various age categories.

Response: As we discussed in the proposed rule, adopting a patient classification system based on diagnosis alone may not explain the wide variation in resource use among IPF patients. There is no indication that regrouping the psychiatric DRGs as the commenter suggests will explain more of the variation in per diem cost than the methodology we are adopting.

Since the DRGs are also used to pay inpatient psychiatric cases treated outside the distinct part psychiatric unit, we believe that before any basic changes to the DRG structure could be proposed, we would first need to conduct a thorough examination of the

potential effects on both the IPPS and the IPF PPS. We have not conducted such an approach because there was insufficient time, and we did not want to delay implementing the IPF PPS.

Comment: Several commenters described a recent study in which the researchers regrouped psychiatric diagnoses and comorbidities and included variables for certain activity of daily living deficits (toileting, transferring, and personal hygiene), patient dangerousness (strong suicide or assaultive tendencies), and patients who undergo electroconvulsive therapy (ECT). The commenters recommended that we adopt the study findings in the final IPF PPS.

Response: Although the commenters did not explicitly identify the study, we believe that they are referring to the CMS funded RTI International® (trade name of Research Triangle Institute) study of inpatient psychiatric care that was designed to complement the development of the IPF PPS. RTI International® addressed two major limitations of the administrative claims and cost report data available to CMS for the IPF PPS.

First, the administrative data only captures the uniform routine daily cost assigned to each patient treated in the same facility, so that no variation in routine daily cost can be observed for patients in the same facility, but who have different resource requirements. This artificial reduction in cost variation may impede efforts to accurately identify and measure the effects of certain patient characteristics. Second, the patient characteristics collected on the claims are limited to demographic and diagnostic information and do not include other characteristics that may be more important in explaining resource use.

The RTI International® study is noteworthy for its success in dealing with these two issues. First, RTI International® developed a measure of cost per patient day that captured variations in patients' daily resource use both within and across facilities. This task was accomplished by collecting information on the time spent in various activities by patients and facility staff over the course of a 3-shift day for a period of 7 days. After converting the staff time data to daily patient costs, RTI International® was able to go beyond the potential constraints of administrative data to study differences among patients across days of the stay.

Second, RTI International® collected a small set of patient characteristics that are not in CMS administrative data. They were able to test the importance of these variables in explaining cost variation. Most important among these factors were certain activities of daily living (toileting, transferring, and personal hygiene) and patient dangerousness (strong suicidal or assaultive tendencies).

Like virtually all studies that collect primary data for a sample population, RTI International® faced choices about how to obtain the most useful information possible with the limited funds available. RTI International® collected information for 4,149 Medicare patient days of care delivered to 834 unique Medicare patients in 40 facilities. We believe that RTI's sample is large enough to provide reliable information about the types of patients treated in all psychiatric facilities. However, the sample is small compared to even the typical 10 or 20 percent samples of the MedPAR data, and data collection costs made it uneconomical to sample all types of IPFs. In particular, rural facilities and small and government-operated hospitals could not be represented as robustly as other types of IPF providers.

In addition, although they collected data for 7 days in each facility, it was uneconomical to collect information for entire stays in a large number of cases. Also, in order to limit the costs of data collection, RTI International® did not collect ancillary service use, but instead relied on claims data for this information.

The findings of the RTI International® study have played an important role in the development of the IPF PPS in several ways. First, RTI International® analysis of its daily cost variable supports the use of the administrative data in developing the IPF PPS without being seriously misled about the relative importance of different variables. For example, both sets of analysis found age to be very important in explaining per diem cost variation. Although RTI International® elected to group diagnoses differently than using DRGs, both analyses supported prior findings that diagnosis plays a limited role in explaining cost variation. RTI International® also found ECT to be an important cost factor.

However, many other variables commonly thought to affect cost either produced inconsistent results or were found to have a minor effect, once more important factors were taken into account. Among these variables were cognitive impairment, risk of falls, Global Assessment of Function (GAF) score, gender, dual diagnosis, and number of medications.

Second, RTI International®'s analysis of cost variation by day of stay proved a very useful point of comparison for the variable per diem adjustment factors that we present in this rule. Third, the RTI International® study provides us with a starting point for future refinements of the IPF PPS. As noted above, RTI International®'s identification of certain patient characteristics not currently collected in the administrative data is very helpful for starting the process of considering whether we might want to collect some or all of these data items in the future. As a result of this research, we did not choose to adopt adjustment variables for activity of daily living deficits or patient dangerousness. We discuss the adjustment for patients who undergo ECT in section VI.B.6.of this final rule.

Comment: One commenter expressed the opinion that the regression results for the age and diagnosis variables would not be skewed by the inability of CMS routine cost variable to capture cost variations among patients within the same facility. The commenter further predicted that the research conducted by RTI International® would find that elderly psychiatric patients use fewer resources than younger patients.

Response: The commenter's prediction that RTI International® would find that elderly psychiatric patients use fewer resources than younger patients was not supported. RTI International® found, as we did in our cost regressions, that elderly patients are more costly than younger patients. There is no way to directly test the commenter's assertion that our regression results are not affected by the limitations of our routine cost variable. In addition, since the RTI International® data was able to capture cost variations among patients within the same facility and RTI International® had results similar to ours about the effects of diagnosis and age on per diem costs, this consistency in results leads us to believe our regression were accurate.

A. Final Regression Analysis

In this final rule, in order to ensure that the IPF PPS would be able to account adequately for each IPF's case-mix, we performed an extensive regression analysis of the relationship between the per diem costs and both patient and facility characteristics to determine those characteristics associated with statistically significant cost differences. For characteristics with statistically significant cost differences, we used the regression coefficients of those variables to determine the size of the corresponding payment adjustments.

The final IPF PPS payment adjustments were derived from a regression analysis of 100 percent of the

FY 2002 MedPAR data file because this was the best data available. The MedPAR data file used for the final regression analysis contains 483,038 cases that have a LOS of 1 day or more. We deleted 8,012 (1.66 percent) from this file because cost report or reasonable routine cost data for certain IPFs were not available. In order to include as many IPFs as possible in the regression, we substituted the FY 2001 Medicare cost report data for routine cost and ancillary cost-to-charge ratios (using the FY 2001 Medicare cost report data).

For the remaining 475,026 cases, we used the same method to trim extraordinarily high or low cost values that we used for the per diem rate development file and in the proposed regression analysis (see section V.A. of this final rule).

The trimming criteria eliminated another 3,490 cases, leaving 471,536 cases that were used in the final regression.

We computed a per diem cost for each Medicare inpatient psychiatric stay, including routine operating, ancillary, and capital components using information from the FY 2002 MedPAR file and data from the FY 2002 Medicare cost reports.

To calculate the cost per day for each inpatient psychiatric stay, routine costs were estimated by multiplying the routine cost per day from the IPF's FY 2002 Medicare cost report by the number of Medicare covered days on the FY 2002 MedPAR stay record. Ancillary costs were estimated by multiplying each departmental cost-to-charge ratio by the corresponding ancillary charges on the MedPAR stay record. The total cost per day was calculated by summing routine and ancillary costs for the stay and dividing it by the number of Medicare covered days for each day of the stay.

Since we will pay for emergency department (ED) costs of IPFs with qualifying EDs and IPFs that are part of hospitals with qualifying EDs, as described in section VI.B.5.b. of this final rule, through a specific adjustment to the day one variable per diem adjustment factor, ED costs were excluded from the dependent variable used in the cost regression. ED costs were excluded in order to remove the effects of ED costs from other payment adjustment factors with which ED costs may be correlated. We need to remove the effects on other payment adjustments to avoid overpaying ED costs. Removing ED costs from the regression has no effect on the calculation of the Federal per diem base rate or on budget neutrality because ED costs were not excluded from those calculations.

The log of per diem cost, like most health care cost measures, appears to be normally distributed. Therefore, the natural logarithm of the per diem cost was the dependent variable in the regression analysis. We included variables in the regression to control for psychiatric hospitals that do not bill ancillary costs and for ECT costs that we will pay separately (see the section VI.A. of this final rule).

The per diem cost was adjusted for differences in labor cost across geographic areas using the FY 2005 hospital wage index unadjusted for geographic reclassifications, in order to be consistent with our use of the market basket labor share in applying the wage index adjustment.

We computed a wage adjustment factor for each case by multiplying the Medicare 2005 hospital wage index based on MSA definitions defined by OMB in 1993 for each facility by the labor-related share (.72528) and adding the non-labor share (.27472). We used the 1997-based excluded hospital with capital market basket to determine the labor-related share. The per diem cost for each case was divided by this factor before taking the natural logarithm (that is, a standard mathematical practice accepted by the scientific community). The payment adjustment for the wage index was computed consistently with the wage adjustment factor, which is equivalent to separating the per diem cost into a labor portion and a non-labor portion and adjusting the labor portion by the wage index.

With the exception of the teaching adjustment, the independent variables were specified as one or more categorical variables. Once the regression model was finalized based on the log normal variables, the regression coefficients for these variables were converted to payment adjustment factors by treating each coefficient as an exponent of the base e for natural logarithms, which is approximately equal to 2.718. The payment adjustment factors represent the proportional effect of each variable relative to a reference variable.

B. Patient-Level Adjustments

We proposed adjustments for the DRG assignment of the patient's principal diagnosis, selected comorbidities, and patient age. The proposed rule included a discussion regarding a gender variable, however, we did not propose a gender adjustment.

1. Adjustment for DRG Assignment

In the proposed rule, we proposed adjustment factors for 15 diagnosis-related groups (DRGs). The adjustment factors were expressed relative to the most frequently reported DRG (DRG 430) and were derived from the proposed regression analysis. We did not propose payments under the IPF PPS for all DRGs that contain a psychiatric ICD–9–CM code because for some DRGs, there were too few psychiatric cases to obtain a reliable adjustment factor.

In this final rule, we are providing payment under the IPF PPS for all DRGs that contain a psychiatric ICD–9–CM code. However, as discussed later in this section, we are not providing a DRG adjustment for these cases.

We proposed that IPFs would continue to report diagnoses using the ICD–9–CM coding system. In addition, we specified that current regulations at § 412.27 require that a psychiatric unit admit only those patients who have a principal diagnosis that is listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM) or classified in Chapter Five (''Mental Disorders'') of the ICD–9–CM. We requested public comment on whether we should continue to reference the DSM. The DSM is currently in its fourth edition, text revision (DSM–IV–TR).

We received a significant number of public comments expressing support for the DSM, including several requesting that we permit IPFs to report diagnoses using DSM codes. Many comments asserted that the DSM provides a common language for psychiatrists and other health care professionals and sets forth diagnostic criteria for mental disorders and ways of measuring and reporting severity. Others agreed that the DSM established validity and provides standardized definitions.

Comment: One commenter indicated that Chapter Five of the ICD–9–CM is too limited to be the only diagnostic codes considered and that symptoms that are commonly treated in inpatient psychiatry include DSM codes that are not in the ICD–9–CM. Another commenter suggested that CMS use a combination or subset of diagnostic codes that includes codes that appear in both Chapter Five of the ICD–9–CM and the DSM–IV–TR.

One commenter expressed concern that misalignment between the DSM–IV–TR and the ICD–9–CM codes would cause underpayment of certain cases. The commenter recommended that CMS develop a modifier to the ICD–9–CM code to ensure that DSM codes

crosswalk to the most appropriate case mix weight.

Response: We agree that the DSM serves an essential function in the diagnosis and treatment of mental illness. For this reason, we are retaining the reference to the DSM in § 412.27 and updating the reference of the DSM–III–TR to the DSM–IV–TR. As explained in the proposed rule, we acknowledge that the DSM is routinely used by clinical staff to diagnose patients and plan treatment, while the ICD–9–CM coding system is currently used for reporting diagnostic information for payment purposes. However, the Standards for Electronic Transaction final rule published in the **Federal Register** on August 17, 2000 (65 FR 50312), identifies the ICD–9–CM as the designated code set for reporting diseases, injuries, impairments, other health related problems, their manifestations, and causes of injury, disease, impairment, or other health-related problems. As a result, the DSM codes may not be reported on Medicare claims.

Several commenters included examples of ICD–9–CM codes that do not crosswalk to the DSM–IV–TR, as well as DSM–IV–TR definitions and codes that do not crosswalk to the ICD–9–CM. Preliminary analysis of the codes confirmed the commenters' findings. We considered the possibility of using a modifier to crosswalk certain ICD–9–CM codes to their respective DSM–IV–TR counterpart, but found this method to be too complex and cumbersome for the purposes of billing since each ICD–9–CM code would require a modifier.

More importantly, as we previously explained in section VI of this final rule, we believe it is essential to maintain the same diagnostic coding for IPFs that is used under the IPPS for providing the same psychiatric care. For these reasons, we are not limiting the Chapter Five ICD–9–CM diagnosis codes that may be reported by IPFs under the IPF PPS at this time. We intend to continue our analysis as we implement the IPF PPS to ensure that we identify the appropriate ICD–9–CM codes for coding of patients' principal diagnoses.

We will reconsider these coding issues as we develop the FY 2006 hospital IPPS proposed rule in order to maintain consistent coding rules for all psychiatric cases.

Comment: One commenter asked why CMS used the existing DRGs, rather than developing new groupings for the DRG classification system based on current data. This commenter also asked whether the DRGs would change if they were designed to explain differences in cost per day, rather than cost per case.

Response: We did not attempt to modify the DRG classifications. (see section VI of this final rule for a detailed explanation). Our rationale for proposing to use the existing DRGs to group IPF PPS cases is that the DRGs are currently used to pay inpatient psychiatric cases under the hospital IPPS.

Instead of explicitly attempting to adapt the DRGs to a per diem system by changing the DRG definitions, we analyzed whether there was empirical support for using the existing DRGs. Specifically, we tested whether the DRGs contributed explanatory power to the explanation of differences in per diem costs. Although previous research indicates that diagnosis plays a limited role in explaining cost variation for psychiatric care, existing DRGs provide an acceptable degree of explanatory power.

Additional research will be needed to determine how the DRG classification system or payment weights under the IPPS would change if they were redesigned to measure cost per day.

Comment: One commenter requested that CMS delay implementation of the IPF PPS until the ICD–10–CM is adopted for Medicare billing purposes.

Response: The National Committee on Vital and Health Statistics (NCVHS) has recommended that HHS, under its HIPAA responsibilities, prepare a proposed regulation to require that the ICD–10–CM be adopted as the HIPAA standard code set to replace the ICD–9–CM. HHS is assessing the NCVHS recommendation. We do not believe it is appropriate to tie implementation of the IPF PPS to another initiative that has not been developed.

Comment: Many commenters requested that CMS adopt the clinical structure of the DSM (the DSM diagnostic categories) to classify IPF cases rather than the DRG classification system. A few commenters suggested that CMS use a modified version of the DSM diagnostic categories.

Response: We tested various groupings of diagnoses. Our data analysis indicated that regrouping the ICD–9–CM codes into the DSM diagnostic categories or other similar categories raised the explanatory power of the payment model by less than one-half of one percent. Thus, the DRGs and the DSM diagnostic categories explain the same amount of per diem cost differences. Moreover, the research conducted by THEORI, a research component of the Greater New York Hospital Association, confirmed our results. Therefore, since we were unable to detect a measurable difference in the explanatory power of the DSM and DRGs with respect to the grouping of the ICD–9–CM codes, we are finalizing the DRG approach.

As mentioned earlier, we are concerned about establishing a different classification scheme for IPF PPS than is used for psychiatric discharges under IPPS. We are also concerned about the fiscal burden associated with establishing a separate classification system for the IPF PPS.

As a result, this final rule includes adjustment factors for the DRG assigned to the claim. The coefficient values and adjustment factors were derived from the final regression analysis. The adjustment factors are expressed relative to DRG 430. See Table 3 at the end of this section and Addendum A.

Comment: Commenters overwhelmingly disagreed with the proposed policy to only pay for a limited selection of psychiatric diagnoses under the IPF PPS. The commenters indicated that all DRGs containing psychiatric codes should be recognized in the final IPF PPS. Other commenters recommended that CMS add a new DRG ''Other Psychiatric Diagnosis'' to include the ICD–9–CM diagnosis codes that are excluded when crosswalked to the DSM–IV–TR.

Response: As we explained earlier in this section, we agree that the IPF PPS should recognize all ICD–9–CM psychiatric codes regardless of their DRG assignment. Therefore, we will provide the Federal per diem base rate payment under the IPF PPS for claims with a principal diagnosis included in Chapter Five of the ICD–9–CM or the DSM–IV–TR. However, only those claims with diagnoses that group to a psychiatric DRG will receive a DRG adjustment. Although the IPF will not receive a DRG adjustment for a principal diagnosis not found in one of our identified 15 psychiatric DRGs, the IPF will still receive the Federal per diem base rate and all other applicable adjustments. Since there are only a few non-psychiatric DRGs that contain one or two rarely used psychiatric codes, whose frequencies were so low that we were unable to calculate an adjustment, we believe this is an equitable way to pay for these cases.

We have not established a new DRG for these psychiatric ICD–9–CM codes that are assigned to non-psychiatric DRGs. Rather, we plan to monitor the data from these other codes and, if indicated through data analysis, may consider proposing revisions to this policy in the future.

Comment: One commenter requested that we revise the DRG adjustment factor to 1.00 for DRG 433 Alchohol/Drug Abuse or Dependence, Left Against

Medical Advise. The commenter indicated that the 0.88 proposed adjustment factor would be insufficient to cover the extensive diagnostic procedures, complex treatment, and monitoring these patients often needed.

The commenter also indicated that since the total reimbursement for these patients is directly related to their length of stay, there should be no penalty attached to the DRG assignment.

Response: Our analysis did not indicate or reflect that a 1.00 adjustment was appropriate. The analysis, a cost regression analysis that used hospital claims data resulted in 0.88 adjustment factor for DRG 433 Alchohol/Drug Abuse or Dependence, Left Against Medical Advise. Unlike IPPS that uses DRG weights as the basis for payment, the IPF PPS payment is based on a Federal per diem base rate and numerous additional payment adjustments. In addition to DRG adjustments, the IPF PPS payment includes payment adjusters to accommodate differing lengths of stays (the variable per diem adjustment) that is intended to account for the increased cost in the early days of an inpatient stay. For more information on the variable per diem adjustments, see section VI.B.5 of this preamble.

Comment: A commenter asked for clarification as to the classification of substance abuse as a psychiatric condition.

Response: Substance abuse is not only included in Chapter Five (Mental Disorders) of the ICD–9–CM and defined in the DSM–IV–TR (Substance-Related Disorders) but is also included in the Psychiatric Boards, which physicians take to become Board Certified in the field of psychiatry. However, substance abuse is rarely the primary diagnosis for inpatient psychiatric treatment, and in those rare cases, there are generally mitigating factors to justify why the patient cannot be treated in an outpatient setting. To be covered as an inpatient hospital service, it must meet the criteria for being medically necessary.

TABLE--3 DRG and Adjustment Factor

Types of DRGs	DRG Code	Reg Coefficients	Adjustment Factors
Procedure w principal diagnosis of mental illness	DRG 424	0.1991	1.22
Acute adjustment reaction	DRG 425	0.0508	1.05
Depressive neurosis	DRG 426	-0.0117	0.99
Neurosis, except depressive	DRG 427	0.0162	1.02
Disorders of personality	DRG 428	0.0207	1.02
Organic disturbances	DRG 429	0.0291	1.03
Psychosis	DRG 430	0.0000	1.00
Childhood disorders	DRG 431	0.0063	0.99
Other mental disorders	DRG 432	-0.0835	0.92
Alcohol/Drug use, LAMA	DRG 433	-0.0319	0.97
Alcohol/Drug, w CC	DRG 521	0.0172	1.02
Alcohol/Drug, w/o CC	DRG 522	-0.0187	0.98
Alcohol/Drug use, w/o rehab	DRG 523	-0.1244	0.88
Degenerative nervous system disorders	DRG 12	0.454	1.05
Non-traumatic stupor & coma	DRG 23	0.0669	1.07

2. Comorbidities

In the proposed rule, we proposed 17 comorbidity categories and identified specific ICD–9–CM codes that would generate a payment adjustment. Our intent was to identify conditions that would require comparatively more costly treatment during an IPF stay than other comorbid conditions.

We specifically solicited comments on other conditions that may be expected to increase the per diem cost of care in IPFs. In response, we received a number of comments regarding our proposed comobidity adjustments. A number of commenters expressed support that the proposed IPF PPS recognized the increased cost associated with comorbid medical conditions. Others identified what they believe to be flaws in the analysis used to develop the proposed comorbidity adjustments. A majority of the commenters indicated that hospitals design specialized programs with highly trained staff to treat Medicare beneficiaries who are disabled or geriatric psychiatric patients. The commenters stated that the proposed comorbidity adjustments are inadequate to capture these coexisting medical and psychiatric conditions requiring treatment during a hospital stay.

We also received comments offering suggestions on how we could improve the comorbidity list. The suggestions ranged from a request for addition of a single ICD–9–CM code to a request for comorbidity categories to account for every ICD–9–CM and DSM–IV–TR diagnosis.

Comment: Commenters expressed concern that payment for treating complex cases would decrease because the proposed comorbidity list does not include the conditions seen in their patient populations. Several comments stated that most psychiatric patients are treated for multiple common conditions and illnesses (for example, heart conditions, stroke), none of which would trigger a payment adjustment under the proposed IPF PPS.

Other commenters stated that the proposed comorbidity list includes mostly acute medical conditions that would require transfer to an acute care hospital. One commenter indicated that the adjustment proposed for renal failure should be much higher. Many commenters stated that the range of diagnostic codes proposed for adjustment often did not include all the ICD–9–CM codes within a diagnostic category. For example, the list of codes under diabetes did not include all the diabetes codes.

Response: We have reconsidered our approach to the comorbidity adjustments and have revised the comorbidity list. We analyzed the FY 2002 data to determine the prevalence of the diagnoses suggested most often in the public comments (for example,

hypertension, chronic constructive pulmonary disease, and urinary tract infection). In an attempt to address the commenters concerns, we had CMS staff physicians and FI Medical Directors who are psychiatrists review the list of proposed comorbidities and cost and frequency data on all ICD–9–CM diagnoses codes that had been submitted on the FY 2002 claims.

We explained to the CMS staff physicians and FI Medical Directors that the data used in calculating the Federal per diem base rate for both the proposed rule and the final rule included all the costs for comorbid diagnoses submitted in the FY 2002 claims. Therefore, the cost for providing patient care (for example, medications, and routine nursing care required for the common conditions seen in the psychiatric population and recommended for comorbidity adjustment by the commenters (that is, heart conditions or strokes) are included already in the Federal per diem base rate and a comorbidity adjustment for their presence was unnecessary.

One significant issue raised by the CMS physician and FI Medical Director panel was the extent of medical treatment permitted in a psychiatric unit. In the secure environment of a psychiatric unit, common treatments such as IV antibiotics therapy would not be permitted as they could compromise patient safety. The prohibition of items that present a potential risk as a mechanism to inflict injury on oneself or others is strictly enforced. Thus, for many medical treatments for the more complex and costly comorbid, medical, or surgical conditions the psychiatric patient would be required to be moved to a medical floor for treatment with one-on-one staff observation. Consequently, since the patient would no longer be a patient of the IPF, it would be unnecessary to give the IPF an adjustment for such a case.

The intent of the comorbidity adjustments is to provide additional payments for a concurrent medical or psychiatric condition that is expensive to treat. The physicians determined that the high cost of certain diagnoses is related to the cost of the therapy to treat the diagnoses. For example, the cost to treat a patient with a malignant neoplasm is related primarily to the cost of the therapy to treat the tumor, whether it is chemotherapy or radiation therapy, or both. As a result, we have added two ICD–9–CM V codes, one for chemotherapy (V58.0) and for one radiation treatment (V58.1). We are also requiring that, in order to receive the comorbidity adjustment for malignant neoplasm, IPFs will need to code the ICD–9–CM code for the specific malignant neoplasm from the ICD–9–CM chapter 2 codes (140–239) and one of the two ICD–9–CM procedures codes (chemotherapy ((V58.0)) or radiation treatment ((V58.1)) to indicate the treatment modality the patient received.

Based on the clinical expertise of the CMS physicians and FI Medical Directors, we made numerous changes to the list of ICD–9–CM codes eligible for a comorbidity adjustment. These changes include adding one new category entitled, ''Developmental Disabilities,'' deleting the ''HIV'' category and moving it into the ''Infectious Diseases'' category, and changing the titles of two categories from ''Malignant Neoplasms'' to ''Oncology Treatments'' and for ''Atherosclerosis of extremity with Gangrene'' to ''Gangrene.''

In response to comments requesting adjustment for Developmental Disabilities and the results of the regression analysis on the FY 2002 data, the higher cost of caring for patients with developmental disabilities indicated a comorbidity adjustment of 1.04 was appropriate. The regression analysis of FY 2002 data would have provided the same adjustment for the ''HIV'' category as for the ''Infectious Disease'' category. Therefore, we merged the two categories under the ''Infectious Disease'' category with an adjustment factor of 1.07. The ''Malignant Neoplasm'' category was modified to ''Onocology Treatments'' since the CMS staff physicians and FI Medical Directors believed the higher cost was related to the treatment of the neoplasms rather than the presence of the tumor. We are also requiring that the treatment code be included on the claim form to receive the 1.07 comorbidity adjustment. The last category change was in the title of ''Atheroscleosis of Extremity with Gangrene to ''Gangrene'' to account for the higher cost of a patient with gangrene regardless of the cause.

The design of the IPF PPS with Federal per diem base rate, together with the numerous available adjustments, outlier policy, and stop loss policy during the 3-year transition should prevent the facility from being disadvantaged by decrease in payment for their more complex patients.

We are providing below a table that compares the proposed comorbidity categories to the categories we are adopting in this final rule.

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TABLE 4--Comparison of the Proposed Comorbidity Categories and changes *to the* Comorbidity Categories in this Final Rule.

Category	ICD Codes Proposed Rule	Changes in Final Rule
HIV	042	Delete HIV category - - Moved code 042 to Infectious Disease Category
Developmental Disabilities		Add 317, 318.0, 318.1, 318.2, and 319
Coagulation Factor Deficit	2860 through 2864	2860 through 2864
Tracheostomy	51900 and V440	51900 through 51909 and V440
Renal Failure, Acute	5846 through 5849, 7885, 9585, V451, V560, V561, and V562	5845 through 5849, 6363, 6373, 6383, 6393, 66932, 66934, 9585
Renal Failure, Chronic	40301, 40311, 40391, 40402, 40412, 40492, 585, and 586	40301, 40311, 40391, 40402, 40403, 40412, 40413, 40492, 40493, 585, 586, V451, V560, V561, and V562
Oncology Treatment	1400 through 1720, 1740 through 1840, and 1850 through 2080	Delete title and replace with Oncology Treatment 140 though 2399 WITH either V580 or V581
Uncontrolled Type I Diabetes Mellitus, with or without complications	25003, 25013, 25023, 25033, 25043, 25053, 25063, 25073, 25083, and 25093	25002, 25003, 25012, 25013, 25022, 25023, 25032, 25033, 25042, 25043, 25052, 25053, 25062, 25063, 25072, 25073, 25082, 25083, 25092 and 25093
Severe Protein Calorie Malnutrition	260 through 262	260 through 262
Eating and Conduct Disorders	3071, 30750, 31203, 31233 and 31234	3071, 30750, 31203, 31233 and 31234
Infectious Diseases	0100 through 0411, 04500 through 05319, 05440 through 05449, 0550 through 0770, 0782 through 0789, and 07950 through 07595 (07595 was error -correct code 07959)	0100 through 04110, 042, 04500 through 05319, 05440 through 05449, 0550 through 0770, 0782 through 07889,and 07950 through 07959
Drug and/or Alcohol Induced Mental Disorders	2910, 2920, 2922, 30300, and 30400	2910, 2920, 29212, 2922, 30300, and 30400
Cardiac Conditions	3910, 3911, 3912, 40201, 4160, and 4210	3910, 3911, 3912, 40201, 40403, 4160, 4210, 4211 and 4219
Atherosclerosis of Extremity with Gangrene	44024	Change Category Title to read "Gangrene" 44024 and 7854
Chronic Obstructive Pulmonary Disease	5100, 51883, 51884, 4920, 494 49120 through 49122 and V461	49121, 4941, 5100, 51883, 51884, and V461
Artificial Openings - Digestive and Urinary	56960, V441 through V443, and V4450	56960 through 56969, 9975, and V441 through V446
Severe Musculoskeletal and Connective Tissue Diseases	6960, 7100, 73000 through 73009, 73010 through 73019, 73020 through 73029, and 7854	6960, 7100, 73000 through 73009, 73010 through 73019, and 73020 through 73029
Poisoning	96500 through 96509, 6954, 9670 through 9700, 9800 through 9809, 9830 through 9839, 986, and 9890 through 9897	96500 through 96509, 9654 9670 through 9699, 9770, 9800 through 9809, 9830 through 9839, 986, and 9890 through 9897

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Comment: Several commenters suggested that CMS include all psychiatric and non-psychiatric diagnoses submitted on the claim, whether they are designated as the primary or secondary.

Response: Billing instructions require hospitals to enter the ICD–9–CM code for the patient's principal diagnosis. The code must be the full ICD–9–CM diagnosis code, including all five digits when applicable. The principal diagnosis is the condition established after study to be chiefly responsible for this admission. Even though another diagnosis may be more severe than the principal diagnosis, the hospital enters the principal diagnosis. Entering any other diagnosis as principal on the claim form may result in incorrect DRG assignment and cause the hospital to be incorrectly paid. The hospital is also instructed to enter the full ICD–9–CM codes for up to 8 additional conditions if they co-existed at the time of admission or develope subsequently, and which had an effect upon the treatment or the length of stay. These codes may not duplicate the principal diagnosis.

The regression analysis established the DRG adjustment factors based on the principal diagnoses reported by hospitals and the comorbidity category adjustments based on the all the diagnoses reported by hospitals as other diagnoses. The principal diagnoses were used to establish the DRG adjustment and were not accounted for in establishing the comorbidity category adjustments, except where ICD–9–CM ''code first'' instructions apply. A description of the ''code first'' instructions appears in the next section of this final rule.

Comment: Several commenters indicated that the comorbidity adjustment factors did not take into account the extensive workup their patients require, such as the need for additional ancillary services (for example, specific medical or neurological examinations, specialized laboratory and radiological tests, supplies, medications, and consultations). In many instances, the commenter stated that these additional services are needed to identify the numerous physical conditions that exacerbate or first present as psychiatric symptoms.

Response: The adjustment factors for the proposed comorbidity categories were derived from the proposed regression analysis. Similarly, the final adjustment factors for the final comorbidity categories were derived from the final regression analysis. With regard to the additional ancillary services the commenters' patients require to establish their principal diagnoses, the variable per diem adjustments discussed in section VI.B. 5. of this final rule are intended to account for higher per diem costs early in an inpatient stay.

Comment: Commenters expressed concern that the comorbidity policy does not account for the costs associated with social issues (for example, poverty, lack of housing, poor nutrition, lack of primary medical care, and the cost of involuntary commitments and guardianship hearings). The commenters also expressed concern that the comorbidity policy does not account for the costs of patients with hearing, sight, and mobility disabilities or when English is not the patient's primary language.

Response: Most of the social issues identified by the commenters are not captured in the FY 2002 IPF claims data. As a result, we are not able to determine whether the psychiatric hospitalizations of patients with various social issues are more costly on a per diem basis than other psychiatric patients. Because we lack data that indicates IPFs that treat patients with various social issues are more costly on a per diem basis, we are not providing an adjustment in these cases.

We note that codes are currently available that describe some of the social issues that impact care delivery and management. For example, there are V codes to indicate that the patient has problems with sight (V41.0), problems with hearing (V41.2), or lack of housing (V60.0). Even though we have codes for problems with sight, hearing, or lack of housing, we had too few cases to be able to extrapolate any valuable empirical data that the presence of these codes correlated to higher per diem costs. We encourage IPFs to code all relevant diagnoses that impact the resources associated with their patient population for future analysis.

We note that one of the fields on the claim form indicates if patients were referred to the IPF by law enforcement or if the commitment were court ordered (FL 20 item 8, court/law enforcement). As a result, we were able to analyze the impact on per diem cost. The results of our analysis are included in section VI of this rule with other patient variables considered.

Comment: One commenter stated that diagnostic data alone may not be descriptive enough to supply the information CMS is seeking regarding comorbidities.

Response: Section 124 of the BBRA provides authority for CMS to require IPFs to submit additional data. We are not mandating new reporting requirements at this time, however, we may establish new reporting requirements based on results of the research underway to refine the IPF PPS.

Comment: One commenter asked how the comorbidity adjustment would be applied if a patient has multiple diagnoses within the same comorbidity category.

Response: IPFs may only receive one adjustment factor for each comorbidity category. However, if a patient has multiple diagnoses in several categories, the adjustment factors for each applicable category are multiplied by the Federal per diem base rate. The following is an example illustrating how payment would be made under the IPF PPS for a patient with multiple comorbidities.

Example: A 68 year old Female Caucasian presents at a qualified ED and is subsequently admitted to a non-teaching inpatient psychiatric facility within the ''I'll Feel Better Hospital'' in rural Smalltown, North Dakota. The ED is determined to be full-service and the patient had not been discharged from an IPPS stay. The patient had a primary diagnosis of Neurotic Depression (IDC–9–CM code 3004) DRG 426 Depressive Neuroses, and comorbid conditions of Obstructive Chronic Bronchitis without exacerbation 491.20, and mechanical complication of Tracheostomy ICD–9–CM code (ICD–9–CM code 519.02), Diabetes with ophthalmic manifestations (ICD–9–CM code 250.53), and Diabetes with peripheral circulatory manifestations (ICD–9–CM code 250.73). The patient length of stay was 10 days. In addition, the patient did not receive ECT during her inpatient stay.

EXAMPLE OF PAYMENT CALCULATION

Type of Adjuster	Example-Related Data	Adjustment Factor
Age	Patient Age =68 years of age	1.10
DRG	Principal Diagnosis--DRG 426 Depressive Neuroses	0.99
Comorbidity	Comorbidity--491.20 Obstructive Chronic Bronchitis without exacerbation Chronic Obstructive Pulmonary Disease Category	------
	Comorbidity--519.02 Mechanical complication of Tracheostomy – Tracheostomy Category	1.06
	Comorbidity--250.53 Diabetes with ophthalmic manifestations Diabetes Category	1.05
	Comorbidity--250.73 Diabetes with peripheral circulatory manifestations Diabetes Category (second diagnosis in same comorbidity category)	-----
ECT Treatments	None received	-----
Variable per diem adjustment	10	------
Patient admitted after IPPS discharge	No	------
Day 1	Facility with a Full-service ED	1.31
Day 2		1.12
Day 3		1.08
Day 4		1.05
Day 5		1.04
Day 6		1.02
Day 7		1.01
Day 8		1.01
Day 9		1.00
Day 10		1.00
Rural Location	Yes	1.17
COLA	No	-----
Teaching	No	-----
Wage Index Factor	Based on IPF location in North Dakota	0.7743
*Federal Per Diem Base Rate		575.95
Labor Portion of Federal Per Diem Base Rate	0.72528 x 575.95	417.73
Non-Labor Portion of the Federal Per Diem Base Rate	0.27472 x 575.95	158.22

*Federal Per Diem Base Rate (found in the addendum) $575.95

Calculate Total Wage Adjusted Rate:

Step 1: Multiply the *Wage Index Factor* (for North Dakota) by the Labor Portion of the Federal base rate to get the *Adjusted Labor Portion* of the Federal per diem base rate = (0.7743 x 417.73 = $323.45).

Step 2: Add the *Adjusted Labor Portion of the Federal Base Rate* to the *Non-Labor Portion* of the Federal per diem base rate to get the *Total Wage Adjusted Rate* = (323.45 + 158.22 = $481.67).

Apply Facility- and Patient-Level Adjusters

Step 1: Using the information in Addendum A, determine which facility- and patient-level adjustment factors are applicable.

1. Teaching Adjustment: None.

2. Rural Adjustment: North Dakota—1.17.

3. COLA: None.

4. DRG Adjustment: DRG 426—Depressive Neuroses—0.99.

5. Age Adjustment: Age 68—1.10.

6. *Comorbidity* (All comorbidity codes are cited as presented in the ICD–9–CM text)

Comorbidity 491.20—Obstructive Chronic Bronchitis without exacerbation—None.

Comorbidity 519.02: Mechanical complication of Tracheostomy—1.06.

Comorbidity 250.53: Diabetes with ophthalmic—manifestations (*Use additional code to identify manifestation as* 362.02)—1.05.

Proliferative Diabetic Retinopathy [*not allowed as principal Dx–"CODE FIRST" underlying disease as DIABETES 250.5*) and Comorbidity—250.73—Diabetes with peripheral Circulatory—None 2nd in Category manifestations, (*Use additional code to identify manifestation as* 443.81—Diabetic Peripheral angiopathy [*not allowed as principal Dx–"CODE FIRST" underlying disease as DIABETES MELLITUS 250.7*).

7. ECT Treatments—None.

Step 2. Multiply the applicable adjustment factors to determine the *PPS Adjustment Factor.* = (1.17 x 0.99 x 1.10 x 1.06 x 1.05 = 1.4181).

Step 3. Calculate the Adjusted Per Diem.

Multiply the Total Wage Adjusted Rate by the PPS Adjustment Factor.
= ($481.67 x 1.4181 = 683.06).

Calculate the variable per diem adjustment.

Step 1. Determine the number of days in the stay.

Length of Stay: 10 days and the facility has a qualifying ED.

Day 1—1.31
Day 2—1.12
Day 3—1.08
Day 4—1.05
Day 5—1.04
Day 6—1.02

Day 7—1.01
Day 8—1.01
Day 9—1.00
Day 10—1.00

Step 2. Multiply the *Variable Per Diem Adjustment Factors* by the Total Wage and PPS-Adjusted Per Diem for each day of the stay to get the *Total Variable Per Diem Amounts* for each day of the stay. (See multiplication in step 3 below.)

Step 3. Add the *Adjusted Variable Per Diem Amounts* to get the *Total Inpatient Psychiatric Facility PPS Payment.*

Day 1 (adjustment factor 1.31) × 683.06 = $894.81
Day 2 (adjustment factor 1.12) × 683.06 = $765.03
Day 3 (adjustment factor 1.08) × 683.06 = $737.70
Day 4 (adjustment factor 1.05) × 683.06 = $717.21
Day 5 (adjustment factor 1.04) × 683.06 = $710.38
Day 6 (adjustment factor 1.02) × 683.06 = $696.72
Day 7 (adjustment factor 1.01) × 683.06 = $689.89
Day 8 (adjustment factor 1.01) × 683.06 = $689.89
Day 9 (adjustment factor 1.00) × 683.06 = $683.06
Day 10 (adjustment factor 1.00) × 683.06 = $683.06
Federal per diem payment amount $7,267.75

Comment: A commenter asked if the comorbidity adjustments would be applied to each day of the stay regardless of the patient's length of stay. For example, poisoning and arteriosclerosis of the extremity with gangrene may have higher cost only for the early days of a stay.

Response: The comorbidity adjustments are applied to each day of the stay. In estimating the cost impact of the comorbidity conditions, our dependent variable reflects the average cost per day over the entire stay. A significant effect on this cost variable for a comorbidity condition means that the average cost per day was higher for cases with the specific condition. Therefore, it is appropriate to apply the estimated effect to each day of the stay.

We would be especially concerned if data analysis began to show longer lengths of stay for DRG 424 stays or significantly more DRG 424 stays, with DRG 424 being the surgical DRG. We intend to monitor for changes in length of stay and the distribution of IPF cases across DRGs to ensure that the decision to pay all applicable adjustments throughout the stay does not lead to inappropriate increases in the length of stay or frequency of those cases.

Comment: One commenter indicated that the comorbidity policy does not distinguish between dormant serious medical conditions and labor-intensive procedures requiring additional behavioral and medical treatments during the IPF stay. Another commenter stated that when a non-psychiatric diagnosis exists in addition to a psychiatric diagnosis, the ICD–9–CM code for the non-psychiatric diagnosis should also be reported on the claim.

Response: In § 412.402 definitions, we proposed the following definition of comorbidity: ''Comorbidity means all specific patient conditions that are secondary to the patient's primary diagnosis and that coexist at the time of admission, develop subsequently, or affect the treatment received or the length of stay or both. Diagnoses that relate to an earlier episode of care that have no bearing on the current hospital stay are excluded.'' A serious medical condition that does not require treatment during the hospital stay must not be reported as a secondary or tertiary diagnosis and will not qualify for a comorbidity adjustment. We are retaining the proposed comorbidity definition in this final rule.

Comment: One commenter recommended that we provide an adjustment to reflect the increased staffing, greater frequency of comorbid conditions, and longer length of stay for developmentally disabled patients.

Response: We analyzed the frequency and costs in the FY 2002 claims data associated with developmentally disabled patients. We identified relevant claims by the presence of an ICD–9–CM code in the 317 through 319 range entered as a diagnosis in addition to a psychiatric principal diagnosis. We found that per diem costs associated with inpatient psychiatric stays of developmentally disabled mentally ill patients, are approximately 4 percent higher than stays for other patients. As a result of this analysis, we are establishing a new comorbidity category to reflect the higher per diem costs of developmentally disabled patients. The final IPF PPS comorbidity categories and adjustment factors are presented in the table below and Addendum A.

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TABLE 5--Diagnosis Codes and Adjustment Factors for Comorbidity Categories

Description of Comorbidity	ICD-9CM Code	Adjustment Factor
Developmental Disabilities	317, 318.0, 318.1, 318.2, and 319	1.04
Coagulation Factor Deficits	2860 through 2864	1.13
Tracheotomy	51900 - through 51909 and V440	1.06
Renal Failure, Acute	5845 through 5849, 6363, 6373, 6383, 6393, 66932, 66934, 9585,	1.11
Renal Failure, Chronic	40301, 40311, 40391, 40402, 40403, 40412, 40413, 40492, 40493, 585, 586, V451, V560, V561, and V562	1.11
Oncology Treatment	1400 through 2399 WITH either V58.0 OR V58.1	1.07
Uncontrolled Type I Diabetes-Mellitus with or without complications	25002, 25003, 25012, 25013, 25022, 25023, 25032, 25033, 25042, 25043, 25052, 25053, 25062, 25063, 25072, 25073, 25082, 25083, 25092, and 25093	1.05
Severe Protein Calorie Malnutrition	260 through 262	1.13
Eating and Conduct Disorders	3071, 30750, 31203, 31233, and 31234	1.12
Infectious Disease	01000 through 04110, 042, 04500 through 05319, 05440 through 05449, 0550 through 0770, 0782 through 07889, and 07950 through 07959	1.07
Drug and/or Alcohol Induced Mental Disorders	2910, 2920, 2922, 30300, and 30400	1.03
Cardiac Conditions	3910, 3911, 3912, 40201, 40403, 4160, 4210, 4211, and 4219	1.11
Gangrene	44024 and 7854	1.10
Chronic Obstructive Pulmonary Disease	49121, 4941, 5100, 51883, 51884, and V461	1.12
Artificial Openings - Digestive and Urinary	56960 through 56969, 9975, and V441 through V446	1.08
Severe Muscloskeletal and Connective Tissue Diseases	6960, 7100, 73000 through 73009, 73010 through 73019, and 73020 through 73029	1.09
Poisoning	96500 through 96509, 9654, 9670 through 9699, 9770, , 9800 through 9809, 9830 through 9839, 986, 9890 through 9897	1.11

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3. Other Coding Issues

We received several comments related to discrepancies with established coding conventions.

Comment: One commenter requested that CMS specify that hospitals must follow the ICD–9–CM Official Guidelines for Coding and Reporting and the Coding Clinic for ICD–9–CM. In addition, the commenter advocated the use of certified coding professionals to assign and validate codes and assist in the development of hospital coding policy.

Response: We agree with the commenter about the value of certified coding professionals. The ICD–9–CM Official Guidelines for Coding and Reporting was developed and approved by the Cooperating Parties for ICD–9–CM: The American Hospital Association, the American Health Information Management Association, the Centers for Medicare & Medicaid Services (formerly the Health Care Financing Administration or HCFA) and the National Center for Health Statistics to be used as a companion document to the official version of the ICD–9–CM as

published by the Department of Health and Human Services and the Coding Clinic for ICD–9–CM, published by the American Hospital Association. In addition, this decision is consistent with the Standards for Electronic Transaction final rule (65 FR 50312). The ICD–9–CM Official Guidelines for Coding and Reporting can be found at *www.cdc.gov/nchs/data/ics9/icdguide.pdf*.

Comment: Several commenters requested that CMS provide detailed information about medical necessity requirements to support an IPF stay. The commenters expressed concern that IPFs are not experienced with medical review and the need to document medical necessity to support the stay. The commenters believe that in the absence of clear national standards for determining medical necessity, IPFs will be subject to various local coverage decisions promulgated by FIs.

Other commenters were concerned about the potential of differential access to inpatient psychiatric care depending on the geographic location of the IPF and how each FI interprets medical necessity. These commenters suggested that CMS incorporate safeguards against clinically unrealistic, inefficient, or inappropriate medical review practices by FIs. The commenters recommended that CMS include a mechanism for impartial appeal of FI decisions to ensure appropriate payment of IPF claims.

Response: Inpatient psychiatric services are intended for patients that require more intense services than can be provided in an outpatient setting. As a result, the patients admitted to an IPF must require intensive, comprehensive, multimodal treatment including 24 hours per day of medical supervision and coordination because of the mental disorder. The need for 24 hours of supervision may be due to the need for patient safety, psychiatric diagnostic evaluation, potential severe side effects of psychotropic medication associated with medical or psychiatric comorbidities, or evaluation of behaviors consistent with an acute psychiatric disorder for which a medical cause has not been ruled out.

The acute psychiatric condition being evaluated or treated by inpatient psychiatric hospitalization must require active treatment, including a combination of services (for example, intensive nursing and medical interventions, psychotherapy, occupational and patient education). Patients must require inpatient psychiatric hospitalization services at levels of intensity and frequency exceeding what may be rendered in an outpatient setting including partial hospitalization programs.

If a provider receives a medical necessity denial, they have the right to appeal the FI's determination that the inpatient hospital services were not reasonable and necessary. A request for reconsideration must be in writing and filed with the FI. The provider should contact their FI for additional information on the appeal process. The prescribed form to request an FI reconsideration ''MCS–2649, Request for Reconsideration of Part A Health Insurance Benefits'' is located on the CMS web site at *www.cms.hhs.gov/forms*.

Comment: Several commenters indicated that the proposed rule included coding policies that were inconsistent with the ICD–9–CM Official Guidelines for Coding and Reporting with respect to the designation of primary and secondary diagnoses (the ''code first'' policy).

Response: In the proposed rule, we inadvertently failed to include the ICD–9–CM instructions pertaining to the code first diagnosis codes. The introduction of the ICD–9–CM text includes ''Instructional Notations'' in which ''code first'' underlying disease is explained. This instruction is for codes that are not intended to be used as a principal diagnosis or for those codes that are not to be sequenced before the underlying disease. The note requires that the underlying disease (etiology) be coded first (identified as the principal and diagnosis) with the code the note is applied to being coded second. This note appears only in the Tabular List (Volume 1).

The ICD–9–CM Official Guidelines for Coding and Reporting includes the following instructional guidance regarding the code first policy:

''(1) The guidelines identify codes that have both an underlying etiology and multiple body system manifestations due to the underlying etiology. The coding convention requires the underlying condition be sequenced first followed by the manifestation. Whenever a combination exists, there is a ''use additional code'' note at the etiology code, and a ''code first'' note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes, that is, etiology followed by manifestation.

(2) ''Code first'' notes are also under certain codes that are not specifically manifestation codes but may be due to an underlying cause. When a ''code first'' note is present and an underlying condition is present, the underlying condition should be sequenced first.

(3) Code, if applicable any causal condition first, notes indicate that this code may be assigned as a principal diagnosis when the causal condition is unknown or not applicable. If a causal condition is known, then the code for that condition should be sequenced as the principal or first-listed diagnosis.

(4) Multiple codes may be needed for late effects, complications and obstetrics to more fully describe a condition. See the specific guidelines for these conditions for further instruction.''

For example, diagnosis code 294.1 Dementia in Conditions Classified Elsewhere is designated as a code first diagnosis and appears in the ICD–9–CM as follows:

294.1 Dementia in Conditions Classified Elsewhere

Code first any underlying physical condition, as:

Dementia in:

Alzheimer's disease (331.0)
Cerebral lipidosis (330.1)
Dementia with Lewy bodies (33.82)
Dementia with Parkinsonism (331.81)
Epilepsy (345.0–345.9)
Frontal dementia (331.19)
Frontotemporal dementia (331.19)
General paresis [syphilis] (094.1)
Hepatolenticular degeneration (275.1)
Huntington's chorea (333.4)
Jacob-Creutzfeldt disease (046.1)
Multiple sclerosis (340)
Pick's disease of the brain (331.11)
Polyarteritis nodosa (446.0)
Syphilis (094.1)

In accordance with the ICD–9–CM Official Guidelines for Coding and Reporting, when a primary (psychiatric) diagnosis code has a ''code first'' note, the provider would follow the instructions in the ICD–9–CM text. For example, 294.1, *Dementia in conditions classified elsewhere* states ''code first any underlying physical condition as:'' the provider would then code the appropriate physical condition, for example, 333.4 Huntington's chorea as the primary diagnosis and 294.1 as the secondary diagnosis. The submitted claim goes through the CMS processing system that will identify the primary diagnosis code as non-psychiatric and search the secondary codes for a psychiatric code to assign a DRG code for adjustment. The system will continue to search the secondary codes for those that are appropriate for comorbidity adjustment.

A list of ICD–9–CM codes identified as code first is provided in Addendum C.

Comment: A commenter questioned whether IPFs would be required to report ICD–9–CM procedure codes.

Response: IPFs will be required to report those ICD–9–CM codes indicated in the billing instructions. As mentioned above, the only unique coding will be for oncology treatment which requires the ICD for the specific neoplasm and the appropriate treatment V code V580 chemotherapy or V581 radiation. In addition, as discussed in section VI.B.5.C. of this final rule, we are providing additional payments for patients who undergo ECT treatments. In order to receive the additional payments, IPFs will have to report the ICD–9–CM procedure code for ECT (code 90870) and indicate the number of ECT treatments the patient received during the IPF stay. We encourage IPFs to provide as much information on the claim form to describe the services furnished to validate the principal diagnosis for payment purposes.

Comment: One commenter asked if delirium is considered a primary, secondary, or medical condition. The commenter also asked if delirium should be considered an adjustment disorder.

Response: Coding decisions are based on how the physician describes the diagnosis. The physician needs to indicate the type or cause of the delirium, which will determine whether the delirium is psychiatric diagnosis, a psychiatric secondary diagnosis (comorbidity), or a medical comorbid condition. According to the ICD–9–CM, delirium is listed as caused by medical conditions, substance or alcohol abuses, or with psychosis. Delirium is primarily located in the 290 series of ICD codes. If the physician indicates that the patient's diagnosis is ''delirium, delirious'' the ICD–9–CM index would refer to ICD–9–CM code 780.09—Alteration in consciouusness—Other. However, if the physician specifies that the delirium is acute, then the ICD–9–CM code is 293.0—Delirium Due to Condition Classified Elsewhere, and if the Delirium is caused by alcohol abuse, the ICD–9–CM code is 291.0—Alcohol withdrawal delirium. We recommend that the commenter review the ICD–9–CM index under the term delirium (to determine the different types of diagnosis).

We are not responsible for the determination of clinical definition and criteria. To establish how a condition is defined or identified, providers should review a text of psychiatric diagnoses. We are providing the definition for delirium and adjustment reaction or disorder as defined in the ICD–9–CM (2004) for the convenience of the reader.

Delirium is defined as ''Transient organic psychotic condition with a short course in which there is a rapidly developing onset of disorganization of higher mental processes manifested by some degree of impairment of information processing, impaired or abnormal attention, perception, memory, and thinking. Clouded consciousness, confusion, disorientation, delusions, illusions, and often vivid hallucination predominate in the clinical picture.''

Adjustment reaction or disorder is defined as ''Mild or transient disorders lasting longer than acute stress reactions which occur in individuals of any age without any apparent preexisting mental disorder. Such disorders are often relatively circumscribed or situation-specific, are generally reversible, and usually last only a few months. They are usually closely related in time and in content to stresses such as bereavement, migration, or other experiences. Reactions to major stress that last longer than a few days are also included. In children, such disorders are associated with no significant distortion of development.''

In review of the DSM diagnostic criteria, delirium is not included in the ''Adjustment Disorder'' category. Based on the ICD–9–CM definition and the DSM diagnostic criteria, we would not expect delirium to be identified as an adjustment disorder.

Comment: One commenter asked how to code multiple addictions, for example, drug and alcohol, or two drug diagnoses.

Response: We encourage IPFs to code all diagnoses requiring active treatment during the IPF stay. The ICD–9–CM index entry for addiction provides several sub-terms to direct the coder to the most appropriate ICD–9–CM code. The ICD–9–CM code for alcohol dependence is 303.9. However, the ICD–9–CM indicates under code 303.9 that a fifth digit is required based on whether the physician inidicates that the dependence is continuous, episodic, in remission, or there is no information, that is, unspecified.

Separate codes are listed for drug addiction. The index refers coders to ''see dependence''. Under dependence, there are a variety of codes depending upon the specific addiction. The coder would enter as many codes as required to cover all the patient's dependencies (drug and alcohol). However, as noted above, only one comorbidity adjustment per comorbidity category will be paid under the IPF PPS.

Comment: Several commenters requested clarification of specific ICD–9–CM codes they suspected were erroneous.

Response: We agree with the commenters and acknowledge that we made the following typographical errors in the proposed rule:

- In Table 3 (68 FR 66931), in the Infectious Disease category, the correct range of codes is 07950 through 07959.
- In table 7 (68 FR 66941), the correct adjustment for Diabetes is 1.10 and the correct adjustment factor for Chronic Renal Failure is 1.14.

4. Patient Age

We proposed a 13 percent payment adjustment for patients 65 years of age and over to reflect the additional costs associated with treating elderly patients. We received a wide range of comments about the proposed age adjustment. In general, the comments favored the creation of additional age groups and payment adjustments.

Comment: Commenters requested clarification on how the proposed 13 percent differential between age groups was calculated. The commenters stated that the proposed adjustment factor is too low and does not reflect the current cost required to treat the elderly.

Several commenters recommended that CMS revise the age groupings to include a payment adjustment for patients under 14 years of age, under 40 years of age, 55 to 64 years of age, and 75 years of age and over. Other commenters suggested a payment adjustment for patients 65 years of age and over with increments added for each additional 5 years in age.

Response: As indicated in the proposed rule (68 FR 66931), the 13 percent differential was calculated using the same cost regression that was used to estimate the payment adjustments for the other variables included in the proposed payment system. The dependent variable was the natural logarithm of average cost per day for each inpatient stay. The regression included a single variable for persons 65 years of age and over to estimate the relative cost per day of persons 65 years of age and over compared to persons less than 65 years of age. Since the cost variable was in logarithms, the age coefficient in the cost regression was then raised to the power of the base e to convert it to the relative payment factor, 1.13.

In response to the public comments to create additional age payment adjustments (under 14 years of age and under 40 years of age, 55 to 64 years of age, and over 75 years of age), we updated our analysis of the impact of age on per diem cost by expanding the age variable (that is, the range of ages for payment adjustments). Since we have relatively few cases for persons under 40 years of age (and virtually no cases for persons under 14 years of age), we

combined all persons under 40 years of age into a single category. Similarly, all persons over 80 years of age were placed in a single category. For patients in between 40 and 80 years of age, we categorized cases into 5-year intervals. As indicated in the proposed rule, the cost per day increases with increasing age. With the exception of the 40 through 44 age group, all the older age groups are more costly than the under 40 years of age group, the differences increase for each successive age group, the differences among the age groups increase for each successive age group, and the differences are statistically significant.

Based on these results, in this final rule we are expanding the relative adjustment factor for age from the single factor for patients 65 years of age and over to 8 adjustment factors beginning with age groupings 45 and under 50 years of age to patients 80 years of age and over. The magnitudes of these factors are shown in Table 6 below and in Addendum A. We are also adopting as final the same methodology we used in the proposed rule (that is, cost regression analysis) except we are using an updated and revised regression based on FY 2002 data and the age groupings described above (that is, 5 year intervals and 8 adjustment factors).

TABLE 6--Age Groupings and Adjustment Factors

Age	Coefficient	Adjustment Factor
Under 45	0.000	1.00
45 and under 50	0.0136	1.01
50 and under 55	0.0215	1.02
55 and under 60	0.0410	1.04
60 and under 65	0.0709	1.07
65 and under 70	0.0963	1.10
70 and under 75	0.1183	1.13
75 and under 80	0.1375	1.15
80 and over	0.1584	1.17

5. Variable Per Diem Adjustments

Cost regressions indicate that the per diem cost declines as the length of stay increases. Therefore, we proposed adjustments to account for ancillary and certain administrative costs that occur disproportionately in the first days after admission to an IPF. As we explained in the proposed rule, we examined the per diem cost over a range of 1 to 14 days. According to the FY 1999 MedPAR data file, the per diem costs were highest on day 1 and declined for days 2 through 8 as follows. Per diem costs for days 9 and thereafter remained relatively constant. The proposed cost regression analysis was used to determine the proposed payment adjustment factors. Relative to a stay of 9 or more days, we proposed a variable per diem adjustment of 26 percent for day 1, a 12-percent adjustment for days 2 through 4, and a 5-percent adjustment for days 4 through 8. No variable per diem adjustments would be made after the 8th day.

We received multiple comments on the proposed variable per diem adjustments, primarily dealing with the amount of the proposed payment adjustments and the breakpoints for the adjustments.

Comment: One commenter asked how CMS determined the cost per day for the different lengths of stay. Another commenter recommended more justification of the method used to control for length of stay. Specifically, this commenter asked whether CMS tested alternative breakpoints for the length of stay categories and whether CMS considered other approaches for estimating the relationship between per diem cost and length of stay. One commenter objected to the proposed length of stays blocks, in which days 2 through 4 and days 5 through 8 would be paid at the same rate rather than declining smoothly for each successive day. The commenter believes that the proposed approach creates incentives to terminate or unnecessarily extend the length of stay.

Response: As indicated in the proposed rule, the relationship between cost per day and length of stay was estimated within the same cost regression used to derive other payment adjustments. First, we defined variables for each stay's length of stay (from 1 to 14 days). The effects of the first 14 days on cost were measured relative to stays of more than 14 days. Based on the results of this regression, we considered payment breakpoints for each day up through 14 days. Based on the size and pattern of variation of the regression coefficients for the individual day coefficients (that is, the magnitude of decline), we decided to group the days into the categories presented in the proposed rule (that is, day 1, days 2 through 4, days 5 through 8, and days 9 and thereafter). We then re-estimated the cost regression including the first 3 of these groups and stays of more than 8 days as the reference group.

As a result of converting the regression coefficients to payment factors, we proposed to pay the first day of each stay 26 percent more than the Federal per diem base rate. Similarly, we proposed to pay days 2 through 4 of each stay 12 percent more than the Federal per diem base rate and days 5 through 8 about 5 percent more than the Federal per diem base rate. The Federal per diem base rate implicitly reflects the cost of stays with more than 8 days.

We used regression analysis to estimate the average differences in per diem cost among stays of different length. Regression analysis simultaneously controls for cost differences associated with the other variables (for example, age, DRG, and presence of specific comorbidities). The regression coefficients measure the relative average cost per day for stays of differing lengths compared to a reference group's length of stay. In the proposed rule, the variable per diem adjustment factors derived from the regression coefficients were applied to specific days within the stay. As indicated above, we proposed to pay all stays 26 percent more than the Federal per diem base rate for day 1, 12 percent more than the base payment amount for days 2 through 4, and 5 percent more than the base payment amount for days 5 through 8.

To accurately measure the relative cost of specific days within the stay, we need estimates of the additional or marginal (not average) cost of those

days. Using the relative average cost differences as if they were marginal cost differences will result in overpayment for the days with payment factors greater than 1.00. The reason for the overpayment is that, using a 4-day stay as an example, the average cost per day over the 4 days already contains the higher marginal costs of the preceding 3 days. In paying more than the 4-day average cost per day for days 1 through 3, we would be paying more than the total cost of the stay.

In reconsidering the variable per diem adjustments for this final rule, we re-evaluated the length of stay breakpoints in the regression and the method of applying the regression results for payment. Using the FY 2002 MedPAR data, we re-estimated the cost regression, expanding the number of length of stay categorical variables from 1 through 14 to 1 through 30 days in order to potentially allow payments to decline in smaller, more increments over a wider range of days. From the regression, we derived factors indicating the average cost per day, for example, a 1-day stay, a 2-day stay, and a 3-day stay, relative to a stay of more than 22 days.

Since the variable per diem adjustments are applied to all IPFs stays, the adjustments should reflect daily cost differences experienced by all types of IPFs, and not cost differences among different types of IPFs with different lengths of stay. Therefore, we also tested the sensitivity of the regression coefficients to the inclusion of the government-operated IPF stays, which tend to have longer lengths of stay than the other types of IPFs. For example, about one-third of all government-operated IPF stays are longer than 22 days, compared to only 10 to 13 percent of stays in for-profit or non-profit hospitals or in psychiatric units. We found that our coefficients varied little depending on whether cases from government-operated IPFs were included or excluded.

CMS-funded research by RTI International®, which was not available for the proposed rule, provides additional information about the variation in relative marginal costs by day of the stay. RTI International® examined the variation in routine resource use across days within stays in its study of a sample of patients from 40 facilities. RTI International® constructed a measure of a patient's routine cost for each of 7 days during which they were collecting data within a facility.

As a result, RTI International® data has a significant advantage compared to the MedPAR data that was available at the time of the proposed rule for examining cost variation by day-of-stay. Specifically, RTI International® data enabled them to estimate a relationship between per diem cost and the day-of-stay that is consistent with the way we used the variable per diem adjustment factors for payment. In addition, since RTI International® did not average daily routine costs over the entire length of stay, its estimates should provide a better approximation of the relationship of marginal cost than we were able to construct. RTI International® did not collect information on ancillary usage by day-of-stay. In constructing its measure of daily total cost, RTI International® allocated 1 day of average ancillary costs from the matching MedPAR stay record. RTI International® used the same breakpoints that we used for the proposed rule.

In the table below, we compare the revised CMS adjustment factors with the RTI International® day-of-stay relative weights. Both sets of factors were scaled to set the day-9 (the median length of stay) factor equal to 1.00. The two series of factors are very similar, with the biggest differences occurring for days 2 to 4 and for day 19 and beyond. The differences for days 2 to 4 may be due to how the two methods handle ancillary costs, especially our exclusion of ED costs from the cost variable used in our regression analysis. The differences for day 19 and beyond probably are a result of the fact that RTI International® only estimated specific day effects for the first 14 days.

Overall, the similarity of the adjustment factors gives us confidence that our variable per diem adjustment factors are reasonably accurate. The revised factors are also responsive to the comment that the variable per diem adjustments should decline more continuously than those presented in the proposed rule. Therefore, in this final rule we are using the updated variable per diem adjustment factors in adjusting per diem payments by day-of-stay. We note that the variable per diem adjustment are made in a budget-neutral manner.

TABLE 7—Variable Per Diem Adjustment

Day-of-Stay	Variable Per Diem Payment Adjustment*	RTI Day of Stay compared to Relative Weights
Day 1	1.31/1.19	1.29
Day 2	1.12	1.18
Day 3	1.08	1.10
Day 4	1.05	1.10
Day 5	1.04	1.01
Day 6	1.02	1.01
Day 7	1.01	1.01
Day 8	1.01	1.00
Day 9	1.00	1.00
Day 10	1.00	1.00
Day 11	0.99	1.00
Day 12	0.99	1.00
Day 13	0.99	1.00
Day 14	0.99	1.00
Day 15	0.98	0.98
Day 16	0.97	0.98
Day 17	0.97	0.98
Day 18	0.96	0.98
Day 19	0.95	0.98
Day 20	0.95	0.98
Day 21	0.95	0.98
Over 21	0.92	0.98

*The adjustment for day 1 would be 1.31 or 1.19 depending on whether the IPF has or is a psychiatric unit in an acute care hospital with a qualifying emergency department. See section VI.C4.d. of this final rule.

Comment: Several commenters recommended that CMS re-evaluate the decision to have no variable per diem adjustment paid after the 8th day. The commenters requested that we re-examine the analysis supporting the conclusion that ''per diem costs for days 9 and thereafter remain relatively consistent with the median length of stay.''

A few commenters expressed concern that averages were used in all analyses except for the proposed variable per diem adjustments that were based on the median length of stay. The commenters believe use of the median creates distortions and requested that CMS analyze the impact if the variable per diem adjustments were based on the average length of stay.

Response: We re-evaluated the decision to make no variable per diem adjustments to the Federal per diem base rate beyond the eighth day. We examined the per diem cost relationship for the first 30 days of the stay and found that beyond day 22, there was no consistent continuing pattern of decline. In addition, since the proportion of stays longer than 21 days is relatively small, there is relatively high statistical variability in the estimates of declining cost increases beyond day 22, which makes the estimates less reliable. As a result of that analysis, we found that the average per diem cost continued to decline until the twenty second day. Therefore, in this final rule we are extending the variable per diem adjustments through day 22. The adjustment for day 22 would be applied to any days after day 21.

We believe the commenter misunderstood the role of the median length of stay in the variable per diem adjustment factors. As indicated in the proposed rule, the median length of stay serves only as a point of reference for the variable per diem adjustment factors relative to the Federal per diem base rate (the day for which the factor equals the base amount). In addition, the actual magnitudes of the variable adjustment factors were not affected by using the median in this manner because the median had no impact on the cost regression from which the variable per diem adjustment factors are derived. The Federal per diem payment would be the same no matter which day of the stay (the median, the mean, or some other day) was used as the reference point. In this final rule, we are adopting as final the same methodology proposed to calculate the variable per diem adjustments.

Comment: A few commenters expressed concern that the lack of variability in average daily charges results in understating the effect of the length of stay variable.

Response: We disagree with the commenters. The RTI International® research evaluated the variation of per diem cost by day of the stay using a measure of routine cost that varied according to the day of the stay. In addition, the comparison of RTI International® results and our results did not support the commenters' concerns that the variable per diem adjustment factors are understated.

Comment: Many commenters recommended increasing the per diem adjustment factor for day 1, or for the first several days of care.

One commenter recommended that in order to avoid the significant impact the proposed rule would have on high cost per discharge-short length of stay providers, the variable per diem adjustments for the first days of the stay should be weighted higher. The commenter recommended that CMS double the adjustments to 52 percent for day 1, 24 percent for days 2 through 4, and 10 percent for days 5 through 8.

Other commenters recommended that days 2 and 3 receive the same adjustment factor as day 1. However, some commenters recommended that the per diem payment be uniform rather than variable throughout the patient's stay. They suggested that a higher per diem base payment amount for each day

of stay would be preferable and more in line with the distribution of costs over an inpatient episode.

Response: These comments reflect a wide range of opinion about the appropriate range and magnitude of the variable per diem adjustment factors. We have updated and revised our variable per diem adjustment policy on the basis of our analysis of FY 2002 data and in response to public comments. In arriving at the final variable per diem adjustments, we have relied upon our empirical analysis, as previously described earlier in this section, to better approximate the additional costs of each successive day of the stay. We have also compared our results with the results of CMS-funded research by the RTI International®. We believe that the outcome of the process we undertook to improve the variable per diem adjustment factors is a reasonably accurate, empirically-based set of adjustment factors.

Comment: Several commenters expressed concern that the length of stay assumptions in the proposed rule did not take into consideration that certain interventions necessitate longer stays. A particular commenter indicated that medical safety standards for ECT dictate stays of more than 9 days.

One commenter stated that the elderly and younger chronically mentally ill adults represent two groups with longer than average lengths of stay. Another commenter stated that length of stay might be increased by the inclusion of trainees in a patient's care.

Response: We are not sure that we understand these comments. As required by the BBRA, the IPF PPS is a per diem system. As a result, the IPF PPS recognizes differences in length of stay and will pay the Federal per diem base rate and applicable adjustments for each day of the inpatient stay. Therefore, the IPF PPS accounts for differences in length of stay regardless of cause (including providing ECT or other factors).

Comment: A few commenters recommended that CMS undertake a research inquiry into the added staffing costs for the first few days of a stay at an inpatient psychiatric unit or develop two per diems, one for routine patients and another for ''clinically determined critical patients.''

Response: The RTI International® study addressed the issue raised by this comment because it examined the variation in routine cost by day of the stay. RTI International® studied this relationship for all the patients in its sample, which included the full range of patients treated in IPFs. In addition, we are not sure how we could define ''clinically determined critical'' patients, especially considering the common practice of admitting to psychiatric facilities only those patients whose medical needs have either been resolved or are sufficiently controlled as to require limited attention for the period of the psychiatric admission.

Comment: One commenter expressed concern that CMS would misinterpret increases in IPF admissions that result from the planned transition of inpatient psychiatric care from government-operated facilities to community-based resources such as private hospitals.

Response: Under the IPF PPS, both admissions referred to in the comment would be paid on a per diem basis, so that each facility (the government-operated facility and the private hospital) would be paid for the days of care it provides.

Comment: One commenter recommended that CMS more accurately reflect the MedPAR data by using a variable Patient Day adjustment equal to the median value of 9 days, rather than limit the adjustments to days 1 through 8.

Response: By extending our analysis through 30 days, we more fully modeled the shape of the relationship between average per diem costs and length of stay and did not truncate the adjustments at either the median or the mean length of stay. As a result, the revised variable per diem adjustment factors presented in this final rule more accurately reflect the cost-day relationship than those we presented in the proposed rule.

Comment: One commenter recommended that CMS provide more justification for the method used to control for length of stay.

A few commenters expressed concern that use of the median length of stay significantly understates the length of stay for an IPF that accepts chronic psychiatric patients (for example, a government-operated psychiatric hospital). The commenters believe that the proposed IPF PPS rewards acute psychiatric facilities for discharging patients quickly and provides an incentive for those facilities to discharge patients into government-operated IPFs.

Response: We believe the commenter misunderstood the intent of the variable per diem adjustment policy, which is not to control for length of stay, but to better align the payment of each day of the say with its corresponding cost. Therefore, the facilities would have no incentive to either shorten or extend a patient's length of stay beyond what is clinically needed.

We agree with the commenters that certain types of IPFs have lengths of stay greater than the median length of stay. The variable per diem adjustment factors are intended to track the relative costs an IPF needs to spend on a case throughout the days of a stay. Thus, a facility with a length of stay greater than the median, or the mean for that matter, should be adequately reimbursed for the cost of care provided to a Medicare beneficiary. As explained above, we do not believe that the final IPF PPS provides an incentive for early discharge from one type of IPF to a government-operated facility. In addition, our use of the median length of stay has no effect on the actual payment amounts for each day of the stay.

6. Other Patient-Level Adjustments

Although we proposed specific patient-level adjustments, we recognized that there were other variables not collected on the claim form. Therefore, we requested public comments on other patient-level adjustments for the IPF PPS. In response to our request for public comments, we received numerous comments recommending that we consider the following other types of adjustments:

a. Gender

We invited public comments on the appropriateness of including a gender variable as a payment adjustment.

Comment: Several commenters stated that elderly female patients represent 68 to 70 percent of the population they serve and recommended that CMS recognize the cost differential in treating female patients.

Response: We analyzed the FY 2002 data and found that the cost regression continues to imply that female patients are approximately 2 percent more costly than male patients. However, as we found in the proposed regression analysis, adding an adjustment for gender increases the explanatory power of the patient model by less than one half of 1 percent, which means that the addition of gender does very little to improve explanatory power of the overall model. In addition, we are unable to determine the extent to which the interaction of psychiatric unit status with age and gender indicates higher direct costs of treating the elderly and women, as opposed to other reasons for the higher costs of psychiatric units. However, to the extent that gender is correlated with age and DRGs, facilities will be partially reimbursed for gender-related costs, since gender was not included as a variable in the regression. Therefore, we are not adopting a patient-level adjustment for gender.

b. Patients Admitted Through the Hospital's ED

We received many comments recommending that we recognize the cost of ED services and provide a patient-level adjustment for patients who were admitted to a distinct part psychiatric unit through the hospital's ED.

Comment: Many commenters recommended that CMS add a patient-level adjustment for patients who are admitted through the ED of the same hospital for inpatient psychiatric care.

Response: Our analysis indicated these cases were more costly on a per diem basis than cases without an ED admission. However, we are not including an adjustment for patients admitted through the ED. We are concerned about creating an incentive for psychiatric units in acute care hospitals with EDs to ensure that all psychiatric patients are admitted through the ED. However, we are providing a facility-level adjustment for psychiatric hospitals, or psychiatric units of acute care hospitals, with qualifying ED. Additional information regarding the analysis of ED costs is included in section VI.B.5.b. of this final rule.

c. Patients Who Receive Electroconvulsive Therapy (ECT)

We received numerous comments recommending that we include ECT as a patient-level adjustment because furnishing ECT treatment adds significantly to the cost of these IPF stays.

Comment: Several commenters recommended that CMS include ECT (procedure code 90870) under DRG 424 (Operating room procedure with principal diagnosis of mental illness) that has an adjustment factor of 1.22. One commenter suggested that DRG 430, ''Psychosis'' be disaggregated into two DRGs, ''Psychosis with ECT,'' incorporating the added costs for ECT treatment and ''Psychosis without ECT.''

Other commenters recommended that CMS provide as an alternative, an add-on payment to the DRG for those patients who receive ECT treatments.

Many commenters recommended modifying the payment structure to include a separate payment adjustment for ECT, which should be higher than the payment adjustment for DRG 424.

Response: After reviewing the public comments, we analyzed cases with ECT using the FY 2002 MedPAR data. We were able to identify ECT cases by the presence of procedure code 90870. Our analysis indicated that ECT cases comprised about 6 percent of all cases, and that almost 95 percent of ECT cases were treated in psychiatric units. Even among psychiatric units, ECT cases are concentrated among a relatively small number of facilities.

Overall, approximately 450 facilities had cases with ECT. Among these facilities, we estimate the mean number of ECT cases per facility to be approximately 25. In addition, approximately one-half of the IPFs providing ECT had no more than 15 cases in FY 2002.

Consistent with the comments we received about ECT, our analysis and review indicated that cases with ECT are substantially more costly than cases without ECT. On a per case basis, ECT cases are approximately twice as expensive as non-ECT cases ($16,287 vs. $7,684). Most of this difference is due to differences in length of stay (20.5 days for ECT cases vs. 11.6 days for non-ECT cases). The ancillary costs per case for ECT cases are $2,740 higher than those for non-ECT cases.

Based on this analysis, in this final rule we are providing an adjustment for each ECT treatment furnished during the IPF stay. In order to receive the payment adjustment, IPFs must indicate on their claims the revenue code and procedure code for ECT (Rev Code 901; procedure code 90870) and the number of units of ECT, that is, the number of ECT treatments the patient received during the IPF stay. Providing this data will ensure that facilities are appropriately reimbursed for the treatments they provided.

After careful review and analysis of IPF claims, we were unable to separate out the cost of a single ECT treatment. Therefore, we are using the pre-scaled and pre-adjusted median cost for procedure code 90870—developed for the hospital OPPS, based on hospital claims data.

We used unadjusted hospital claims data under the OPPS, that is, the pre-scaled and pre-adjusted median hospital cost per treatment, to establish the ECT payment because we did not want the ECT payment under the IPF PPS to be affected by factors that are relevant to OPPS but not specifically applicable to IPFs. The median cost is then standardized and adjusted for budget neutrality. We will adjust the ECT rate for wage differences in the same manner that we adjust the per diem rate. The median cost for all hospital OPPS services are posted after publication of the hospital OPPS proposed and final rules at the following address: *http://www.cms.hhs.gov/providers/hopps.*

As explained above, we decided to pay the median cost for an ECT treatment, posted as part of the calendar year (CY) 2005 OPPS update, which is based on CY 2003 outpatient hospital claims. The amount is $311.88. Using the same OPPS CY 2003 claims that were used to calculate the aforementioned ECT median, we were able to calculate the average number of ECT treatments for a given patient to be approximately 9. A rate of $311.88 per ECT treatment multiplied by 9 is very close to the $2740 difference in ancillary costs observed for ECT and non-ECT cases. Accordingly, we believe that the payment adjustments for ECT will appropriately and adequately provide payment for ETC services provided to IPF patients. After applying the standardization factor, behavioral offset, stop-loss adjustment, and outlier adjustment (as described in section V.C. of this final rule), the adjusted ECT payment is $247.96.

We have established the ECT adjustment as a distinct payment under the PPS methodology, our preferred approach would be to include a patient level adjustment as a component of the model (for example, determined through the regression analyses) to account for the higher costs associated with ECT. We believe the approach will better control incentives towards over-utilization and be more consistent with the approach used for other patient level adjustments under the PPS. During the transition period we expect to collect more data on the number of ECT treatments per stay, and associated costs. We will utilize these data to evaluate alternative approaches for incorporating an adjustment for ECT in the payment system. We expect to complete this analysis during the first year of the transition and potentially propose changes at the time of the first annual update of the payment system.

ECT is an intensive procedure. Therefore, we are concerned that including a payment adjustment for ECT treatments in the final IPF PPS could result in a rise in the use of ECT treatment. We will monitor this area to ensure that the increased payments do not lead to changes in the frequency of utilization.

d. Patients Involuntarily Committed to the IPF

We did not proposed to provide a payment adjustment for patients who are involuntarily committed to an IPF. However, we received multiple comments encouraging us to recognize the additional costs associated with these patients.

Comment: Several commenters indicated that patients involuntarily committed to an IPF often require costly court proceedings before treatment can

begin and that the hospital my incur cost for caring for these patients while awaiting the court decision.

Other commenters identified patient management issues, for example, more frequent one-on-one staff attention and more complex discharge planning. A few commenters indicated that involuntarily committed patients are often uncooperative and difficult to treat. One commenter reported a 27 percent longer length of stay for involuntarily committed patients.

Response: One of the fields on the claim form indicates if patients were referred to the IPF by law enforcement or if the commitment were court ordered (FL 20, item 8, court/law enforcement). As a result, we were able to analyze the FY 2002 claims data to determine if the costs identified by the commenters are evident in the claims. The data did not indicate that patients involuntarily committed to the IPF are more costly on a per diem basis. We note that many of the costs associated with involuntary commitments (for example, legal fees, staff time to accompany the patient to court, and transportation costs) are part of the hospital's average routine per diem cost.

In addition, there are certain costs that are the responsibility of the court system or law enforcement, for example, where a court orders a 3-day psychiatric evaluation for a patient or where discharge is delayed pending court action. Thus, IPFs should be adequately reimbursed for patients involuntarily committed, even in the absence of a specific payment adjustment.

Therefore, at this time we are not providing an adjustment for involuntarily committed patients.

e. Administrative Necessary Days

We received several comments recommending that we recognize the cost of administrative necessary days for continued inpatient care when discharge is delayed due to a lack of community resources.

Comment: Commenters indicated that hospitals would be unable to discharge a patient without an appropriate discharge plan. The commenters requested that CMS provide reimbursement for this type of situation.

Response: Current hospital discharge planning requirements in § 482.43(a) and (b) require the discharge planning evaluation to include the likelihood of a patient needing post-hospitalization services and the availability of those services. Hospital personnel must complete the evaluation on a timely basis so that appropriate arrangements for post-hospital care are made before discharge, and to avoid unnecessary delays in discharge.

In addition, § 482.43(c)(4) requires that the hospital must reassess the patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan.

Moreover, § 412.27(c)(5) states, ''the record of each patient who has been discharged must have a discharge summary that includes a recapitulation of the inpatient's hospitalization in the unit and recommendations from appropriate services concerning follow-up or aftercare as well as a brief summary of the patient's condition on discharge.''

Consequently, if an IPF determines that a patient needs post-hospitalization placement, then a statement to this effect is expected to be included in their discharge plan. Furthermore, if a patient cannot be safely discharged without this post-hospitalization placement and this placement is not available, then the patient has not met their discharge objectives and requires continued active treatment.

After careful review, we have decided not to provide additional payment for administrative necessary days for several reasons. Since claim data does not include coding or documentation for administrative data, we are unable to identify and discern the cost of these days. Therefore, we are unable to determine the extent to which the costs of administrative necessary days are included in the Federal per diem base payment amount.

Finally, since the IPF PPS is a per diem payment methodology, we are concerned about inadvertently creating an incentive to unnecessarily delay discharge in order to receive additional payment for administrative necessary days.

C. Facility-Level Adjustments

In the proposed rule, we proposed adjustments for the IPF's wage area, rural location, and teaching status.

1. Wage Index

Due to the variation in costs and because of the differences in geographic wage levels, we proposed that payment rates under the IPF PPS be adjusted by a geographic wage index. We proposed to use the unadjusted, pre-reclassified hospital wage index to account for geographic differences in labor costs. In the proposed rule, we proposed to use the inpatient acute care hospital wage data to compute the IPF wage since there is not an IPF-specific wage index available. We believe that IPFs generally compete in the same labor market as acute care hospitals since the inpatient acute care hospital wage data should be reflective of labor costs of IPFs. We believe this to be the best available data to use as proxy for an IPF specific wage index. We proposed to adjust the labor-related portion of the proposed Federal per diem base rate for area differences in wage levels by a factor reflecting the relative facility wage level in the geographic area of the IPF compared to the national average wage level for these hospitals. We believe that the actual location of the IPF as opposed to the location of affiliated providers is most appropriate for determining the wage adjustment because the data support the premise that the prevailing wages in the area in which the IPF is located influence the cost of a case. Thus, in the proposed rule and in this rule, we are using the inpatient acute care hospital wage data without regard to any approved geographic reclassification as specified in section 1886(d)(8) or 1886(d)(10) of the Act. Specifically, in this rule, we are using the FY 2005 hospital wage index (unadjusted, pre-reclassified) based on MSA definitions defined by OMB in 1993 (as opposed to the new MSA definitions that were used to define labor markets for the FY 2005 IPPS). Once we implement the IPF PPS, we will assess the implications of the new MSA definitions on IPFs. At the time of the proposed rule, the 2003 MSA definition had not been implemented for any medicare programs and consequently, were not proposed. We note that, after the publication of the IPF PPS proposed rule, new MSA definitions have been adopted for use in the IPPS. We, however, are not adopting those new definitions in this final rule. We expect that use of the new MSA (or labor market) definitions may have a significant impact on the wage index applied to IPFs and associated payments. Thus, before their use could be proposed, we would have to conduct a thorough analysis of their impact on the IPF PPS. Moreover, and most importantly, we believe it is appropriate to provide an opportunity for IPFs and other interested parties to comment on the use of the new definitions before proceeding with their possible application. We plan to publish in a proposed rule any changes that we consider for new labor market definitions, in order to provide the public with an opportunity to comment.

Comment: Several commenters recommended that CMS apply the hospital wage index with geographic reclassifications in the same way that other hospital PPS adjust payments to reflect wage differences. Commenters

believe that the reclassification process ensures that areas that are geographically close to an MSA may compete to employ a sufficient amount of skilled healthcare workers. Other commenters believe that the pre-reclassified wage index may result in a potential decrease in payment, especially for psychiatric units within hospitals that draw from the same workforce as acute care hospitals.

Response: The statute does not require geographic reclassification of other hospitals paid under TEFRA (for example, freestanding psychiatric hospitals) or other hospitals paid under different prospective payment systems. Geographic reclassifications are not recognized under the IRF or LTCH payment systems, and are not recognized under the final IPF PPS.

Comment: A few commenters requested a modification to the portion of the payment that is adjusted by the wage index. The commenters stated that the proposed wage index should be applied to 72.8 percent of the Federal per diem base rate, as reflected in the proposed 1997-based excluded hospital with capital market basket. Generally, commenters in wage areas with a wage index above 1.0 indicated that the proposed labor portion of the payment was too low and commenters in wage areas with a proposed wage index less than 1.0 indicated that the labor portion was too high.

One commenter indicated that psychiatric care is more labor intensive than other modes of inpatient care, thus the commenter recommended that CMS research the costs of providing psychiatric care, and develop a labor adjustment that adequately compensates for the increased intensity of care for psychiatric patients.

Response: In both the proposed rule and in this final rule, to account for wage differences, we first identified the proportion of labor and non-labor components of costs. We used the 1997-based excluded hospital market basket with capital to determine the labor-related share of cost. We calculated the labor-related share as the sum of the weights for those cost categories contained in the 1997-based excluded hospital with capital market basket that are influenced by local labor markets. These cost categories include wages and salaries, employee benefits, professional fees, labor-intensive services, and a share of capital-related expenses.

The labor-related share for the implementation period of the final IPF PPS (January 1, 2005 through June 30, 2006) is the sum of the relative shares which measure the relative importance of each labor-related cost category for this period. It also reflects the different rates of price change for these cost categories between the base year (FY 1997) and this period. 0 labor-related components of operating costs (wages and salaries, employee benefits, professional fees, and labor-intensive services) is 68.818 percent, as shown below in Table 8. Since capital cost also contains a significant component of labor-related cost, the labor-related share of total cost will be greater than the labor-related share of operating costs alone. The portion of capital cost that is influenced by local labor markets is estimated to be 46 percent. Because the capital accounts for 7.323 percent of the 1997-based excluded hospital with capital market basket for the period January 1, 2005 through June 30, 2006, the labor-related share of capital cost is 46 percent of 7.323 percent. The result, 3.369 percent, is then added to the 68.818 percent calculated for operating costs to determine the labor-related share of total cost. The resulting labor-related share that we are using in this IPF PPS rule is 72.247 percent. The table below shows that the labor-related share would have been 72.571 percent if we had not rebased the excluded hospital with capital market basket using more recent 1997 data rather than using 1992 data. As shown in Table 8, rebasing results in a lowering of the labor-related share by 0.324 percentage points.

The base methodology used to calculate the labor-related share for IPFs is the same as that used for calculating the labor-rated share for IPPS, SNFs, HHAs, LTCH, and IRFs PPS. The difference is that except for the IPPS, we use the relative importance for the effective period in developing this share, which changes annually. For IPPS, the labor share remains constant until the market basket is rebased.

CMS agrees with the commenter that it is important to have a market basket and labor share appropriate for use under the IPF PPS. We believe that using the excluded hospital with capital market basket accomplishes this goal. However, we indicated in the proposed rule that we plan to continue to study the feasibility of developing a market basket specific to IPF services. We hope that we may eventually be able to develop a market basket and labor-related share based primarily on IPF data (see 68 FR 66928).

Table 8--Labor-Related Share of Total Cost

Component of Total Cost	Component Relative Shares 1992-based Market Basket (January 1, 2005 to June 30, 2006)	Component Relative Shares 1997-based Market Basket (January 1, 2005 to June 30, 2006)
Wages and salaries	49.435	48.396
Employee benefits	12.446	11.432
Professional fees	2.047	4.534
Postage	0.243	
All other labor intensive services	5.162	4.517
SUBTOTAL	69.333	68.818
Labor-related share of capital costs	3.238	3.369
TOTAL	72.571	72.247

The labor-related relative share of total cost in this rule changed from that in the proposed rule for two reasons. First, the labor-related share of 72.247 in this rule comes from Global Insight's 2004: quarter 3 forecast, with historical data through 2004: quarter 2, while the proposed rule used data from the 2002: quarter 4 forecast, with historical data through 2002: quarter 3, to calculate the proposed labor share of 72.828. Second, in addition to using more historical data in a more recent forecast, there is a different implementation period in this final rule, meaning that different periods of data were used to calculate the labor-related relative importance in this rule.

Comment: Several commenters requested that CMS establish a floor for the urban wage index so that an urban wage index would not fall below the wage index in a rural area in the same state. Another commenter requested that CMS apply the section of the MMA to the IPF PPS, which would limit an IPF's wage index to a minimum of 1.

Response: We did not propose a wage index floor. We are unclear of what the commenter is referring to because there is no MMA provision that limits the hospital wage index to a minimum of 1.0. In order to be consistent with the wage area adjustments used in the PPS developed for other excluded hospitals, we did not apply a floor wage index under the IPF PPS.

Comment: Many commenters suggested that CMS use more recent hospital wage data for the final IPF PPS.

Response: We are also using the best available hospital wage index data in this final rule (that is, the wage data used to establish the FY 2005 IPPS wage index for the October 1, 2004). We will continue to use the best data available for future updates to the IPF PPS.

2. Rural Location

We proposed a 16 percent payment adjustment for those IPFs located in a rural area. This adjustment was based on the proposed regression analysis, which indicated that the per diem cost of rural facilities was 16 percent higher than that of urban facilities after accounting for the influence of the other variables included in the regression. Many rural IPFs are small psychiatric units within small general acute care hospitals. In the proposed rule, we stated that small-scale facilities are more costly on a per diem basis because there are minimum levels of fixed costs that cannot be avoided, and they do not have the economies of size advantage.

We received several comments regarding the proposed rural adjustment. Most commenters supported the rural adjustment and encouraged us to recognize the higher cost incurred in rural settings.

Comment: Commenters expressed concern that despite the 16 percent adjustment to the Federal per diem base rate for IPFs located in rural areas Medicare payment would decrease for rural psychiatric units.

Response: In implementing this rule, we updated our cost regression analysis using the most recent complete data available (that is, FY 2002 data). Based on the results of our regression analysis, we are now providing a payment adjustment for IPFs located in rural areas of 17 percent instead of the proposed 16 percent. The small change in the rural payment adjustment is largely the result of the adjustment we made to the cost data to account for the ED adjustment. A full description of the ED policy appears later in this section.

As is the case with implementing any prospective payment system, since the payment rates are not directly tied to the costs of each individual facility, relatively high cost facilities may experience reductions in Medicare payments. However, our analysis of the impact of this rule during the first year of implementation (see section VIII of this final rule) show that on average rural facilities are expected to have a payment to cost ratio of 1.00. This means that Medicare payments during the first year of the IPF PPS transition are expected to be the same as they would have been had the IPF PPS not been implemented and IPFs continued to be paid 100 percent.

Comment: Several commenters specifically expressed concern that the multipliers used for urban and rural facilities are inappropriate and do not adequately adjust for higher per bed cost in smaller facilities. In addition, several commenters encouraged CMS to add a reasonable payment adjustment for urban psychiatric units.

Other commenters stated that if the proposed rules are adopted, hospitals may choose to close their psychiatric units.

Response: We did not include an explicit payment adjustment for urban facilities in the proposed rule and we are not adopting one in this final rule. We are not including this type of adjustment factor since our adjustment for rural facilities is based on an explicit comparison of the relative per diem costs of rural and urban facilities after accounting for the effects of the other variables included in the regression as previously explained in the cost regression section of this final rule. The result of that comparison (as reflected in our cost regression) was that rural facilities are more costly than urban facilities, largely because rural facilities are smaller on average than urban facilities. In addition, because a variable reflecting facility size was not included in the cost regression, the rural payment adjustment factor may partially reflect the influence of size on per diem cost.

As previously stated, we have not included an explicit payment adjustment factor to account for the higher per diem costs of small facilities, because we think that to do so is counter to the basic principle of prospective payment systems that payment adjustments should be based on characteristics that are not under the control of the facility. Specifically in the case of psychiatric units where a facility can choose how much of its inpatient psychiatric care it wishes to include in its Medicare certified unit, we would be concerned that a facility could reduce the size of its Medicare-certified unit in order to increase Medicare payments.

We plan to monitor the impact of the IPF PPS on the financial status of psychiatric facilities. We are particularly concerned about potential effects of facility closures on beneficiaries' access to inpatient psychiatric care. As a result of this issue, we are adopting a stop-loss provision as part of the transition to assist all IPFs with revenue shortfalls during the transition period (see section V.C.3. of this final rule for a discussion of the stop-loss provision).

3. Teaching Adjustment

We proposed to establish a facility level adjustment to the Federal per diem base rate for IPFs that are teaching institutions. In the past, we have made direct graduate medical education (GME) payments (for direct costs such as resident and faculty physician salaries, and other direct teaching costs) to teaching hospitals including those paid under the IPPS and those paid under the TEFRA rate of increase limits. However, we did not make separate indirect medical education (IME) payments to teaching hospitals paid under the TEFRA rate-of-increase limits because payments to these hospitals are based on the hospitals' reasonable costs. IME payments are authorized under the IPPS statute to be paid as an add-on to the IPPS per case payment, and there are no per case payments under the TEFRA system. In this final rule, we are establishing a facility-level adjustment for IPFs that are, or are part of, teaching institutions. The facility-level adjustment we are providing for teaching hospitals under the new IPF PPS parallels the IME payments paid under the IPPS. Both payments are add-on adjustments to the amount per case (there is now a per case payment to which the IPF teaching adjustment will be added) and both are based in part on the number of full-time equivalent (FTE) residents training at the facility.

In the proposed rule, we proposed to calculate a teaching adjustment based on the IPF's ''teaching variable,'' which is one plus the ratio of the number of FTE residents training in the IPF divided by the IPF's average daily census (ADC). Based on our initial regression analysis, we proposed to raise the teaching variable to the .5215 power. We also requested suggestions from the public regarding how to estimate IPFs' indirect teaching costs

and alternative methodologies to recognize the higher costs of teaching IPFs. However, we did not receive any suggestions on this issue.

Accordingly, we are adopting our proposed formula for calculating the adjustment in this final rule. Based on the final regression analysis using FY 2002 data, we are raising the teaching variable from .5215 power to the .5150 power.

We also indicated we were considering alternatives to limit the incentives for IPFs to add FTE residents for the purpose of increasing their teaching adjustment. We indicated that we were considering imposing a cap, similar to that established by sections 4621 and 4623 of the BBA for the IPPS, and noted that these caps already apply to teaching hospitals, including IPFs, for purposes of direct GME payments according to regulations at § 413.75 through § 413.83.

As indicated in the proposed rule (68 FR 66932), we were concerned about establishing an open-ended payment for the teaching adjustment because the BBA froze the number of residents that hospitals may count for both direct and indirect GME payments in order to reduce incentives for teaching institutions to add residents. We recognized that if we imposed no limits on the teaching adjustment under the IPF PPS, teaching programs in those facilities could grow and receive payments in a manner that is inconsistent with that in teaching hospitals paid under the IPPS. In addition, we were concerned that if a teaching hospital had a distinct part psychiatric unit and had a number of FTE residents above the amount recognized for reimbursement under the BBA limits, the hospital could potentially circumvent those limits by assigning residents to train in the IPF. For example, if a teaching hospital has 110 FTE residents of which only 100 are recognized for purposes of Medicare IME reimbursement under the BBA limits, the hospital could assign the excess 10 residents to its distinct part psychiatric unit where those FTE residents would be included for purposes of the teaching adjustment to the IPF PPS payments, which is similar in amount to IPPS IME payments. As a result, the hospital would be able to count all 110 FTE residents for purposes of calculating a teaching adjustment, in contradiction to the Congress' intent in establishing the BBA limits.

We considered imposing a cap that would operate in a substantially similar manner to the BBA limits on the number of FTE residents that may be counted for purposes of making IPPS IME payments. The BBA cap operates by limiting the number of allopathic and osteopathic FTE residents that Medicare will recognize for the purposes of calculating IPPS IME payments to no more than the number of FTE residents in a teaching hospital's most recent cost reporting period ending on or before December 31, 1996. In addition, the BBA placed a cap on the entire resident-to-bed ratio used to calculate the IPPS IME payment so that a hospital's ratio in its current cost reporting period could not exceed the ratio from its previous cost reporting period.

In response to public comments on the teaching adjustment, only one commenter agreed with the appropriateness of establishing a cap on the number of FTE residents that may be counted for purposes of the teaching adjustment under the IPF PPS. The majority of commenters was opposed to imposition of any resident cap and indicated that a cap would be arbitrary and burdensome.

After carefully reviewing the public comments, we have decided to adopt a cap on the number of FTE residents that may be counted under the IPF PPS for the teaching adjustment. We made this decision in order to—(1) exercise our statutory responsibility under the BBA to prevent any erosion of the resident caps established under the IPPS that could result from the perverse incentives created by the facility adjustment for teaching under the IPF PPS; and (2) avoid creating incentives to artificially expand residency training in IPFs, and ensure that the resident base used to determine payments is related to the care needs in IPF institutions.

In adopting the FTE resident cap for purposes of the IPF PPS teaching adjustment, we wish to emphasize that we are not limiting the number of residents teaching institutions can hire or train; we are limiting the number of residents that may be counted for purposes of calculating the IPF PPS teaching adjustment, and thus, the amount Medicare will pay for the teaching adjustment under the new IPF PPS.

The FTE resident cap we are establishing will work identically in freestanding teaching psychiatric hospitals and in distinct part psychiatric units with GME programs. In order to establish the cap on the number of residents used in calculating the IPF PPS teaching adjustment, the following policies will apply.

- Similar to the regulations for counting FTE residents under the IPPS as described in § 412.105(f), we will calculate the ''base year'' number of FTE residents that trained in the IPF based on the hospital's most recently filed cost report before November 15, 2004. Residents with less than full-time status and residents rotating through the psychiatric hospital or unit for less than a full year will be counted in proportion to the time they spend in their assignment with the IPF (for example, a resident on a full-time, 3-month rotation to the IPF will be counted as 0.25 FTEs for purposes of counting residents to calculate the ratio). Hospitals can file adjusted cost report data with their FIs until the cost report is settled if they believe the resident counts as submitted on that cost report are incorrect. For purposes of determining an IPF's teaching adjustment under the IPF PPS, the number of FTE residents in the numerator cannot exceed the number of FTE residents in the hospital's most recently filed cost report.
- The denominator used to calculate the teaching adjustment under the IPF PPS is the IPF's average daily census (ADC) from the current cost reporting period. As we indicated in the proposed rule, although a hospital's number of available beds is used in the denominator of the IPPS IME adjustment, the ADC is used in the denominator of the ratio used to compute the IME adjustment under the capital PPS as specified at § 412.322. We are using the ADC for the teaching adjustment under the IPF PPS rather than the number of beds because the ADC is more closely related to the IPF's patient load, and thus, its need for interns and residents. As we stated in the proposed rule, we also believe the ADC is easier to define precisely and less subject to manipulation.

Thus, under the IPF PPS, we are placing a cap on the number of FTE residents (that is, the numerator) used for purposes of computing the teaching adjustment, and not on the ADC (the denominator), or on the entire ratio. An IPF's FTE resident cap will ultimately be determined based on the final settlement of the hospital's cost report filed most recently before November 15, 2004. If a change is made to the base year cost report, the intermediary will reconcile any changes in IPF PPS teaching payments as appropriate.

If a psychiatric hospital or unit has fewer FTE residents in a given year than in the base year, payments in that year will be based on the lower number. This approach is consistent with the IME adjustment under the IPPS. The hospital will be free to add FTE residents and count them for purposes of calculating the teaching adjustment until it returns to its base year FTE resident count.

In this final rule, we are adopting the policy currently applied under the BBA

for IPPS teaching hospitals that start new teaching programs as specified in § 413.79 (1) for new teaching IPFS and for teaching IPFs that start new programs. We note that under § 412.105(f)(1)(vi) concerning IME payments under the IPPS, hospitals that have shared residency rotational relationships may elect to apply their respective IME resident caps on an aggregate basis via a Medicare GME affiliation agreement. Our intent is not to affect affiliation agreements and rotational arrangements for hospitals that have residents that train in more than one hospital. We are not implementing a provision concerning affiliation agreements specifically pertaining to the FTE caps used in the teaching adjustment under the IPF PPS at this time. This is an area we expect to closely monitor, and we will consider allowing IPFs to aggregate and adjust their FTE caps through affiliation agreements in the future.

We believe these policies fairly balance our responsibilities under the statute to assure appropriate enforcement of the BBA and the overall limits on payment adjustments for teaching hospitals with the greater precision that can be achieved by adjusting payments for teaching IPFs. We also believe that we have designed a cap that balances the need for limits with the unique conditions of teaching programs in freestanding psychiatric hospitals and in distinct part psychiatric units. We will, however, monitor the impact of these policies closely and consider changes in the future when appropriate.

Comment: Several commenters indicated that a cap amounts to an absolute freeze on the number of residents that Medicare will recognize for payment purposes. In addition, the commenters stated that a cap allows only decreases and no increases in established resident counts at any time.

Response: We acknowledge that the number of FTE residents will be frozen under the IPF PPS. As discussed above, we are adopting a cap on the number of FTE residents that may be counted under the IPF PPS teaching adjustment. This policy is to exercise our statutory responsibility under the BBA to prevent any erosion of the resident caps established under the IPPS that could result from the perverse incentives created by the facility adjustment for teaching hospitals under the IPF PPS. In addition, we wish to avoid creating incentives to artificially expand residency training in IPFs, and ensure that the resident base used to determine payments is related to the care needs in IPF institutions. Again, we will monitor the impact of these policies closely and consider changes in the future when appropriate.

Comment: Several commenters were concerned that the administrative burden in reviewing resident counts back to 1996 cost reports would be excessive and recommended not imposing an FTE resident cap for the IPF PPS teaching adjustment for this reason.

Response: The resident cap under the IPPS is based on the hospital's 1996 cost report. However, the resident cap we are establishing under the IPF PPS relies on the number of residents training in the IPF for the most recently filed cost report before November 15, 2004. In addition, establishing the IPF PPS resident cap does not require the hospitals to submit information not currently included in their cost reports. As a result, we do not believe there is a significant burden associated with establishing the IPF PPS resident cap.

Comment: Several commenters asked if the teaching adjustment would be limited to those hospitals with a dedicated psychiatric teaching program. In addition, the commenters asked if the adjustment would also apply to hospitals that schedule rotations to the psychiatric unit from a non-psychiatric teaching program.

Response: Under the IPPS, Medicare makes IME payments only for costs associated with residents in approved graduate medical education (GME) programs as defined in § 412.105(f)(1)(i) that are approved by one of the organizations listed in § 415.152, not residents in other types of teaching programs. Thus, IPFs that have residents in approved GME programs will receive the IME adjustment. The GME program could be a psychiatric teaching program or scheduled rotations to the IPF unit from a non-psychiatric teaching program.

Comment: One commenter urged CMS to consider applying any cap on the number of interns and residents in a manner that is less sensitive to rapid declines in patient census. The commenter believes the use of the ratio of residents to ADC will negatively affect government-operated IPFs.

Response: Although we are unsure of the commenter's point, the commenter seems to be implying that the teaching adjustment would decline if there were a reduction in the IPF's ADC. However, a decrease in the ADC would result in an increase in the teaching adjustment.

Comment: One commenter requested that CMS provide an example to show how the calculation of the teaching adjustment would be computed. The commenter requested that the example use a hypothetical resident count and ADC and the final teaching adjustment factor.

Response: We were not able to present a single proportional factor that represents the payment adjustment for teaching as we did for most of the other payment variables (for example, age and rural location). The reason is because the teaching adjustment varies among teaching hospitals depending on the degree of their teaching intensity as measured by the ratio of interns and residents to the ADC.

The following example shows a step-by-step calculation of the teaching adjustment for 2 teaching hospitals. Hospital A has an interns and residents to ADC ratio of 0.10. Hospital B has an interns and residents to ADC ratio of 0.20.

Step 1: Add 1.0 to the interns and residents to ADC ratio:

Hospital A: 1.0 + 0.1 = 1.1
Hospital B: 1.0 + 0.2 = 1.2

Step 2: Raise the factors in Step 1 to the power given by the regression coefficient for the teaching variable (.5150).

Hospital A: $1.1 \times \exp(.5150) = 1.050$
Hospital B: $1.2 \times \exp(.5150) = 1.098$

The Step 2 results indicate that Hospital A's payment will be 5.1 percent higher than the comparable payment for a non-teaching hospital and the Hospital B's payment will be 9.9 percent higher than the comparable payment for a non-teaching hospital.

Step 3: Multiply the factors obtained in Step 2 by the appropriate per diem payment adjusted by all other relevant payment factors. For purpose of this example, the per diem payment is assumed to be $625 for both Hospital A and Hospital B.

Hospital A: $\$625 \times 1.050 = \$656.25$
Hospital B: $\$625 \times 1.098 = \$686.25$

The step 3 results indicate that Hospital A's per diem payment would be $656.25 compared to $686.25 for Hospital B.

Comment: A commenter questioned why CMS used the ratio of interns and residents to the ADC, rather than the ratio of interns and residents to the number of beds.

Response: Using the ADC rather than the number of beds as the denominator of the teaching variable has two main advantages: Whereas there are many different and frequently imprecise ways of counting beds (licensed beds, available beds, staffed beds), the ADC is a single standard measure that hospitals know how to calculate. It is just the total number of patients days of care divided by 365, the number of days in the year.

Average daily census, which reflects the number of occupied beds in a year, is a readily available, more consistent measure than the number of beds because patient days are more accurately measured than are beds. Because it is directly measured by patient days, ADC is also less subject to understatement in an effort to increase the value of the teaching variable and in turn, teaching payments.

4. Other Facility-Level Adjustments

In the proposed rule, we indicated that we considered facility-level adjustments for IPFs located in Alaska and Hawaii and an IPF's disproportionate share intensity. Other adjustment factors discussed in this section were requested in public comments.

a. Adjustment for Psychiatric Units

In the proposed rule, we did not propose an adjustment for psychiatric units. We received a significant number of public comments expressing concern that the proposed IPF PPS is biased towards psychiatric hospitals and detrimental to psychiatric units. Therefore, the commenters requested that we provide an adjustment specifically for psychiatric units. We are not adopting an adjustment for psychiatric units in this final rule.

Comment: Several commenters stated that the data analysis indicated that the average per diem cost in psychiatric units ($615) was 37 percent higher than the average per diem cost in psychiatric hospitals ($444). Although the proposed patient and facility adjustments account for 19 percent of the difference in average per diem costs, the commenters expressed concern that the proposed rule did not propose a specific adjustment for psychiatric units to account for the remaining 18 percent difference in average per diem costs.

Many commenters attribute the difference in average per diem cost to the types of patients admitted to psychiatric units and psychiatric hospitals. The commenters stated that patients admitted to psychiatric units generally present with multiple medical conditions in addition to severe or multiple psychiatric symptoms. In addition, EDs in acute care hospitals with psychiatric units serve as the portal for almost all psychiatric emergency patients, who usually are admitted to the psychiatric unit. As a result, psychiatric units have different patterns of care and staffing in order to treat patients with emergency psychiatric needs as well as comorbid medical conditions.

The commenters stated that freestanding psychiatric hospitals are not equipped or staffed to treat patients with complex comorbid medical conditions and generally do not admit patients who require treatment of chronic physical illnesses or who are not medically stable. As a result, freestanding psychiatric hospitals have lower average per diem costs than psychiatric units.

Many commenters recommended that we provide a Medicare-dependent IPF designation that would be applied to any IPF with at least an 80 percent Medicare share of admissions. An organization representing small, rural IPFs provided information describing rural psychiatric units and the patients generally treated in these units. The commenter indicated that rural psychiatric units usually have 12 or fewer beds and treat a high proportion (at least 80 percent of total patient days) of Medicare beneficiaries. The material furnished by the organization indicated that approximately 54 percent of these hospitals are located in areas not adjacent to a metropolitan area and 15 percent are in ''completely rural'' areas.

The organization indicated that these small rural Medicare-dependent units generally have average costs per day that are 27 percent higher than the national average due to the acuity of the patients they serve. In addition, an analysis conducted by the organization indicates an 11.9 percent negative impact between current TEFRA payments and estimated payments under the proposed IPF PPS.

Commenters also indicated that many of the psychiatric units are small, Medicare-dependent, and located in underserved rural and urban areas where they are the sole mental health provider. These commenters were concerned that inadequate Medicare payment would cause hospitals to close these units, resulting in diminished access to mental health services. The commenters stated that the proposed adjustments were insufficient and requested a specific adjustment for psychiatric units or, as an alternative, a temporary adjustment until we are able to refine the IPF PPS and account for more of the difference in average per diem cost.

Response: As we discussed in the November 2003 proposed rule, we do not believe it is appropriate to pay an adjustment to all psychiatric units for all cases, regardless of the unit's cost, efficiency, or case-mix.

With respect to providing an adjustment for psychiatric units, as explained previously in this final rule, the payment model we are adopting for IPFs explains approximately 33 percent of the variation in per diem cost among IPFs. As a result, we believe the IPF PPS will generate payments that are reasonably related to the per diem cost in psychiatric units. In addition, IPFs located in rural areas will receive an adjustment to account for higher per diem costs.

Commenters stated that IPFs have many patients with longer stays or multiple co-morbidities. The IPF PPS provides a base payment amount and adjustments for each day of the stay and multiple co-morbidity categories as well as a variety of other adjustments, we believe IPF PPS payments to psychiatric units will adequate meet their costs.

In addition, we are providing a stop-loss provision during the 3-year transition period during which a stop-loss policy will be in place to ensure that small rural, Medicare-dependent, and urban psychiatric units get an IPF PPS payment amount that is no less than 70 percent of what they would have otherwise been paid under TEFRA had the IPF PPS not been implemented. This ''safety net'' will prevent an IPF from sustaining a significant financial ''loss'' by converting to the IPF PPS. Simultaneously, these providers will learn how to adjust their business structures efficiently under the IPF PPS framework. See section V.C. of this final rule.

b. Cost of Living Adjustment

i. IPFs Located in Alaska and Hawaii

As indicated in the proposed rule, we did not propose a cost-of-living adjustment (COLA) for IPFs located in Alaska and Hawaii. Based on the FY 1999 data, there were two psychiatric hospitals and no psychiatric units in Alaska and one psychiatric hospital and one psychiatric unit in Hawaii. Our analysis indicated that some IPFs in Alaska and Hawaii would ''profit'' from the proposed IPF PPS and other IPFs would experience a ''loss.'' Based on the limited number of cases in the analysis, we determined that the results were inconclusive and therefore we did not propose a COLA for IPFs located in Alaska and Hawaii.

We received several comments requesting a COLA for IPFs located in Alaska and Hawaii. In response to the public comments, we analyzed the FY 2002 data. The FY 2002 data, unlike the FY 1999 data, demonstrated that IPFs in Alaska and Hawaii had costs disproportionately higher than IPFs across the nation. In the absence of a COLA, IPFs located in Alaska and Hawaii would receive payments under the IPF PPS that were far below their

cost. Thus, the results of our analysis conclusively demonstrate that a COLA for IPFs located in Alaska and Hawaii would improve payment equity for these facilities. As a result of this analysis, we are providing a COLA adjustment in this final IPF PPS based on the higher costs found in Alaska and Hawaii IPFs.

Comment: A few commenters recommended that CMS provide a facility-specific adjustment to the per diem payment amount to reflect the higher cost-of-living in Alaska.

One commenter recommended using the 25 percent Alaska COLA used under hospital IPPS for non-labor costs as a proxy adjustment for IPFs located in Alaska. The commenter stated that, despite the lack of IPF cases to study, CMS recognizes the need for a COLA adjustment for hospitals in Alaska under the hospital IPPS. The commenter indicated that MedPAC recently recommended that CMS provide an adjustment to the non-labor costs of skilled SNFs located in Alaska and Hawaii.

Response: As indicated above, we analyzed the cases in the FY 2002 data and found that there are two IPFs in Alaska and four in Hawaii. Based on our analysis of the FY 2002 stays for these IPFs, we find that a COLA adjustment is warranted. However, the small number of cases from each IPF would make development of a facility-specific adjustment erroneous because, with few cases, a small number of extremely high-cost or low-cost cases could easily overstate or understate the IPF's per diem cost. In general, the COLA would account for the higher costs in the IPF and will eliminate the projected loss that IPFs in Alaska and Hawaii would experience absent the COLA. We will make a COLA adjustment for IPFs located in Alaska and Hawaii by multiplying the non-labor share of the Federal per diem base rate by the applicable COLA factor based on the county in which the IPF is located. The COLA factors were obtained from the U.S. Office of Personnel Management and used in other PPS system. For the convenience of the reader, Table 8 below lists the specific COLA for Alaska and Hawaii IPFs.

TABLE 9—COLA Factors for Alaska and Hawaii IPFS

	Location	COLA
Alaska	All areas	1.25
Hawaii	Honolulu County	1.25
	Hawaii County	1.165
	Kauai County	1.2325
	Maui County	1.2375
	Kalawao County	1.2375

ii. IPFs located in California

Although we did not propose a cost-of-living adjustment for a specific State, we received a comment requesting that we provide an adjustment for California. We are not making a COLA to IPFs located in California as detailed below.

Comment: One comment recommended that CMS establish a facility-specific adjustment for psychiatric units located in California to reflect the higher resource costs associated with mandatory staffing ratios.

Response: Although recently imposed State staffing ratios would not be evident in the FY 2002 data, we analyzed the FY 2002 MedPAR data to assess whether IPFs located in California have higher per diem cost than IPFs located in other States. We determined that after adjustment for facility mix, IPF per diem costs in California are slightly higher (1.6 percent). While we did not assess the variation for each State, we acknowledge that every State will have some variation from the average cost per day under the IPF PPS. We do not believe the slightly higher per diem cost in California warrants a special adjustment. There may be laws in other States that could create a cost difference greater or lower than California and it is not practical to account for all of the cost differences in every State resulting from State and local laws.

c. Disproportionate Share Intensity

As indicated in the proposed rule, we did not propose an adjustment for disproportionate share hospital (DSH) status because the proposed regression analysis did not support an increase in payments. If we had proposed a payment adjustment for DSH facilities based on our empirical analysis, we would have proposed a reduction to the Federal per diem base rate paid to DSH facilities. Based on our analysis, we found a statistically significant negative relationship between per diem cost and DSH status. We did not believe that negative payment adjustment would be consistent with the intent of a DSH adjustment, which is intended to provide additional payments to providers to account for the costs of treating low-income patients. Therefore, we proposed no DSH adjustment.

We received numerous comments regarding the DSH adjustments. Most of the commenters disagreed with the proposed rule and stated that our reason for not providing a DSH adjustment was inadequate. A significant number of comments recommended that we re-examine the regression analysis and include a favorable DSH adjustment in the IPF PPS final rule. Based on the analysis discussed below, we are not providing a DSH adjustment in this final rule.

Comment: Several commenters stated that hospitals providing large amounts of care to low-income individuals often serve as key access points for low-income Medicare beneficiaries and other low-income patients requiring psychiatric care.

Response: In the proposed rule, we indicated that we would continue to monitor whether we could find empirical evidence to indicate a relationship between disproportionate patient percentages and higher per diem costs to support the establishment of a DSH adjustments. We re-examined our regression analysis, as commenters requested, but did not find any relationship between DSH intensity and higher per diem costs. Our analysis of the FY 2002 data yielded the same results as our analysis of the FY 1999. Therefore in this final rule we are not making a DSH adjustment.

Comment: One commenter stated that since CMS provided for a DSH adjustment in both the hospital IPPS and IRF PPS, IPFs should also receive this additional payment.

Another commenter indicated that the reluctance to allow psychiatric hospitals to participate in DSH payments is

related to the belief that the DSH hospitals are low cost providers.

Response: Consistent with the approach we have taken in the proposed rule and in this final rule, we believe that any IPF PPS DSH payment adjustment should be supported by data showing that DSH facilities experience higher per diem costs than other IPFs. Our data failed to demonstrate that the IPFs who serve a disproportionate number of low income patients have higher per diem costs. Therefore, we do not see a justification to make a DSH adjustment in the IPF PPS. Unlike IPFs, the IPPS and IRF PPS had data supporting the need for a DSH adjustment. IPPS and IRF PPS data showed that serving a disproportionate share of low income patients has a direct connection to higher facility costs.

Comment: A commenter suggested that if government-operated hospitals bias the result, the analysis should be redone excluding those hospitals.

Response: We believe the commenter misunderstood our statements in the proposed rule about the impact of government-operated hospitals in our analysis. Our intention was not that the government-operated hospitals might be responsible for the finding of a negative relationship between per diem cost and the DSH variable. Instead, we were emphasizing that many observers might think that the limitations of measuring DSH for government-operated hospitals (too low a value for their DSH variable) might explain why we found higher DSH intensity associated with lower cost. However, our finding was not attributable to the government-operated hospitals because we found the same negative relationship when we excluded them from the regression.

Comment: Some commenters indicated that because Medicaid does not pay for services to certain individuals in an institution for mental diseases (IMD), low-income beneficiaries in psychiatric hospitals cannot be identified as Medicaid beneficiaries. In addition, the commenters believe that the Medicaid proportion will be biased downwards smaller than it should be.

Response: In the proposed rule and in this rule, the basis for the decision not to provide a DSH adjustment is our inability to find a correlation between available measures of low-income patient percentages and higher per diem costs. As previously indicated, potential measurement error in the Medicaid proportion did not explain the lack of a positive correlation between per diem cost and DSH status. We recognize that inpatients in institutions for mental diseases may still be eligible for Medicaid for purposes of the calculation of the DSH percentage (although there might be little incentive for facilities to establish a patient's Medicaid eligibility when there is no Medicaid payment available). The fact remains that, with currently available data, we found no basis for a DSH adjustment.

Comment: Several commenters asked how section 402 of the MMA would impact payments under the IPF PPS.

One commenter recommended that CMS wait until after December 8, 2004, to develop the IPF DSH factors (when the MMA is implemented and CMS begins to furnish DSH data to all hospitals). The commenter indicated that they expect the data to be a viable source of information that could be used to establish an appropriate DSH adjustment factor for the IPF PPS.

Response: Section 402 of the MMA has no effect on the IPF PPS as it only applies to DSH under the IPPS. The commenter is apparently referring to section 951 of the MMA, which requires that the Secretary arrange to furnish subsection (d) hospitals (those hospitals subject to the hospital IPPS) with the data necessary to compute the number of patient days used in computing the disproportionate patient percentage. We acknowledge that it is possible for this requirement to improve the accuracy of the disproportionate patient percentages for hospitals at some future point in time. However, we are making our decision not to include a DSH adjustment based on the best available data. If better data becomes available that indicates a need for a DSH adjustment, and an appropriate methodology for such an adjustment, the issue can be addressed in a future rulemaking.

d. IPFs With Full-Service Emergency Departments (EDs)

We did not propose an adjustment for IPFs with a qualifying ED. However, we received many comments requesting a facility adjustment for hospitals that maintain an ED and provide crisis management services. Several commenters recommended that IPFs with an ED should receive a facility-level adjustment empirically determined through the regression model. One commenter recommended a 20 percent adjustment factor for IPFs in hospitals with an ED.

In this final rule, we are providing an adjustment to the Federal per diem base rate to account for the costs associated with maintaining a full-service ED. We conducted an analysis, as described below, to develop an appropriate payment adjustment to account for ED costs and to define the subset of IPFs that have, or are part of acute care hospitals that have, a full-service ED.

The overhead costs associated with maintaining an ED are included in each IPF's routine cost amount, but since routine costs are reported as a average, we are unable to determine the portion of the routine cost directly attributable to ED costs. As an alternative, we analyzed cases admitted through the ED using FY 2002 claims data. ED cases were identified by the presence of ED or ambulance charges on the MedPAR record. We found that about one-third of all cases were admitted through the ED, and that 98 percent of the cases were treated in psychiatric units. Among the psychiatric hospitals and units with at least one admission from an ED, the ED admissions comprise about 43 percent of all admissions.

In analyzing the relative cost of ED and other admissions, we limited the comparison to IPFs with ED admissions to avoid attributing cost differences to ED admissions that are due to other unrelated factors. On a per case basis, ED admissions are actually slightly less expensive than other admissions ($7,672 versus $8,036). Most of the difference results from the fact that ED stays are about one day shorter than other psychiatric stays (10.6 days versus 11.5 days). The ED costs average about $198 per case, and the mean difference in ancillary costs per case (which includes ED costs) is about $196. Thus, the ED costs effectively account for all of the difference in ancillary costs per case between the ED and other admissions. On average, admissions through the ED do not appear to require any more ancillary services than other admissions except for the ED costs themselves.

Although this analysis indicated that patients admitted through the ED were more costly on a per diem basis than cases without an ED admission, we are not including an adjustment for patients admitted through the ED. As explained previously, we are concerned about creating an incentive for psychiatric units in acute care hospitals with EDs to inappropriately admit all psychiatric patients through the ED of the acute care hospital in which it is located in order to receive a patient-level ED adjustment. An ED adjustment at the patient level would be approximately $200. To the extent a psychiatric unit ensured that all of its patients were admitted for inpatient psychiatric care through the ED of the acute care hospital in which it is located, even though admission through the ED was unnecessary and inappropriate, Medicare would be substantially overpaying for these cases.

As an alternative, we have decided to provide a facility-level adjustment for IPFs, for both psychiatric hospitals and acute care hospitals with a distinct part psychiatric unit, that maintain a qualifying ED. We are providing the adjustment to psychiatric units in acute care hospitals because the costs of the ED are allocated to all hospital departments, including the psychiatric units. We intend that the adjustment only be provided to hospitals with EDs that are staffed and equipped to furnish a comprehensive array of emergency services and that meet the definition of a ''dedicated emergency department'' in § 489.24 and the definition of ''provider-based entity'' in § 413.65. We are defining a full-service ED in order to avoid providing an ED adjustment to an intake unit that is not comparable to a full-service ED with respect to the array of emergency services available or cost.

However, where a psychiatric unit would otherwise qualify for the ED adjustment, but an individual patient is discharged from that acute care hospital, we would not apply the ED adjustment. The reason we would not give an ED adjustment in this case is that the costs associated with maintaining the ED would have already been paid through the DRG payment paid to the acute care hospital. Thus, if we provided an ED adjustment in this case, the hospital would be paid twice for the overhead costs of the ED.

The ED adjustment will be incorporated into the variable per diem adjustment for the first day of each stay. That is, IPFs with qualifying EDs, will receive a higher variable per diem adjustment for the first day of each stay than will other IPFs.

Three steps were involved in the calculation of the ED adjustment factor. First, we estimated of the proportion by which the ED costs of a case would increase the cost of the first day of the stay. Using the IPFs with ED admissions in 2002, we divided their average ED cost per stay admitted through the ED ($198) by their average cost per day ($715), which equals 0.28. Second, we adjusted the factor estimated in step 1 to account for the fact that we will pay the higher first day adjustment for all cases in the qualifying IPFs, not just the cases admitted through the ED. Since on average, 44 percent of the cases in IPFs with ED admissions are admitted through the ED, we multiplied 0.28 by 0.44, which equals 0.12. Third, we added the adjusted factor calculated in the previous 2 steps to the variable per diem adjustment derived from the regression equation that we used to derive our other payment adjustment factors. The first day payment factor from this regression is 1.19. Adding the 0.12, we obtained a first day variable per diem adjustment for IPFs with a qualifying ED equal to 1.31.

D. Other Proposed Adjustments and Policy Changes

1. Outlier Policy

We proposed a 2 percent outlier policy to promote access to IPFs for those patients who require expensive care and to limit the financial risk of IPFs treating unusually costly cases. As explained in the proposed rule, we believe that it is appropriate to include an outlier policy in order to ensure that IPFs treating unusually costly cases do not incur substantial ''losses'' and promote access to care for patients requiring expensive care. Providing these additional payments to IPFs for costs that are beyond the IPF's control will also improve the accuracy of the payment system. Similar to the proposed rule, our payment simulations continue to support establishment of the outlier policy at 2 percent of total payments because it affords protection for vulnerable IPFs (and patients) while providing appropriate levels of payment for all other cases that are not outlier cases. The 2 percent target continues to provide an appropriate balance between patient access, IPF financial risk, and the payment rate reduction required for all cases to offset the cost of the policy.

We proposed to make outlier payments on a per case basis rather than on a per diem basis because it is the overall financial ''gain'' or ''loss'' of the case, and not of individual days, that determines an IPF's financial risk and, as a result, access for unusually costly cases. In addition, because patient level charges (from which costs are estimated) are typically aggregated for the entire IPF stay, they are not reported in a manner that would permit accurate accounting on a daily basis.

Thus, we proposed to make outlier payment for discharges in which estimated costs exceed an adjusted threshold amount ($4,200 multiplied by the IPF's facility adjustments, that is, wage area, rural location, teaching, and cost of living adjustment for IPFs located in Alaska and Hawaii) plus the total IPF adjusted payment amount for the stay. Where the case qualifies for an outlier payment, we proposed to pay 80 percent of the difference between the estimated IPF's cost for the case and the adjusted threshold amount for days 1 through 8 of the stay, and 60 percent of the difference for day 9 and thereafter. We established 80 percent and 60 percent to lost sharing ratios because we were concerned that a single ratio established at 80 percent (like other Medicare hospital prospective payment systems) might provide an incentive under the IPF per diem system to increase length of stay in order to receive additional payments. After establishing the ratios, we determined the threshold amount of $4,200 through payment simulations designed to compute a dollar loss beyond which payments are estimated to meet the 2 percent outlier spending target. In this final rule, we adopted this proposed outlier policy methodology, with an adjusted threshold amount of $5700. The revised amount is based on updated simulations using more recent data (from FY 2002) and the modified policy for the loss sharing ratios (see below).

In this final rule, we modified application of the loss-sharing provision of the outlier policy to pay 80 percent of the difference between the IPF's estimated cost for the case and the adjusted threshold amount for days 1 through 9 of the stay (including median length of stay instead of days 1 through 8 up to the median length of stay) and 60 percent thereafter. As we explain above, we decided to reduce the 80 percent loss-sharing ratio by an additional 20 percent, resulting in a 60 percent loss sharing ratio for day 10 and thereafter. With this modification, we will pay 80 percent of the costs eligible for outlier payments for all cases whose length of stay is no greater than the median length of stay (9 days) of all Medicare inpatient psychiatric cases.

In the proposed rule, we proposed a number of policies to ensure the accuracy and integrity of our outlier payments. We are adopting these policies in this final rule, as decribed below.

Referring back to the payment calculation example in Section VI.B.2 of this final rule, the total estimated payment for the case is $7267.75. The adjusted threshold amount is calculated below:

Step 1: Multiply threshold by labor share and the wage area.

$5700 × 0.72528 (labor share) × 0.7743 (area wage index) = $3201.03

Step 2: Add this number to the non-labor share threshold amount.

$5700 × 0.27472 (non-labor share) = $1565.90

$1565.90 + $3201.03 = $4766.93

Step 3: Apply the other facility-level adjustments.

$4766.96 × 1.17 (rural adjustment) × 1.0 (teaching adjustment) = $5577.31

Step 4: Calculate the adjusted threshold amount by adding the estimated payment amount to the amount above.

$5577.31 + $7267.75 = $12,845.06

If estimated costs exceed the adjusted threshold amount ($12,845.06), then the case will qualify for an outlier payment. If the IPF in the example reports charges of $21,000 and they have a cost-to-charge ratio of 0.8, then the estimated cost of the case would be $16,800. The outlier amount is calculated below:

Step 1: Calculate the difference between the estimated cost and the adjusted threshold amount.

$16,800—$12.845.06 = $3954.94

Step 2: Divide by the length of stay (in our example, 10 days).

$3594.94 / 10 = $395.49

Step 3: For days 1 through 9 of the stay, the IPF receives 80% of this difference.

$395.49 × 0.80 = $316.40

$316.40 × 9 days = $2847.60

Step 4: For days 10 and beyond, the IPF receives 60% of the difference.

395 × 0.60 = $237.30 (in the example, the patient stays for 10 days, so the IPF receives the above amount for day 10 only).

Therefore, the IPF in the example would receive a total outlier payment of $3084.90.

($2847.60 + $237.30).

a. Statistical Accuracy of Cost-to-Charge Ratios

We believe that there is a need to ensure that the cost-to-charge ratio used to compute an IPF's estimated costs should be subject to a statistical measure of accuracy. Removing aberrant data from the calculation of outlier payments will allow us to enhance the extent to which outlier payments are equitably distributed and continue to reduce incentives for IPFs to under serve patients who require more costly care. Further, using a statistical measure of accuracy to address aberrant cost-to-charge ratios would also allow us to be consistent with the outlier policy under the hospital inpatient prospective payment system. Therefore, we are making the following two proposals:

• We will calculate two national ceilings, one for IPFs located in rural areas and one for facilities located in urban areas. We will compute the ceiling by first calculating the national average and the standard deviation of the cost-to-charge ratios for both urban and rural IPFs.

To determine the rural and urban ceilings, we will multiply each of the standard deviations by 3 and add the result to the appropriate national cost-to-charge ratio average (either rural or urban). We believe that the method explained above results in statistically valid ceilings. If an IPF's cost-to-charge ratio is above the applicable ceiling, the ratio is considered to be statistically inaccurate. Therefore, we will assign the national (either rural or urban) median cost-to-charge ratio to the IPF. Due to the small number of IPFs compared to the number of acute care hospitals, we believe that statewide averages used in the hospital inpatient prospective payment system, would not be statistically valid in the IPF context.

In addition, the distribution of cost-to-charge ratios for IPFs is not normally distributed and there is no limit to the upper ceiling of the ratio. For these reasons, the average value tends to be overstated due to the higher values on the upper tail of the distribution of cost-to-charge ratios. Therefore, we will use the national median by urban and rural type as the substitution value when the facility's actual cost-to-charge ratio is outside the trim values. Cost-to-charge ratios above this ceiling are probably due to faulty data reporting or entry, and, therefore, should not be used to identify and make payments for outlier cases because these data are clearly erroneous and should not be relied upon. In addition, we will update and announce the ceiling and averages using this methodology every year.

• We will not apply the applicable national median cost-to-charge ratio when an IPF's cost-to-charge ratio falls below a floor. We are adopting this policy because we believe IPFs could arbitrarily increase their charges in order to maximize outlier payments.

Even though this arbitrary increase in charges should result in a lower cost-to-charge ratio in the future (due to the lag time in cost report settlement), if we propose a floor on cost-to-charge ratios, we will apply the applicable national median for the IPFs actual cost-to-charge ratio. Using the national median cost-to-charge ratio in place of the provider's actual cost-to-charge ratio would estimate the IPF's costs higher than they actually are and may allow the IPF to inappropriately qualify for outlier payments.

Accordingly, we will apply the IPF's actual cost-to-charge ratio to determine the cost of the case rather than creating and applying a floor. In such cases as described above, applying an IPF's actual cost-to-charge ratio to charges in the future to determine the cost of the case will result in more appropriate outlier payments.

Consistent with the policy change under the hospital inpatient prospective payment system, IPFs will receive their actual cost-to-charge ratios no matter how low their ratios fall. We are still assessing the procedural changes that would be necessary to implement this change. For this final rule, we are finalizing the above described policies.

b. Adjustment of IPF Outlier Payments

As discussed in the hospital inpatient prospective payment system final rule for outliers, we have implemented changes to the IPPS outlier policy used to determine cost-to-charge ratios for acute care hospitals, because we became aware that payment vulnerabilities exist in the current outlier policy. Because we believe the IPF outlier payment methodology is likewise susceptible to the same payment vulnerabilities, we are adopting the following changes:

• Include in § 412.424(c)(2)(v) a cross-reference to § 412.84(i) that was included in the final rule published in the **Federal Register** on June 9, 2003 (68 FR 34515). Through this cross-reference, FIs will use more recent data when determining an IPF's cost-to-charge ratio. Specifically, as provided in § 412.84(i), FIs will use either the most recent settled IPF cost report or the most recent tentatively settled IPF cost report, whichever is later to obtain the applicable IPF cost-to-charge ratio. In addition, as provided under § 412.84(i), any reconciliation of outlier payments will be based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled.

Include in proposed § 412.424(c)(2)(v) a cross reference to § 412.84(m) (that was included in the final rule published in the **Federal Register** on June 9, 2003 (68 FR 34415) to revise the outlier policy under the hospital inpatient prospective payment system). Through this cross-reference, IPF outlier payments may be adjusted to account for the time value of money during the time period it was inappropriately held by the IPF as an ''overpayment.'' We also may adjust outlier payments for the time value of money for cases that are ''underpaid'' to the IPF. In these cases, the adjustment will result in additional payments to the IPF. Any adjustment will be based upon a widely available index to be established in advance by the Secretary, and will be applied from the midpoint of the cost reporting period to the date of reconciliation.

We received several comments on the proposed outlier policy. Most of the comments expressed support for the proposed outlier policy.

Comment: Many commenters indicated that the outlier level is too low and that there should be a mechanism to appeal an outlier payment. The commenters

recommended establishing the outlier policy at 5 percent of the total IPF PPS.

Response: We are maintaining a 2 percent outlier policy in the final IPF PPS. The 2 percent outlier target percentage is lower than the target outlier percentage of other prospective payment systems that contain outlier polices, which range from 3 percent in the inpatient rehabilitation PPS to 8 percent in the LTCH PPS. The target outlier percentage in IPPS is about 5 percent. However, these other systems are per case or per episode payment systems in which Medicare's payment does not automatically account for the higher costs associated with longer lengths of stay. In a per diem system, such as the IPF PPS, there is less of a need for outlier payments because it automatically adjusts payments for length of stay. Therefore, we believe that 2 percent of total IPF PPS payment is appropriate. We estimate that approximately 5 percent of IPF cases would meet the fixed dollar loss threshold amount and qualify for an average outlier payment of $3,248.

If the provider is dissatisfied with the amount of payment, they can invoke existing appeal rights.

Comment: Several commenters recommended modifying the outlier calculation so that the proposed risk sharing percentage of 60 percent for the ninth and subsequent days is increased to 80 percent.

Response: We proposed to reduce the risk sharing percentage from 80 percent to 60 percent after the 8th day of the stay. The choice of the 8th day was based on the fact that a single variable per diem adjustment was proposed for days 5 through 8, and we thought it appropriate to make the change in the risk sharing percentage change coincide with the change in the variable per diem adjustment factor. After analyzing new data and based on public comments, we have revised the variable per diem adjustment factors so that they vary continuously over the first 22 days of the stay. As a result, there is no longer any reason to make the change in the risk sharing percentage coincide with the variable per diem adjustment factors. In this final rule, we are changing the risk sharing percentage from 80 percent to 60 percent after the 9th day of the stay. We chose to include the 9th day in the 80 percent risk sharing category because 9 days is the median length of stay. The median implies that one-half of the cases have a length of stay greater than 9 days, and the other half have a length of stay less than 9 days, which also can be interpreted as implying that the ''typical'' case has a length of stay of 9 days. We will pay the 80 percent risk sharing percentage for all cases whose length of stay is less than or equal to the length of stay of the typical case. We are reducing the risk sharing percentage for cases whose length of stay exceeds that of the typical case, because as we noted in the proposed rule (68 FR 66934), we are concerned that a single risk sharing percentage at 80 percent might provide an incentive to increase length of stay in order to received additional outlier payments. Reducing the amount Medicare shares in the loss of high cost cases provides an incentive for an IPF to contain costs once a case qualifies for outlier payments. The reduction from 80 percent to 60 percent is adequate to provide such an incentive, while maintaining a significant degree of risk sharing.

Comment: Many commenters requested that CMS provide additional information to the sample calculation presented in the proposed rule. The commenters also recommended that CMS explain the circumstances under which an outlier would be paid (interim billing or at the time of discharge).

Response: Since outlier payments will be made on a per-case basis, a determination as to whether a case qualifies for an outlier payment cannot be made until discharge. We are concerned about the potential for overpayments associated with IPF stays that may appear to qualify for outlier payments early in the stay, but do not meet the fixed dollar loss threshold once all costs and IPF PPS payments are considered. To avoid this situation, we proposed in § 412.432(d), that additional payments for outliers are not made on an interim basis. Rather, outlier payments are made based on the submission of a discharge bill. We are adopting this provision in this final rule.

Comment: Several commenters recommended clarification on the methodology for determining the cost-to-charge ratio, a clear definition of the numerator and denominator in the ratio, identifying the applicable worksheet location for data on costs and charges, as well as the appeal or comments that might be available when the national cost-to-charge ratios are published.

Response: We intend to follow similar procedures as outlined in the IPPS final rule published in the **Federal Register** on June 9, 2003 (68 FR 34498). IPF PPS outlier methodology requires the FI to calculate the provider's overall Medicare cost-to-charge ratio using the facility's latest settled cost report or tentatively settled cost report (whichever is from the later period), and associated data. Cost-to-charge ratios will be updated each time a subsequent cost report is settled or tentatively settled. *Total Medicare charges* will consist of the sum of inpatient routine charges and the sum of inpatient ancillary charges including capital. *Total Medicare costs* will consist of the sum of inpatient routine costs (net of private room differential and swing bed cost) plus the sum of ancillary costs plus capital-related pass-through cost only. Based on current Medicare cost reports and worksheet, specific FI instructions are described below.

For freestanding IPFs, Medicare charges will be obtained from Worksheet D–4, column 2, lines 25 through 30, plus line 103 from the cost report. For freestanding IPFS, total Medicare costs will be obtained from worksheet D–1, Part II, line 49 minus (Worksheet D, Part III, column 8, lines 25 through 30, plus Worksheet D, Part IV, column 7, line 101). Divide the Medicare costs by the Medicare charges to compute the cost-to-charge ratio.

For IPFs that are distinct part psychiatric units, total Medicare inpatient routine charges will be estimated by dividing Medicare routine costs on Worksheet D–1, Part II, line 41, by the result of Worksheet C, Part I, line 31, column 3 divided by line 31, column 6. Add this amount to Medicare ancillary charges on Worksheet D–4, column 2, line 103 to arrive at total Medicare charges. To calculate the total Medicare costs for distinct part units, data will be obtained from Worksheet D–1, Part II, line 49 minus (Worksheet D, part III, column 8, line 31 plus Worksheet D, Part IV, column 7, line 101). All references to Worksheet and specific line numbers should correspond with the subprovider identified as the IPF unit, that is the letter ''S'' is the third position of the Medicare provider number. Divide the total Medicare costs by the total Medicare charges to compute the cost-to-charge ratio.

If the provider is dissatisfied with the FI's cost-to-charge ratio determination, they can invoke their applicable appeal rights.

2. Interrupted Stays

In the proposed rule, we proposed an interrupted stay policy based on our concern that IPFs could maximize inappropriate Medicare payment by prematurely discharging patients after they receive the higher variable per diem adjustments and then readmitting the same patient. Under the proposed policy, if a patient is discharged from an IPF and returns to the same IPF before midnight on the fifth consecutive day following discharge, the case is

considered to be continuous for applying the variable per diem adjustments and determining whether the case qualifies for outlier payments. Therefore, we would not apply the variable per diem adjustments for the second admission and would combine the costs of both admissions for the purpose of outlier payments. We proposed this policy in order to lower the incentive for a hospital to move patients among Medicare-covered sites in order to maximize Medicare payments. We received many public comments regarding the proposed interrupted stay policy. Most of the commenters requested that we delete the interrupted stay policy, provide an exception for discharges to an acute care hospital in order to receive medical or surgical services, for readmissions due to psychiatric decompensation, or shorten the duration of the interrupted stay policy. In this final rule, we are retaining the interrupted stay policy, but we are shortening the duration to 3 days.

Therefore, if a patient is discharged from an IPF and admitted to any IPF within 3 consecutive days of the discharge from the original IPF stay, the stay would be treated as continuous for purposes of the variable per diem adjustment and any applicable outlier payment.

For example a patient is discharged from an IPF on March 10 after an initial stay of 7 days and is admitted to another IPF on March 12 (before midnight of the 3rd consecutive day). The ''readmission'' is considered a continuation of the initial stay. Therefore day 1 of the readmission will be considered day 8 of the combined stay for purposes of the variable per diem stay and any applicable outlier payment.

Comment: A few commenters stated that after a 5-day interruption, the patient would need a full workup similar to the admission process on the first day. One commenter stated that the proposed 5-day interrupted stay policy financially penalizes IPFs for ensuring that their patients receive necessary emergency medical care.

Most commenters requested that we shorten the duration of the interrupted stay policy. Other commenters stated that a 5-day interrupted stay policy would require IPFs to hold claims and not bill Medicare until after the fifth day of discharge and that a 5-day interrupted stay policy could cause IPFs to delay readmissions to avoid the policy.

Several commenters recommended that we reduce the duration of the interrupted stay policy to 3 days to coincide with the 72-hour rule for bundling of outpatient charges under IPPS. Other commenters suggested a 3-day interrupted stay policy in order to be consistent with the interrupted stay policy in the IRF prospective payment system. However, a few commenters suggested that we extend the interrupted stay policy to readmissions to the IPF within 15 or 30 days of the patients discharge that would prompt a readmission review by the hospital's Quality Improvement Organization.

Response: In the proposed rule, we indicated that an absence from the IPF of less than 5 days would not necessitate repeating many of the admission-related services such as psychiatric evaluations and the patient's medical history. After receiving public comments we reanalyzed the duration of the interrupted stay policy. We now agree that after a 5-day absence from the IPF there are psychiatric and laboratory tests that would need to be repeated. As a result, we have revised the duration of the interrupted stay policy in this final rule from 5 days to 3 days.

Comment: Several commenters did not believe an interrupted stay policy was necessary to avoid inappropriate transfers and readmissions to the IPF. One commenter stated that adequate safeguards already exist, such as the physician certification and recertification requirements, significant medical malpractice risk of premature discharge, periodic review of practice patterns by local licensing and national accreditation bodies, and FI audits.

Response: Despite the safeguards identified by the commenters, inappropriate transfers and readmissions of psychiatric patients continue to occur. For this reason, we continue to believe an interrupted stay policy is necessary to discourage inappropriate discharges and readmissions to IPFs.

Comment: The majority of commenters requested that we provide an exception to the interrupted stay policy when a patient is discharged to an acute care hospital for medical care. The commenters maintain that the resources required to treat the patient at the time of readmission are of similar intensity to those required at the point of first admission. All assessments (including history and physical and psychiatric assessment) as well as the comprehensive treatment plan need to be reviewed and revised. In addition, the medical condition that required treatment must be addressed and incorporated into the ongoing treatment. One commenter suggested that discharges and subsequent readmissions to the IPF due to psychiatric decompensation should not be subject to the interrupted stay policy as well.

Response: Although we agree that some additional resources will be expended by IPFs when a patient is readmitted, we believe the resources required to reassess a patient upon readmission would be greatly reduced after a 3-day interrupted stay compared to the proposed 5-day interrupted stay policy. In addition, since almost three fourths of IPFs are distinct part psychiatric units in acute care hospitals, we remain concerned about hospitals inappropriately shifting patients between the psychiatric unit and the medical unit, thus receiving both the full DRG payment for the admission to the acute care hospital, and IPF payment for the admission to the excluded psychiatric unit.

Comment: One commenter asked if the interrupted stay policy applies if a patient is discharged to receive acute care and is readmitted to a different IPF than the IPF that originally discharged and transferred the patient. The commenter indicated that the shuffling of psychiatric patients from hospital to hospital is an abusive practice that the interrupted stay policy should address.

Response: We share the commenter's concern about the ''shuffling'' of psychiatric patients from hospital to hospital. We believe adopting an interrupted stay policy will address this concern from the viewpoint of the IPF PPS.

One example is when a patient is discharged from a psychiatric unit to receive acute care and discharged at the completion of the hospital IPPS stay, then transferred to a freestanding psychiatric hospital rather than returning to the psychiatric unit. Under the interrupted stay policy, if the readmission to the psychiatric hospital occurs within the 3-day interrupted stay timeframe, of the initial psychiatric unit stay, we would not pay the psychiatric hospital the variable per diem adjustments for the initial days of the original psychiatric unit stay otherwise applicable to the stay. The transferring hospital would send the psychiatric hospital the patient's medical record that will include information regarding the prior psychiatric stay in accordance with the hospital condition of participation for discharge planning (§ 482.43).

As a result, we have revised § 412.424(d) to clarify that if a patient is discharged from an IPF and is readmitted to the same or another IPF before midnight on the third consecutive day following the discharge from the original IPF stay, the case is considered to be continuous for

applying the variable per diem adjustments and determining whether the case qualifies for outlier payments.

Comment: Several commenters asked if the interrupted stay policy would apply if a patient is transferred from a distinct part psychiatric unit to the hospital's medical unit and is readmitted to the IPF within the 5-day interrupted stay timeframe, but with a different principal diagnosis.

Response: In the situation described by the commenter, the interrupted stay policy would apply. A psychiatric patient whose illness is severe enough to require inpatient psychiatric treatment, should be receiving care for all of their psychiatric conditions. Therefore, if this psychiatric patient was discharged for acute medical care, and upon discharge from the acute medical hospital the patient still required inpatient psychiatric treatment, that treatment should be considered a continuation of the original stay. Thus, the principal diagnosis upon readmission is not relevant to the interrupted stay policy.

Comment: One commenter asked if the interrupted stay policy would apply when a patient is discharged to a partial hospitalization program, decompensates while in that program, necessitating a readmission to the IPF within 5 days of the discharge from the IPF.

Response: Under this final rule, if a patient was in an IPF and was discharged to a partial hospitalization program but then required readmission to an IPF within the 3-day timeframe, the stay is considered an interrupted stay. The interrupted stay policy applies to all discharges and subsequent readmissions to an IPF within 3 consecutive days.

3. Stop-Loss Provision

Many commenters who believed that they would be disadvantaged by implementation of the IPF PPS, requested that we provide additional payments through a risk sharing arrangement. We considered alternatives that would reduce financial risk to facilities expected to experience substantial reductions in Medicare payments during the period of transition to the IPF PPS.

Specifically, we considered stop-loss policies that would guarantee each facility, total IPF PPS payments no less than a minimum percent of its TEFRA payments, had the IPF PPS not been implemented. The two values for the minimum percent of TEFRA payments we examined were 70 percent and 80 percent. The 80 percent option was considered because 80 percent is a commonly used rate of risk-sharing in Medicare programs. We pay 80 percent of the estimated costs of outlier cases beyond the outlier threshold, and 80 percent is similarly used in other Medicare PPS's, as well as in many other insurance arrangements. The 70 percent option was assessed as an alternative, because it more narrowly targets stop-loss payments to facilities with greater financial risk.

Each of these policies was applied to the IPF PPS portion of Medicare payments during the transition. Hence, during year 1, three-quarters of the payment would be based on TEFRA and one-quarter on the IPF PPS. In year 2, one-half of the payment would be based on TEFRA and one-half on the IPF PPS. In year 3, one-quarter of the payment would be based on TEFRA and three-quarters on the IPF PPS. In year 4 of the IPF PPS, Medicare payments are based 100 percent on the IPF PPS.

The combined effects of the transition and the stop-loss policies would be to ensure that the total estimated IPF PPS payments would be no less than 92.5 or 95 percent in year 1, 85 or 90 percent in year 2, and 77.5 or 85 percent in year 3, depending upon whether the 70 percent or the 80 percent stop-loss option were implemented. Under the 70 percent policy, 75 percent of total payment would be TEFRA payments, and the 25 percent would be IPF PPS payments, which would be guaranteed to be at least 70 percent of the TEFRA payments. The resulting 92.5 percent of TEFRA payments is the sum of 75 percent and 25 percent times 70 percent (which equals 17.5 percent).

The 70 percent of TEFRA payment stop-loss policy would require a reduction in the Federal per diem and ECT base rates of 0.39 percent in order to make the stop-loss payments budget neutral. We estimate that about 10 percent of IPFs would receive stop-loss payments under the 70 percent policy.

The 80 percent of TEFRA stop-loss policy would require a reduction in the Federal per diem rate of almost 2 percent in order to make the stop-loss policy budget neutral. We estimate that almost 27 percent of all facilities would receive additional payments under the 80 percent stop-loss policy.

We also considered a risk-sharing policy modeled on the same principles as the case-level outlier policy, but applied at the facility level. Under this approach, we considered the case in which an IPF would have to incur a 12 percent loss in IPF PPS payments relative to TEFRA and then we would pay 80 percent of additional losses. This approach was estimated to require a reduction in the Federal per diem and ECT base rates of about 12 percent.

In order to target the stop-loss policy to the IPFs that may experience the greatest impact relative to current payments and to limit the size of the reductions to the Federal per diem and ECT base rates required to maintain budget neutrality, we are adopting the 70 percent stop-loss provision. We have added a new paragraph (d) to § 412.426 to include the 70 percent stop-loss provision as part of the 3-year transition to the IPF PPS. We will monitor expenditures under this policy to evaluate its effectiveness in targeting stop-loss payments to IPFs facing the greatest financial risk.

4. Physician Recertification Requirements

In the proposed rule, we proposed to modify the timing of the first physician recertification after admission to the IPF. We proposed to revise § 424.14(d) to require that a physician recertify a patient's continued need for inpatient psychiatric care on the tenth day following admission to the IPF rather than the 18th day following admission to the IPF.

Also, we proposed to amend § 424.14 by adding a new paragraph (c)(3) to require that, in recertifying a patient's need for continued inpatient care, a physician must indicate that the patient continues to need, on a daily basis, inpatient psychiatric care (furnished directly by or requiring the supervision of IPF personnel) or other professional services that, as a practical matter, can be provided only on an inpatient basis. We received a few comments supporting the proposed change. However, most of the commenters did not support the proposed changes and indicated inconsistencies in the timeframes currently required for IPFs that warrant additional analysis. As a result, we are not including the proposed physician re-certification requirements in this final rule. We will continue to require that a physician recertify a patient's continued need for inpatient psychiatric care on the 18th day following admission to the IPF.

VII. Implementation of the IPF PPS

A. Transition Period

1. Existing Providers

We proposed a 3-year transition period during which IPFs would receive a blended payment of the Federal per diem payment amount and the facility-specific payment amount the IPF would receive under the TEFRA payment methodology. We proposed that the first year of the transition would be 15 months. Thus the first year of transition is for cost reporting periods beginning

on or after April 1, 2004 and before July 1, 2005. The proposed total payment for this period would consist of 75 percent based on the TEFRA payment system and 25 percent based on the proposed IPF prospective payment amount.

We also proposed that for cost reporting periods beginning on or after July 1, 2005 and before July 1, 2006, the total payment would consist of 50 percent based on the TEFRA payment system, and 50 percent based on the proposed IPF prospective payment amount. In addition, we also proposed that for cost reporting periods beginning on or after July 1, 2006 and before July 1, 2007, the total payment would consist of 25 percent based on the TEFRA payment system and 75 percent based on the proposed IPF prospective payment amount. Thus, we proposed that payments to IPFs would be at 100 percent of the proposed IPF prospective payment amount for cost reporting periods beginning on or after July 1, 2007.

We proposed this transition period so existing IPFs would have time to adjust their cost structures and integrate the effects of changing to the IPF PPS payment system. We specified that we would not allow IPFs the option to be paid at 100 percent of the IPF PPS payment amount in the first year of the transition, but would require all IPFs to receive the blended IPF payments during the 3-year transition period.

However, new IPFs would be paid the full Federal per diem payment amount rather than a blended payment amount. This is because the transition period is intended to provide currently existing IPFs time to adjust to payment under the new system. A new IPF would not have received payment under TEFRA for delivery of IPF services before the effective date of the IPF PPS. Therefore, we believe new IPFs do not need a transition to adjust their operating or capital financing that IPFs that have been paid under the TEFRA payment methodology would need.

In the proposed rule (68 FR 66920), we defined new IPFs as those IPFs that, under current or previous ownership or both, have their first cost reporting period as an IPF beginning on or after April 1, 2004. In this final rule, we define a new provider as those IPFs that, under current or previous ownership or both, have their first cost reporting period as an IPF beginning on or after January 1, 2005 to coincide with the effective date of the final IPF PPS.

Comment: The majority of commenters requested that we provide an option for IPFs to forego the transition and be paid at 100 percent of the IPF PPS payment amount in the first year of the transition. The commenters stated that other PPSs, specifically IRF PPS and LTCH PPS, included that option.

The commenters also stated that a mandatory transition period causes IPFs to continue to be paid under the outdated TEFRA payment system. The commenters requested that IPFs that are substantially underpaid under TEFRA or those that would be last to begin the transition to the IPF PPS because of the timing of their cost reporting year should be permitted to receive 100 percent of the Federal per diem payment amount.

One commenter stated that failure to provide for a 100 percent IPF PPS payment option disadvantages efficient providers. The commenter indicated IPFs that choose this option would strive to become more cost efficient more quickly. In addition, the blended payment methodology during the transition period could lead to payments that are less than current cost-based payments and would penalize IPFs that have a low TEFRA rate. Several commenters indicated that a 100 percent IPF PPS payment option would avoid the complications and financial burden of a blended payment process due to accounting difficulties caused by being paid under two payment systems.

One commenter indicated that the protection offered by the transition is short-lived and that psychiatric units suffering the greatest losses will experience significant financial hardship until the IPF PPS is refined to account for more of the variation in the per diem costs of psychiatric units and psychiatric hospitals.

Another commenter indicated that hospitals would be unable to offset Medicare ''losses'' under the IPF PPS with gains in other services. The commenter indicated that it would be very difficult for many of these hospitals to support ''losses'' in their psychiatric units for the long term and that some hospitals may decide to close their psychiatric units, which would result in diminished access for beneficiaries.

However, several commenters specifically requested that CMS retain the proposed 3-year transition period. The commenters stated that the IPF PPS could have unexpected financial consequences for IPFs and the full transition period is needed to enable IPFs to adapt to the new payment system. The commenters are concerned that allowing immediate implementation of the IPF PPS would dilute the Federal per diem base rate and exacerbate the redistributive effect of the new payment system. Several commenters indicated that the availability of new funding, a 100 percent of the Federal per diem payment amount option would result in further reductions to the Federal per diem base rate. As a result, these commenters would support a 100 percent option, but only if there is new funding available.

Other commenters requested that CMS phase-in the new IPF PPS more slowly, to allow corrections to any serious errors in the IPF PPS before full implementaion. Commenters recommended that CMS lengthen the transition to 5 or 6 years and perhaps for as long as 10 years to enable CMS to refine the IPF PPS before the full implementation.

Response: We have retained the transition period in the final IPF PPS. We believe this approach strikes an appropriate balance between IPFs that are prepared immediately to move to full implementation of the IPF PPS and those IPFs that need time to make the changes before the full implementation of the new PPS.

Section 305(b)(10)(c) of BIPA allowed IRFs to elect to be paid 100 percent of the adjusted facility Federal prospective payment for each cost reporting period to which the blended payment methodology would other wise have been applied. In implementing LTCHs 5-year transition period of the PPS, one of the goals was to transition hospitals to full prospective payments as soon as appropriate. Due to the longer length of the transition period, under the LTCH PPS, we allowed LTCHs to elect payment based on 100 percent of the Federal rate at the start of any of its cost reporting periods during the 5-year transition period. Once the election to be paid 100 percent of the Federal per diem base rate was made, the LTCH was not able to revert to the transition blend.

The IPF statute does not mandate that IPFs be given the option to elect to be paid 100 percent of IPF PPS payment amount immediately Federal rate. The shorter timeframe of a 3-year transition period was to provide all IPFs adequate time to make the most prudent adjustments to their operations and capital financing to secure the maximum benefits of the new PPS.

Absent the availability of additional funds, the reallocation of existing funds in budget neutral payment systems cause shifts in facility payments. The aim of having an IPF PPS payment amount that is a blend of an ever-decreasing TEFRA portion and ever increasing IPF PPS portion is to mitigate dramatic negative effects of converting too quickly to a new payment system. Every budget neutral payment system will impact different provider groups

differently. Some providers believe that they will ''gain'' under the new IPF PPS while others believe they will do less well compared to the payments they have received under TEFRA.

To provide the impartial treatment to all IPFs, in the final IPF PPS, we have required all IPFs to participate in the 3-year transition period. Therefore, prolonging the transitional period to 5 or 10 years would not help providers who believe they have been disadvantaged under TEFRA as well as those who feel they are not being helped under IPF PPS for a an even longer period of time.

However, we share the commenter's concern about the ability of IPFs to adjust to the IPF PPS so that access to inpatient mental health care is maintained. Thus, we have tried to ensure continued access to mental health care by accounting for the complexity of patients with concurrent psychiatric and medical health conditions. We have created a PPS with numerous patient and facility level adjustments, an outlier policy, as well as a stop-loss policy that when used in combination with the transition period should ensure that an IPF PPS payment adequately reflects the costs of furnishing inpatient psychiatric care to Medicare beneficiaries.

2. New Providers

We proposed a definition of a new IPF because new IPFs will not participate in the 3-year transition from cost-based reimbursement under TEFRA to the IPF PPS. The transition period is intended to provide existing IPFs time to adjust to payment under the IPF PPS. A new IPF would not have received payment under TEFRA for the delivery of IPF services before the effective date of the IPF PPS. Therefore, we do not believe that new IPFs require a transition period in order to make adjustments to their operating and capital financing, as will IPFs that have been paid under TEFRA, or need to otherwise integrate the effects of changing from one payment system to another payment system.

For purposes of applying the IPF PPS 3-year transition period, we proposed to define a new IPF as a provider of inpatient hospital psychiatric services that otherwise meets the qualifying criteria for IPFs, set forth in § 412.22, § 412.23, § 412.25, and § 412.27 under present or previous ownership (or both), and its first cost reporting period as an IPF begins on or after April 1, 2004, the effective date of the proposed IPF PPS. In this final rule, we are finalizing the definition, except we are replacing April 1, 2004 with January 1, 2005 in order to account for the revised effective date of the final IPF PPS. In other words, we are finalizing the definition of a new IPF as a provider of inpatient hospital psychiatric services that otherwise meets the qualifying criteria for IPFs, set forth in § 412.22, § 412.23, § 412.25, and § 412.27 under present or previous ownership (or both), and its first cost reporting period as an IPF begins on or after January 1, 2005.

B. Claims Processing

We proposed to continue processing claims in a manner similar to the current claims processing system. Hospitals would continue to report diagnostic information on the claim form and the FIs would continue to enter clinical and demographic information in their claims processing systems for review by the Medicare Code Editor (MCE).

Comment: We received a variety of comments from all-inclusive rate and nominal cost hospitals regarding specific billing issues.

Response: We are issuing operational instructions to address the specific billing issues raised by the commenters.

C. Annual Update

In the proposed rule, we indicated that section 124 of Public Law 106–113 does not specify an update strategy for the IPF PPS and is broadly written to give the Secretary discretion in proposing an update methodology. Therefore, we reviewed the update approach used in other hospital prospective payment systems (specifically, the IRF and LTCH PPS update methodologies).

As a result of this analysis, we proposed the following strategy for updating the IPF PPS: (1) use the FY 2000 bills and cost report data and the most current ICD–9–CM codes and DRGs when we issue the IPF prospective payment system final rule; (2) implement the system effective for cost reporting periods beginning on or after April 1, 2004; and (3) update the Federal per diem base rate on July 1, 2005, since a July 1 update coincides with more hospital cost reporting cycles and would be administratively easier to manage. As a result, the implementation period for the proposed IPF PPS was the 15-month period April 1, 2004 to June 30, 2005.

In this final rule, we calculated the final Federal per diem base rate to be budget neutral during the implementation period of the final IPF PPS. As in the proposed rule, for future updates, we will use a July 1 through June 30 annual update cycle. Similar to the proposed rule, we will not update the IPF PPS during the first year of implementation because we believe there would be an insufficient amount of time under the IPF PPS to generate data useful in updating the system. Thus, the implementation period for the final IPF PPS is the 18-month period January 1, 2005 through June 30, 2006. As a result, the first update to the IPF PPS will occur on July 1, 2006, and updated for each subsequent 12-month period thereafter.

As we noted in the proposed rule, we believe it is important to delay updating the adjustment factors derived from the regression analysis until we have IPF PPS data that includes as much information as possible regarding the patient-level characteristics of the population that each IPF serves. For this reason, we do not intend to update the regression and recalculate the Federal per diem base rate until we have analyzed one complete year of data under the IPF PPS. Until that analysis is complete, we proposed to publish a notice in the **Federal Register** each spring to update the IPF PPS and identified the various elements of the IPF PPS that we would update.

In this final rule, we are adopting the proposed annual update with minor modifications to reflect the policies contained in this final rule. For example, we did not include an adjustment for ECT in the proposed rule and as a result, the proposed update strategy did not address how we would update that payment amount.

We will publish a notice in the spring of CY 2006 to update the IPF PPS effective July 1, 2006 and will publish a update notice for each 12-month period thereafter. In the notice, we will:

- Update the Federal per diem base rate using the excluded hospital with capital market basket increase in order to reflect the price of goods and services used by IPFs.
- Apply the best available hospital wage index with an adjustment factor to the Federal per diem base rate to ensure that aggregate payments to IPFs are not affected by an updated wage index.
- Update the fixed dollar loss threshold to maintain an outlier policy that is 2 percent of total estimated IPF PPS payments.
- Describe relevant ICD–9–CM coding and DRG classification changes discussed in the IPPS that would affect IPF PPS coding and payment.
- Update the payment amount for ECT based on the best available OPPS data.

Finally, as we indicated in the proposed rule, we may propose an update methodology for the IPF PPS in the future. We anticipate that the update methodology would be based on the

excluded hospital with capital market basket index along with other appropriate factors relevant to psychiatric service delivery such as productivity, intensity, new technology, and changes in practice patterns.

Comment: Several commenters requested that we delay the proposed April 1, 2004 implementation date until October 1, 2004 in order to be consistent with the October 1 update cycle for the IPPS. The commenters believe that an October 1 update cycle for the IPF PPS would avoid confusion and coding errors that would occur because of the introduction of ICD–9–CM and DRG changes mid-cycle. In addition, the commenters believe adopting an update cycle consistent with the IPPS would facilitate cost efficiency by also allowing educational efforts for coding and DRG changes to occur once per year.

Response: While we appreciate the commenter's concerns, it is important that CMS retain the flexibility to develop administratively feasible update schedules for the various prospective payment systems that must be updated annually. Therefore, we are retaining a July 1 through June 30 cycle for annual updating of the IPF PPS.

Comment: A few commenters requested clarification regarding the timing of implementation since hospitals have different cost reporting year start dates.

Response: IPFs will begin the first transition year of the IPF PPS at the beginning of their next cost reporting period after January 1, 2005. For example, if an IPF's cost reporting year begins on March 1, the IPF would begin to receive a blended payment amount consisting of 75 percent based on TEFRA payments and 25 percent based on IPF PPS payments for all discharges that occur after March 1, 2005.

VIII. Future Refinements

In the proposed rule, we described research efforts by RTI International® and the University of Michigan that were underway at the time the proposed rule was published. Section VI. of this final rule describes the outcome of the RTI International® project to study modes of practice and patient characteristics to analyze the components of the routine cost category of the Medicare cost report.

The University of Michigan project would assist us in developing a patient classification system based on a standard assessment tool, the Case Mix Assessment Tool (CMAT). We attached a draft of the assessment tool and explained that it had not been submitted to the Office of Management and Budget (OMB) for review in order to obtain approval to pilot test the draft assessment tool. We indicated that a public comment period would be available as part of the OMB review process.

We received multiple comments on the CMAT instrument.

Most of the comments received focused on the overall content of the instrument. There were several commenters that opposed the potential implements of the instrument.

Comment: One commenter indicated that CMAT appeared to address the primary diagnostic needs of the mentally ill, but fell short on the collection of information on functional status. The commenters recommended that variables be added to CMAT instrument to collect information on social integration and the recreational use of time. The commenter also indicated that it was not clear how the functionality section would affect payment. Other commenters recommended that the instrument be revised to capture better information on patient conditions and resources needed to provide care. One commenter indicated that while the CMAT, as proposed, was an excellent tool for describing psychiatric signs and symptoms, it fails to assess active comorbid medical conditions. Another commenter recommended that the CMAT instrument be expanded to collect information on the use of seclusion and restraints. Another commenter also indicated that the CMAT should contain sections that specifically address the assessment reference date, common observational periods, and multiaxial assessments.

Response: We are aware that the current draft CMAT instrument would not collect extensive information on patient conditions and comorbid conditions. However, if the instrument is pilot tested, and ultimately fielded for refinement purposes, we are planning to match the CMAT with CMS administrative files. This comparison will augment the collection capacity of the CMAT and provide detailed information of medical conditions. The draft CMAT instrument, which has not been proposed, is currently undergoing OMB review. Following this review, the instrument is to be pilot tested. The variables suggested in these comments (for example, seclusion and restraints, assessment dates, observational periods, and multi-axial assessments) are being evaluated for potential inclusion in the pilot test.

Comment: One commenter recommended that because the CMAT is controversial, any pilot test findings should be made available to the public.

Response: The results of the pilot test will be made available to the public. We plan to test the feasibility of administration, reliability and validity of the instrument, and recommendations regarding potential modifications to the draft CMAT. A report from the pilot test will be available, and CMS will use this report and experience garnered from the pilot test to determine next steps for the instrument. We will then decide whether to propose the use of the CMAT instrument to assist us in developing a patient classification system.

Comment: Several commenters expressed support for development of a standardized instrument to collect patient level information to augment CMS administrative data. One commenter stated that the costs for an instrument would be outweighed by the benefits of creating a tool that collects information on patient conditions and necessary resources, so long as the tool is easy to use and complete.

Another commenter was pleased with the development of the CMAT and indicated that only when information from the refined variables in CMAT are available would it be appropriate to implement the IPF PPS.

Response: We will implement the IPF PPS before the CMAT is pilot tested because once the instrument has been pilot tested and the instrument reflects changes resulting from the testing, the instrument will have to be cleared by the Office of Management and Budget (OMB). We do not want to further delay implementation of the IPF PPS while the CMAT is tested and approved. However, a detailed OMB information collection package will be prepared and made available to the public.

In addition, there are a number of steps that are necessary to insure that assessment instruments collect the most useful information. Pending the pilot test results and a national fielding of the CMAT instrument following the pilot test, and OMB clearance of a final instrument, we would potentially use these variables to propose future refinements to the IPF PPS.

Comment: Many of the comments focused on the burden associated with completion of the CMAT instrument. Commenters stated that completion of the CMAT instrument for each discharged patient would require additional staff. The commenters recommended that CMS consider providing an adjustment to the Federal per diem base rate payment amount for the additional staff resources that would be required to complete the CMAT instrument.

One commenter indicated that IPFs are already faced with funding and management challenges and should not be asked to allocate resources away from direct patient care to fulfill a reporting requirement.

Response: The CMAT instrument and supporting materials is currently undergoing OMB review for potential fielding of the pilot test. One of the considerations of OMB review is to assess the potential burden on providers to complete the pilot test. One of the areas that will be assessed in administering the pilot test is the direct burden on the facilities to complete the instrument. CMS will assess the results of the pilot test to determine the feasibility of administering this instrument on a national basis, and the overall resources required to complete the instrument.

If the pilot test is implemented, we have proposed approaches that could lessen the burden for administration, such as, automation of the instrument. In addition, we would allow the treatment team members providing patient care to complete the form, rather than to request that only nurses complete the form. CMS will monitor the experience in administering the form throughout the pilot test. Finally, the report on the pilot test will address the burden on staff of completing the CMAT instrument.

Comment: One commenter indicated that the CMAT instrument, as currently drafted, would collect excessive and duplicative (to the medical record) information. Other commenters stressed that the instrument was time-consuming to complete and the potential use of the information proposed for collection was not clear. These commenters indicated that the relationship of the proposed data collection to case mix and reimbursement was not described.

Some commenters referred to their experiences in implementing the assessment instruments currently in use for SNFs and IRFs, and indicated that the instruments used in those payment systems do not adequately collect information on the resources needed to provide patient care.

One commenter recommended that all research regarding the development of the CMAT instrument cease. Another commenter indicated that the tool, as currently drafted, requested superfluous data with too many gameable variables. Commenters also indicated that collection of the information contained on the CMAT instrument was not necessary for refinement purposes. Instead, they recommended expanding the variables that are collected as part of either the cost reports or the claims.

Response: We are aware that some of the variables proposed to be pilot tested in the draft CMAT instrument (which we did not propose to use in the proposed IPF PPS) may appear to be duplicative of the medical record. The availability in the medical record of the potential variables to be collected by the CMAT instrument are expected to facilitate the completion of the instrument and reduce completion time.

The number of steps to pilot test and implement an instrument on a national basis are many. When data is available on a national basis, we will be in a better position to test the predictability and usefulness of the variables and determine whether its use should be proposed as a refinement to the IPF PPS.

We are aware of the option of adding variables to the cost reports or claims. We have explored this option in developing other payment systems. Pending decisions on the implementation of the pilot test, we will explore either supplementing material from the CMAT or collecting stand alone variables using the cost reports or claims. In addition, we disagree with the commenters that suggest research for the development of the CMAT cease. Not only might continued development of the CMAT provide possible new useful information on patient resource needs and staffing utilization, it might ascertain whether our case mix is correct or need refinements. Furthermore, we believe the best way to ensure that our IPF PPS continues to be an adequate payment system is to continue research on all fronts so that we have the best available information to us when we must make policy decisions.

Comment: Commenters raised concerns regarding the limitation of the draft CMAT instrument for collecting staffing information.

Response: We note that other CMS research studies are currently working towards providing information on staffing resources needed to provide patient care. We will review the findings from the studies and consider incorporating them in any proposed refinements to the IPF PPS.

Comment: A few commenters recommended that CMS engage in additional research to acquire a greater understanding of the payment dynamics between comorbidities and resource utilization before implementing the IPF PPS.

Many commenters suggested that further analysis is needed to explain the difference in average per diem costs between psychiatric units and freestanding psychiatric hospitals. One commenter suggested an approach that would mirror a swing-bed methodology for patients needing both psychiatric and non-psychiatric inpatient services.

Response: Additional research is planned that will address many outstanding questions regarding differences among IPFs, unit characteristics, patient characteristics, discharge and transfer criteria, and economic incentives.

The current research agenda includes a project to assess the relationship between facilities that have scatter bed and organized DRG units and the IPF PPS. In addition, this research project will examine the role played by smaller psychiatric inpatient units and facilities, the continued use of partial hospitalizations and outpatient programs and their role in complementing and substituting for inpatient care. This project will further monitor the relationship between the IPF PPS, the OPPS, and IPPS payment systems over time.

Comment: One commenter indicated that if there was any future research in support of the IPF PPS it should focus only on costs and payment, and build off existing facility and payment variables. The commenter did not support the creation of a new set of variables requiring additional data collection unless there was evidence that it would dramatically increase the predictability of the models. The commenter recommended research that focused on mode of practice and staffing patterns across different types of inpatient psychiatric facilities.

Another commenter specifically questioned the need for the CMAT instrument in collecting new variables. The commenter also recommended that CMS consolidate all research efforts regarding payment for inpatient psychiatric services.

Response: In general, the majority of the prospective payment systems focus on data that predict the cost and/or payment for the provision of services. While this is the current focus, it is our position that costs and payments may be influenced by a number of variables that are beyond those currently used for payment. We anticipate that in the future, quality and outcome measures may be useful in determining payments. In addition, in most of the prospective payment systems that rely on patient assessment data, additional variables are collected that may not be directly or significantly related, at that time, to the payment system, but could nonetheless be useful at some future time.

We believe that relying only on those variables that are currently perceived as directly or significantly influencing payment, may preclude potential

refinements to the IPF PPS, limit research in the area, and prohibit the future inclusion of variables that could significantly predict payment, outcome, and quality. Therefore, we are reluctant to restrict further research and scientific excellence by building only on existing and available facility and payment variables.

Comment: For patient characteristics, a commenter recommended adding two statistical parameters to the RTI International® study, length of the IPF stay and length of time since their last psychiatric hospitalization.

Response: We agree that it would be useful to investigate the potential relationship between the frequency of an individual's hospitalizations, their length of stay, and the per diem cost of their care. In addition, we believe that the issue is relevant as a topic for our monitoring and evaluation activities.

IX. Comments Beyond the Scope of the Final Rule

In response to the proposed rule, many commenters chose to raise issues that are beyond the scope of our proposals. In this final rule, we are not summarizing or responding to those comments in this document. However, we will review the comments and consider whether to take other actions, such as revising or clarifying CMS program operating instructions or procedures, based on the information or recommendations in the comments.

X. Provisions of the Final Rule

We are making a number of revisions to the regulations in order to implement the IPF PPS. Specifically, we are making conforming changes in 42 CFR parts 412 and 413. We are establishing a new subpart N in part 412, ''Prospective Payment System for Hospital Inpatient Services of Inpatient Psychiatric Facilities.'' We have reorganized the regulations text to make it easier to follow.

This subpart implements section 124 of the BBRA, which requires the implementation of a per diem prospective payment system for IPFs. Subpart N sets forth the framework for the IPF PPS, including the methodology used for the development of the Federal per diem base payment amount and related rules. These revisions and others are discussed in detail below.

Section 412.1 Scope of Part

We are revising the authority citation to include ''Section 124 of Public Law 106–113'' and ''Section 405 of Public Law 108–173.''

We are revising § 412.1 by redesignating paragraphs (a)(2) and (a)(3) as paragraphs (a)(3) and (a)(4).

We are adding a new paragraph (a)(2) that specifies that this part implements section 124 of Public Law 106–113 by establishing a per diem based prospective payment system for inpatient operating and capital costs of hospital inpatient services furnished to Medicare beneficiaries by an inpatient psychiatric facility that meets the conditions of subpart N.

We are revising § 412.1 by redesignating paragraphs (b)(12) and (b)(13) as paragraphs (b)(13) and (b)(14).

We are revising newly redesignated paragraph (b)(13) by removing reference ''paragraph (a)(3)'' and adding the reference ''paragraph (a)(4)'' in its place.

We are revising newly redesignated paragraph (b)(14) by removing reference ''paragraph (a)(2)'' and adding the reference ''paragraph (a)(3)'' in its place.

We are adding a new paragraph (b)(12) that summarizes the content of the new subpart N and sets forth the general methodology for paying operating and capital costs for inpatient psychiatric facilities effective with cost reporting periods beginning on or after January 1, 2005.

Section 412.20 Hospital Services Subject to the Prospective Payment Systems

We are amending § 412.20(a) by adding a reference to IPFs.

We are revising § 412.20 by redesignating paragraphs (b), (c), and (d), as paragraphs (c), (d), and (e).

We are adding a new paragraph (b) that indicates that effective for cost reporting periods beginning on or after January 1, 2005, covered inpatient hospital inpatient services furnished by an IPF as specified in § 412.404 of subpart N are paid under the IPF PPS.

Section 412.22 Excluded Hospitals and Hospital Units: General Rules

We are amending § 412.22(b) by revising paragraph (b) to state that except for those hospitals specified in paragraph (c) of this section, and § 412.20(b), (c), and (d), all excluded hospitals (and excluded hospital units, as described in § 412.23 through § 412.29) are reimbursed under the cost reimbursement rules set forth in part 413 of this chapter, and are subject to the ceiling on the rate of hospital cost increases as specified in § 413.40.

Section 412.23 Excluded Hospitals: Classifications

We are revising § 412.23 by redesignating paragraphs (a)(1) and (a)(2) as paragraphs (a)(2) and (a)(3).

We are adding a new paragraph (a)(1) that specifies the requirements a psychiatric hospital must meet in order to be excluded from reimbursement under the hospital IPPS as specified in § 412.1(a)(1) and to be paid under the IPF PPS as specified in § 412.1(a)(2).

We are revising paragraph (b) by removing the reference ''§ 412.1(a)(2)'' and adding the reference to ''412.1(a)(3).''

We are revising paragraph (b)(9) by removing the reference to ''§ 412.2(a)(2)'' and adding the reference to ''412.1(a)(3)'' in its place.

We are revising paragraph (e) by removing the reference to ''§ 412.1(a)(3)'' and adding ''§ 412.1(a)(4)'' in its place.

Section 412.25 Excluded Hospital Units: Common Requirements

We are amending § 412.25(a) by adding a reference to § 412.1(a)(2).

Section 412.27 Excluded Psychiatric Units: Additional Requirements

We are amending the introductory text of § 412.27 by adding reference to § 412.1(a)(1) and (a)(2).

We are amending § 412.27(a) by removing the words the ''Third Edition,'' and adding in its place, ''Fourth Edition, Text Revision.''

Section 412.429 Excluded Rehabilitation Units: Additional Requirements

We are revising the introductory text by removing the reference ''§ 412.1(a)(2)'' and adding ''§ 412.1(a)(3)'' in its place.

Section 412.116 Method of Payment

We are revising § 412.116 by redesignating paragraphs (a)(3) and (a)(4) as paragraphs (a)(4) and (a)(5).

We are adding a new paragraph (a)(3) that specifies the cost-reporting period to which the IPF PPS applies and how payments for inpatient psychiatric services are made to a qualified IPF.

Section 412.130 Exclusion of New Rehabilitation Units and Expansion of Units Already Excluded

Subpart N—Prospective Payment System for Hospital Inpatient Services of Inpatient Psychiatric Facilities

We are revising paragraph (a)(1) and paragraph (a)(2) by removing reference to ''§ 412.1(a)(2)'' and adding reference ''§ 412.1(a)(3)'' in its place.

We are adding a new subpart N as follows:

Section 412.400 Basis and Scope of Subpart

We are adding a new § 412.400. In § 412.400(a), we provide the requirements for the implementation of a PPS for IPFs.

In § 412.400(b), we specify that this subpart sets forth the framework for the IPF PPS, including the methodology used for the development of payment rates and associated adjustments, the application of a transition period, and related rules for IPFs for cost reporting periods beginning on or after January 1, 2005.

Section 412.402 Definitions

In § 412.402, we are defining the following terms for purposes of this new subpart:

- *Comorbidity*
- *Federal per diem base rate*
- *Federal per diem payment amount*
- *Federal per diem*
- *Fixed dollar loss threshold*
- *Inpatient psychiatric facilities*
- *Interrupted stay*
- *Outlier payment*
- *Principal diagnosis*
- *Rural area*
- *Urban area*

Section 412.404 Conditions for Payment Under the Prospective Payment System for Hospital Inpatient Services of Psychiatric Facilities

In § 412.404(a), we specify that IPFs must meet the following general requirements to receive payment under the IPF PPS:

- The IPF must meet the conditions as specified in this subpart.
- If the IPF fails to comply fully with the provisions of this part, then CMS may, as appropriate—

++ Withhold (in full or in part) or reduce payment to the IPF until the facility provides adequate assurances of compliance; or

++ Classify the IPF as a hospital subject to the IPPS.

In paragraph (b), we specify that, subject to the special payment provisions of § 412.22(c), an IPF must meet the general criteria set forth in § 412.22 for exclusion from the hospital IPPS as specified in § 412.1(a)(1). Additionally, a psychiatric hospital must meet the criteria set forth in § 412.23(a), § 482.60, § 482.61, and § 482.62 and psychiatric units must meet the criteria set forth in § 412.25 and § 412.27.

In paragraph (c), we specify the prohibited and permitted charges that may be imposed on Medicare beneficiaries.

In paragraph (c)(1), we specify that except as permitted in paragraph (c)(2), an IPF may not charge the beneficiary for any services for which payment is made by Medicare, except as permitted in paragraph (c)(2), even if the IPFs costs are greater than the amount the facility is paid under the IPF PPS.

In paragraph (c)(2), we specify that an IPF receiving payment for a covered stay may charge the Medicare beneficiary or other person for only the applicable deductible and coinsurance amounts under § 409.82, § 409.83, and § 409.87.

In paragraph (d), we specify the following provisions for furnishing IPF services directly or under arrangement:

Applicable payments made under the IPF PPS are considered payment in full for all inpatient hospital services (as defined in § 409.10(a)). In addition, we specify the following—

- Inpatient hospital services do not include physician, physician assistant, nurse practitioner, clinical nurse specialist, certified nurse midwives, qualified psychologist, and certified registered nurse anesthetist services.
- Payment is not made to a provider or supplier other than the IPF, except for services provided by a physician, physician assistant, nurse practitioner, clinical nurse specialist, certified nurse midwives, qualified psychologist, and certified registered nurse anesthetist.
- The IPF must furnish all necessary covered services to the Medicare beneficiary directly or under arrangement (as defined in § 409.3).

In paragraph (e), we specify that IPFs must meet the recordkeeping and cost reporting requirements of § 412.27(c), § 413.20, and § 413.24.

Section 412.422 Basis of Payment

In § 412.422(a), we specify that under the IPF PPS, IPFs will receive a predetermined per diem amount, adjusted for patient characteristics and facility characteristics, for inpatient hospital services furnished to Medicare Part A fee-for-service beneficiaries. In addition, we specify that during the transition period, payment is based on a blend of the Federal per diem payment amount and the facility-specific payment rate as specified in § 412.426.

In § 412.422(b), we specify that payments made under the IPF PPS represent payment in full for inpatient operating and capital-related costs associated with furnishing Medicare covered service in an IPF, but not for the cost of an approved medical education program described in § 413.85 and § 413.86 and for bad debts of Medicare beneficiaries as specified in § 413.80.

Section 412.424 Methodology for Calculating the Federal Per Diem Payment Amount

In § 412.424, we specify the methodology for calculating the Federal per diem base rate for IPFs.

In paragraph (a), we specify the data sources used to calculate the Federal per diem base rate.

In paragraph (b), we specify that we determine the average inpatient operating, ancillary, and capital related per diem cost for which payment is made to IPF as described in paragraph (a)(1).

In paragraph (c), we specify that the methodology used for determining the Federal per diem base rate for cost reporting periods beginning on or after January 5, 2005 through June 30, 2006 includes the following:

- The updated average per diem amount
- The budget-neutrality adjustment factor
- Outlier payments
- Standardization
- Computation of the Federal per diem base rate

In paragraph (d), we specify that the Federal per diem payment amount for IPFs is the product of the Federal per diem base rate, the facility-level adjustments applicable to the IPF and the patient-level adjustments applicable to the case as described below:

- Facility-level adjustments include:

++ Adjustment for wages
++ Rural location
++ Teaching adjustments
++ Cost of living adjustments for IPFs in Alaska and Hawaii
++ IPFs with qualifying emergency departments

- Patient-level adjustments include:

++ Age
++ Diagnosis-related group assignment
++ Principal diagnosis
++ Comorbodities
++ Variable per diem adjustments

- Other payment adjustments include:

++ Outlier payments
++ Stop-loss payments
++ Special payment provision for interrupted stay
++ Patients who receive ECT treatments
++ Adjustment for high-cost outlier cases

In paragraph (d), we specify the special payment provisions for interrupted stays.

Section 412.426 Transition Period

In § 412.426(a), we specify the duration of the transition period to the IPF PPS. In addition, we specify that IPFs receive a payment that is a blend of the Federal per diem payment

amount and the facility-specific payment amount the IPF would receive under the TEFRA payment methodology.

In paragraph (b), we specify how the facility-specific payment amount is calculated.

In paragraph (c), we specify that a new IPF, that is, a facility that under present or previous ownership, or both, has its first cost reporting period as an IPF beginning on or after January 1, 2005, is paid based on 100 percent of the full Federal per diem payment.

Section 412.428 Publication of Updated to the IPF PPS

In § 412.428, we specify how we plan to publish information each year in the **Federal Register** to update the IPF PPS.

Section 412.432 Method of Payment Under the IPF PPS

In § 412.432, we specify the following method of payment used under the IPF PPS:

- General rules for receiving payment
- Periodic interim payments including—
++ Criteria for receiving periodic interim payments
++ Frequency of payments
++ Termination of periodic interim payments
- Interim payment for Medicare bad debts and for costs of an approved education program and other costs paid outside the PPS
- Outlier payments
- Accelerated payments including—
++ General rule for requesting accelerated payments
++ Approval of accelerated payments
++ Amount of the accelerated payment
++ Recovery of the accelerated payment

Section 413.1 Introduction

We are revising the authority citation to include ''Section 124 of Public Law 106–113.''

We are amending § 413.1(d)(2)(ii) by removing the words ''psychiatric hospitals (as well as separate psychiatric units (distinct parts) of short-term general hospitals).''

We are revising § 413.1 by redesignating paragraphs (d)(2)(iv), (d)(2)(v), (d)(2)(vi), and (d)(2)(vii) as paragraphs (d)(2)(vi), (d)(2)(vii), (d)(2)(viii), and (d)(2)(ix).

We are adding a new paragraph (iv) to specify that for cost reporting periods beginning before January 1, 2005, payment to psychiatric hospitals (as well as separate psychiatric units of short-term general hospitals) that are excluded under subpart B of part 412 of this chapter from the PPS is on a reasonable cost basis, subject to the provisions of § 413.40.

We are adding a new paragraph (v) to specify that for cost reporting periods beginning on or after January 1, 2005, payment to psychiatric hospitals that meet the conditions of § 412.404 of this chapter is made under the PPS as described in subpart N of part 412.

Section 413.40 Ceiling on the Rate of Increase in Hospital Costs

Section 413.40(a)(2)(i) specifies the types of facilities to which the ceiling on the rate of increase in hospital inpatient costs is not applicable.

We are revising § 413.40(a)(2)(i) by redesignating paragraphs (a)(2)(i)(C) and (a)(2)(i)(D) as paragraphs (a)(2)(i)(D) and (a)(2)(i)(E).

We are adding a new paragraph (a)(2)(i)(C) to § 413.40 to clarify that § 413.40 is not applicable to psychiatric hospitals and psychiatric units under subpart N of part 412 of this chapter for cost reporting periods beginning on or after January 1, 2005.

We are republishing paragraph (a)(2)(ii).

We are revising paragraph (a)(2)(ii)(B) to include reference to psychiatric hospitals and psychiatric units as specified in § 412.22, § 412.23, § 412.25, § 412.27, § 412.29, and § 412.30 of this chapter.

We are revising paragraph (a)(2)(iii) by redesignating paragraphs (a)(2)(iii) and (a)(2)(iv) as paragraphs (a)(2)(iv) and (a)(2)(v).

We are revising paragraph (a)(2)(ii)(C) by removing reference to ''paragraph (a)(2)(iv)'' and adding the reference to ''paragraph (a)(2)(v)'' in its place.

We are adding a new paragraph (a)(2)(iii) to specify psychiatric facilities are excluded from the prospective payment system as specified in § 412.1(a)(1) and paid under § 412.1(a)(2) for cost reporting periods beginning on or after January 1, 2005.

Section 413.64 Payment to Providers: Special Rules

We are amending § 413.64(h)(2)(i) to add a reference to hospitals paid under the IPF PPS.

Section 413.70 Payment for Services of a CAH

We are revising paragraph (e) to specify that for cost reporting periods beginning before January 1, 2005, payment is made on a reasonable cost basis, subject to the provisions of § 413.40. For cost reporting periods beginning on or after January 1, 2005, payment is based on prospectively determined rates under subpart N § 412.400 through § 412.432) of part 412 of this subchapter.

XI. Collection of Information Requirements

These regulations do not impose any new information collection requirements. The burden of the requirements in § 412.404(e), reporting and recordkeeping requirements, are captured in the burden for the cross-referenced § 412.27(c), § 413.20, and § 413.24 under OMB approval numbers 0938–0301, 0938–0050, 0938–0358, and 0938–0600.

XII. Regulatory Impact Analysis

A. Overall Impact

We have examined the impact of this final rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Act, the Unfunded Mandates Reform Act of 1995 (UMRA) (Pub. L. 104–4), and Executive Order 13132).

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

Based on analysis of the aggregate dollar impacts for each of the different facility types, we have determined that the re-distributive impact of the IPF PPS among facility types is $96 million in the first year the system is fully implemented. In addition, our analysis showed that an estimated payment ''reduction'' of almost $48 million would occur for psychiatric units and an estimated payment ''increase'' of $18 million would occur for for-profit hospitals, $27 million for government-operated hospitals, and slightly more than $3 million for non-profit hospitals. Although this final rule does not meet the $100 million threshold established by Executive Order 12866 in its first year of implementation, we have determined that this final rule is a major rule within the meaning of Executive Order 12866 in its first year of implementation, because the re-distributive effects are estimated to be close to constituting a shift of $100 million in the first year of implementation. In addition, although we have not estimated the distributional

impact of this rule in subsequent years, because of the trends in medical expenditure discussed below, we believe it is likely that the rule would have distributional impacts greater than $100 million in subsequent years, relative to TEFRA payments. In addition, because the IPF PPS must be budget neutral in accordance with section 124(a)(1) of Public Law 106–113, we estimate that there will be no budgetary impact for the Medicare program as discussed later in this analysis.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small government jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $29 million or less in any 1 year. Medicare fiscal intermediaries are not considered to be small entities. Individuals and States are not included in the definition of a small entity.

HHS considers that a substantial number of entities are affected if the rule impacts more than 5 percent of the total number of small entities as it does in this rule. We included all freestanding psychiatric hospitals (79 are non-profit hospitals) in the analysis since their total revenues do not exceed the $29 million threshold. We also included psychiatric units of small hospitals, that is, fewer than 100 beds. We did not include psychiatric units within larger hospitals in the analysis because we believe this final rule would not significantly impact total revenues of the entire hospital that supports the unit. We have provided the following RFA analysis in section B, to emphasize that although the final rule would impact a substantial number of IPFs that were identified as small entities, we do not believe it would have a significant economic impact. Based on the analysis of the 1063 psychiatric facilities that were classified as small entities by the definitions described above, we estimate the combined impact of the IPF PPS will be a 5-percent increase in payments relative to their payments under TEFRA. We have prepared the following analysis to describe the impact of the final rule in order to provide a factual basis for our conclusions regarding small business impact.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of an MSA and has fewer than 100 beds. We have determined that this final rule would have a substantial impact on hospitals classified as located in rural areas. As discussed earlier in this preamble, we are providing a payment adjustment of 17 percent for IPFs located in rural areas. In addition, we are establishing a 3-year transition to the new system to allow IPFs an opportunity to adjust to the new system. Therefore, the impacts shown in Table 10 below reflect the adjustments that are designed to minimize or eliminate any potentially significant negative impact that the IPF PPS may otherwise have on small rural IPFs.

Section 202 of the UMRA also requires that agencies assess anticipated costs and benefits before issuing any final rule that may result in expenditures in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million or more. This final rule does not mandate any requirements for State, local, or tribal governments nor would it result in expenditures by the private sector of $110 million or more in any 1 year.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a final rule that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications.

We have examined this final rule under the criteria set forth in Executive Order 13132 and have determined that the final rule will not have any negative impact on the rights, roles, and responsibilities of State, local, or tribal governments or preempt State law.

B. Anticipated Effects

Below, we discuss the impact of this final rule on the Federal Medicare budget and on IPFs.

1. Budgetary Impact

Section 124(a)(1) of Public Law 106–113 requires us to set the payment rates contained in this final rule to ensure that total payments under the IPF PPS are projected to equal the amount that would have been paid if the IPF PPS had not been implemented. As a result of this analysis, which is discussed in section V.B.2.b. of this final rule, we are establishing a budget-neutrality adjustment to the Federal per diem base rate. Thus, there will be no budgetary impact to the Medicare program by implementation of the IPF PPS.

2. Impacts on Providers

To understand the impact of the IPF PPS on providers, it is necessary to compare estimated payments that would be made under the current TEFRA payment methodology (current payments) to estimated payments under the IPF PPS. The IPFs were grouped into the categories listed below based on characteristics provided in the Online Survey and Certification and Reporting (OSCAR) file and the 2002 cost report data from HCRIS:

- Facility Type
- Location
- Teaching Status Adjustment
- Census Region
- Size

To estimate the impacts among the various categories of IPFs, we had to compare estimated future payments that would have been made under the TEFRA payment methodology to estimated payments under the IPF PPS. We estimated the impacts using the same set of providers (1,806 IPFs) that was used for the regression analysis to calculate the budget-neutral Federal per diem base rate, and to determine the appropriateness of various adjustments to the Federal per diem base rate. A detailed explanation of the methods we used to simulate TEFRA payments and estimate payments under the IPF PPS is provided in section V. of this final rule.

The impacts reflect the estimated ''losses'' or ''gains'' among the various classifications of IPF providers for the first year of the IPF PPS. Prospective payments were based on the budget-neutral Federal per diem base rate of $572 adjusted by the IPFs' estimated patient-level, facility-level adjustments, and simulated outlier amounts. This simulated PPS payment was compared to the IPF's payments based on its cost from the cost report inflated to the midpoint of the implementation period (January 1, 2005 through June 30, 2006) and subject to the updated per discharge target amount. Table 10 below illustrates the aggregate impact of the IPF PPS on various classifications of IPFs. The first column identifies the type of IPF, the second column indicates the number of IPFs for each type of IPF, and the third column indicates the ratio of IPF PPS payments to the current TEFRA payments in the first period of the transition.

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TABLE 10--Aggregate Impact

Facility By Type	Number of Facilities	Ratio of Prospective Payment Amount to TEFRA Payment with Transition
All Facilities	1806	1.00
By Type of Ownership:		
Psychiatric Hospitals		
Government	178	1.13
Non-profit	79	1.02
For-profit	150	1.05
Psychiatric Units	1399	0.98
All Facilities	1806	1.00
Rural	429	1.00
Urban	1377	1.00
By Urban or Rural Classification:		
Urban by Facility Type		
Psychiatric Hospitals		
Government	139	1.12
Non-profit	72	1.02
For-profit	139	1.05
Psychiatric Units	1027	0.98
Rural by Facility Type		
Psychiatric Hospitals		
Government	39	1.14
Non-profit	7	1.00
For-profit	11	1.03
Psychiatric Units	372	0.99
By Teaching Status:		
Non-teaching	1537	1.00
Less than 10% interns and residents to beds	148	1.00
10% to 30% interns and residents to beds	72	0.99
More than 30% interns and residents to Beds	49	0.97
By Region:		
New England	126	1.00
Mid-Atlantic	306	1.03
South Atlantic	325	0.99
East North Central	169	0.99
East South Central	238	1.01
West North Central	159	1.00
West South Central	237	0.98
Mountain	83	1.00
Pacific	156	0.99
By Bed Size:		
Psychiatric Hospitals		
Under 12 beds	26	0.97
12 to 25 beds	46	1.01
25 to 50 beds	91	1.05
50 to 75 beds	82	1.04
Over 75 beds	162	1.10
Psychiatric Units		

Facility By Type	Number of Facilities	Ratio of Prospective Payment Amount to TEFRA Payment with Transition
Under 12 beds	600	0.96
12 to 25 beds	474	0.98
25 to 50 beds	228	0.99
50 to 75 beds	58	1.00
Over 75beds	39	1.01

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3. Results

We measured the impact of the IPF PPS by comparing estimated payments under the IPF PPS relative to current TEFRA payments. This was computed as a ratio of IPF PPS payment to current TEFRA payment for each classification of IPF. We have prepared the following summary of the impact of the IPF PPS set forth in this final rule.

a. Facility type

We grouped the IPFs into the following four categories: (1) Psychiatric units; (2) government-operated hospitals; (3) for-profit hospitals; and (4) non-profit hospitals. Roughly 77 percent of all IPFs are psychiatric units. The impact analysis in Table 10 indicates that under the IPF PPS, freestanding psychiatric hospitals receive an estimated ''increase'' relative to the current payment. Psychiatric units have an estimated IPF PPS payment to current TEFRA payment ratio of 0.98, the government-operated hospitals have an estimated IPF PPS payment to current TEFRA payment ratio of 1.13, and the non-profit and for-profit hospitals have an estimated IPF PPS payment to current TEFRA payment ratio of 1.02 and 1.05, respectively.

b. Location

Approximately 24 percent of all IPFs are located in rural areas. The impact analysis in Table 10 indicates that under the IPF PPS, the estimated IPF PPS payment to current TEFRA payment ratio is approximately 1.00 for rural and urban IPFs. When we group all of the IPFs by facility type within urban and rural locations, the impact analysis indicates that the estimated IPF PPS payment to current TEFRA payment ratios would be between approximately 0.98 and 1.05 for all IPFs except government-operated hospitals. Under the IPF PPS, the payment ratios for rural and urban government-operated hospitals are estimated to be 1.14 and 1.12, respectively.

c. Teaching Status Adjustment

Using the ratio of interns and residents to the average daily census for each facility as a measure of the magnitude of the teaching status, we grouped facilities into the following four major categories: (1) Non teaching; (2) less than 0.10 (it is not a percent) ratio of interns and residents to average daily census; (3) 0.10 to 0.30 ratio of interns and residents to average daily census; and (4) more than 0.30 ratio of interns and residents to average daily census. Facilities with a teaching ratio greater than 0.10, have payment ratios less than 1.00.

d. Census Region

Under the IPF PPS, IPFs in the Mid-Atlantic region receive a payment ratio of approximately 1.03 when compared to IPFs in other regions that receive payment ratios between approximately 0.98 and 1.01. Specifically, the New England States, the West North Central States, and the Mountain States receive payment ratios of 1.00. The South Atlantic States, East North Central States, and the Pacific States, receive payments ratios of approximately 0.99. The East South Central States have a payment ratio of 1.01, and the West South Central States have a ratio of 0.98.

e. Size

We grouped the IPFs into 5 categories for each group of psychiatric facilities based on bed size: (1) Under 12 beds; (2) 12 to 25 beds; (3) 25 to 50 beds; (4) 50 to 75 beds; and (5) over 75 beds. Under the IPF PPS, the majority of IPFs' bed sizes were categories in which the payment ratio would be greater than 0.98. Under the IPF PPS, large IPFs with over 75 beds receive the highest payment ratio (1.10 for psychiatric hospitals and 1.01 for psychiatric units), while psychiatric units with less than 10 beds receive the lowest payment ratio of 0.96.

4. Effect on the Medicare Program

Based on actuarial projections resulting from our experience with other prospective payment systems, we estimate that Medicare spending (total Medicare program payments) for IPF services over the next 5 years would be as follows:

TABLE 11--Estimated Payments

Fiscal Time Periods	Dollars in Millions
January 1, 2005 to June 30, 2006	$6,196
July 1, 2006 to June 30, 2007	$4,053
July 1, 2007 to June 30, 2008	$4,143
July 1, 2008 to June 30, 2009	$4.306
July 1, 2009 to June 30,2010	$4,524

These estimates are based on the current estimate of increases in the number of proposed excluded hospitals with capital market basket as follows:

- 3.4 percent for FY 2005;
- 3.0 percent for FY 2006;
- 2.8 percent for FY 2007;
- 2.7 percent for FY 2008;
- 3.0 percent for FY 2009; and
- 3.0 percent for FY 2010.

We estimate that there would be a change in fee-for-service Medicare beneficiary enrollment as follows:

- 0.5 percent in FY 2005;
- -7.3 percent in FY 2006;
- -4.7 percent in FY 2007;
- -0.2 percent in FY 2008;
- -0.1 percent in FY 2009; and
- 1.4 percent in FY 2010.

Consistent with the statutory requirement for budget neutrality in the initial implementation period, we intend for estimated aggregate payments under the IPF PPS to equal the estimated aggregate payments that would be made if the IPF PPS were not implemented. Our methodology for estimating payments for purposes of the budget-neutrality calculations uses the best available data.

After the IPF PPS is implemented, we will evaluate the accuracy of the assumptions used to compute the budget-neutrality calculation. We intend to analyze claims and cost report data from the first year of the IPF PPS to determine whether the factors used to develop the Federal per diem base rate are not significantly different from the actual results experienced in that year. We are planning to compare payments under the final IPF PPS (which relies on an estimate of cost-based TEFRA payments using historical data from a base year and assumptions that trend the data to the initial implementation period) to estimated cost-based TEFRA payments based on actual data from the first year of the IPF PPS. The percent difference (either positive or negative) would be applied prospectively to the established prospective payment rates to ensure the rates accurately reflect the payment levels intended by the statute. We intend to perform this analysis within the first 5 years of the implementation of the IPF PPS.

Section 124 of Public Law 106–113 provides the Secretary broad authority in developing the IPF PPS, including the authority for appropriate adjustments. In accordance with this authority, as stated above, we may make a one-time prospective adjustment to the Federal per diem base rate in an effort to ensure that the best historical data available forms the foundation of the prospective payment rates in future years.

5. Effect on Beneficiaries

Under the IPF PPS, IPFs will receive payment based on the average resources consumed by patients for each day. We do not expect changes in the quality of care or access to services for Medicare beneficiaries under the IPF PPS. In fact, we believe that access to IPF services would be enhanced due to the patient and facility level adjustment factors, all of which are intended to adequately reimburse IPFs for expensive cases. Finally, the stop-loss policy is intended to assist IPFs during the transition. In addition, we expect that paying prospectively for IPF services will enhance the efficiency of the Medicare program.

6. Computer Hardware and Software

We do not anticipate that IPFs will incur additional systems operating costs in order to effectively participate in the IPF PPS. We believe that IPFs possess the computer hardware capability to handle the billing requirements under the IPF PPS. Our belief is based on indications that approximately 99 percent of hospital inpatient claims are submitted electronically. In addition, we are not adopting significant changes in claims processing (see section IV. C. of this final rule).

C. Alternatives Considered

We considered the following alternatives in developing the IPF PPS: One option we considered incorporated not only the patient-level and facility-level variables described previously, but also a site-of-service distinction. Under this approach, psychiatric units would have received a higher per diem payment, all other factors being equal, based on the assumption that psychiatric units on average treat a more complex and costly case-mix. A psychiatric unit adjustment to the otherwise applicable per diem payment rate would reflect the absence of a more sophisticated patient classification system specifically linked to resource use. Our analysis of the FY 2002 cost report and billing data used to develop the final IPF PPS reveals that an adjustment would have increased the otherwise applicable per diem payment to psychiatric units by approximately 33 percent. The average 2002 IPF per diem costs was $615 for psychiatric units, $534 for non-profit hospitals, $448 for proprietary providers, and $378 for governmental-operated facilities. While some of the higher than average per diem cost in psychiatric units may be due to a greater medical and surgical acuity among patients treated in psychiatric units, part of the difference is likely attributable to economy of scale inefficiencies associated with operating small units, including higher overhead expenses, and generally lower occupancy rates. A psychiatric unit site-of-service distinction in payment rates would represent a proxy adjuster in lieu of a more sophisticated patient classification system.

We considered alternative policies in order to reduce financial risk to facilities in the event that they experience substantial reductions in Medicare payments during the period of transition to the IPF PPS. As discussed previously in this final rule, we have adopted a provision that would guarantee each facility an average payment per case under the IPF PPS that is estimated to be no less than a minimum proportion of its average payment per case under TEFRA. We analyzed the impact on losses if we were to make a payment adjustment to ensure that the minimum IPF PPS per case payment to an IPF is at least 70 percent of its TEFRA payment.

The stop-loss adjustment will be applied to the IPF PPS portion of Medicare payments during the transition. For example, during year 1 of the 3-year transition period, three-quarters of the payment is based on TEFRA, and one-quarter of the payment is based on the Federal rate. We would apply the stop-loss adjustment to the portion of the IPF's payments during the transition based on the Federal rate. We estimate that the combined effects of the transition and the stop-loss policies will ensure that per case payments relative to pre-IPF PPS TEFRA per case payments are no less than 92.5 percent in year 1, 85 percent in year 2, and 77.5 percent in year 3. We estimate that about 10 percent of IPFs will receive additional payments under the stop-loss policy.

The 70 percent of TEFRA stop-loss policy would require a reduction in the per diem rate to make the stop-loss policy budget neutral. As a result, we made a reduction to the Federal per diem base rate of 0.4 percent in order to maintain budget neutrality.

In accordance with the provisions of Executive Order 12866, this rule was reviewed by OMB.

List of Subjects

42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

■ For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as follows:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT PSYCHIATRIC SERVICES

■ 1. The authority citation for part 412 is revised to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh), Sec. 124 of Pub. L. 106–113, 113 Stat. 1515, and Sec. 405 of Pub. L. of 108–173, 117 Stat. 2266, 42 U.S.C. 1305, 1395.

Subpart A—General Provisions

■ 2. Section 412.1 is amended as follows:
■ a. Redesignating paragraphs (a)(2) and (a)(3) as paragraphs (a)(3) and (a)(4).
■ b. Adding a new paragraph (a)(2).
■ c. Redesignating paragraphs (b)(12) and (b)(13) as paragraphs (b)(13) and (b)(14).
■ d. Adding a new paragraph (b)(12).
■ e. Amending newly redesignated paragraph (b)(13) by removing the reference ''paragraph (a)(3)'' and adding the reference ''paragraph (a)(4)'' in its place.
■ f. Amending newly redesignted paragraph (b)(14) by removing the reference ''paragraph (a)(2)'' and adding the reference ''paragraph (a)(3)'' in its place.

The additions read as follows:

§ 412.1 Scope of part.

(a) * * *

(2) This part implements section 124 of Public Law 106–113 by establishing a per diem prospective payment system for the inpatient operating and capital costs of hospital inpatient services furnished to Medicare beneficiaries by a psychiatric facility that meets the conditions of subpart N of this part.

* * * * *

(b) * * *

(12) Subpart N describes the prospective payment system specified in paragraph (a)(2) of this section for inpatient psychiatric facilities and sets forth the general methodology for paying the operating and capital-related costs of inpatient hospital services furnished by inpatient psychiatric facilities effective with cost reporting periods beginning on or after January 1, 2005.

* * * * *

Subpart B—Hospital Services Subject to and Excluded From the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital Related Costs

■ 3. Section 412.20 is amended as follows:
■ a. Revising paragraph (a).
■ b. Redesignating paragraphs (b), (c), and (d) as paragraphs (c), (d), and (e).
■ c. Adding a new paragraph (b).

The revision and addition read as follows:

§ 412.20 Hospital services subject to the prospective payment systems.

(a) Except for services described in paragraphs (b), (c), (d), and (e) of this section, all covered hospital inpatient services furnished to beneficiaries during the subject cost reporting periods are paid under the prospective payment system as specified in § 412.1(a)(1).

(b) Effective for cost reporting periods beginning on or after January 1, 2005, covered inpatient hospital services furnished to Medicare beneficiaries by a inpatient psychiatric facility that meets the conditions of § 412.404 are paid under the prospective payment system described in subpart N of this part.

* * * * *

■ 4. Section 412.22 is amended by revising paragraph (b).

§ 412.22 Excluded hospitals and hospital units: General rules.

* * * * *

(b) *Cost reimbursement.* Except for those hospitals specified in paragraph (c) of this section, and § 412.20(b), (c), and (d), all excluded hospitals (and excluded hospital units, as described in § 412.23 through § 412.29) are reimbursed under the cost reimbursement rules set forth in part 413 of this chapter, and are subject to the ceiling on the rate of hospital cost increases as specified in § 413.40 of this chapter.

* * * * *

■ 5. Section 412.23 is amended as follows:
■ a. Republishing paragraph (a) introductory text.
■ b. Redesignating paragraphs (a)(1) and (a)(2) as paragraphs (a)(2) and (a)(3).
■ c. Adding a new paragraph (a)(1).
■ d. Amending the introductory text to paragraph (b) by removing the reference ''§ 412.1(a)(2)'' and adding the reference to ''§ 412.1(a)(3)'' in its place.
■ e. Amending paragraph (b)(9) by removing the reference to ''§ 412.2(a)(2)'' and adding the reference to ''§ 412.1(a)(3)'' in its place.
■ f. Revising the introductory text to paragraph (e).

The republication and addition read a follows:

§ 412.23 Excluded hospitals: Classifications.

* * * * *

(a) *Psychiatric hospitals.* A psychiatric hospital must—

(1) Meet the following requirements to be excluded from the prospective payment system as specified in § 412.1(a)(1) and to be paid under the prospective payment system as specified in § 412.1(a)(2) and in subpart N of this part;

* * * * *

(e) *Long-term care hospitals.* A long-term care hospital must meet the requirements of paragraph (e)(1) and (e)(2) of this section and, when applicable, the additional requirement of § 412.22(e), to be excluded from the prospective payment system specified in § 412.1(a)(1) and to be paid under the prospective payment system specified in § 412.1(a)(4) and in Subpart O of this part.

* * * * *

■ 6. Section 412.25 is amended by revising the paragraph (a) introductory text to read as follows:

§ 412.25 Excluded hospital units: Common requirements.

(a) *Basis for exclusion.* In order to be excluded from the prospective payment systems as specified in § 412.1(a)(1) and to be paid under the prospective payment system as specified in 412.1(a)(2), a psychiatric unit must meet the following requirements.

* * * * *

■ 7. Section 412.27 is amended as follows:
■ a. Revising the introductory text.
■ b. Amending paragraph (a) by removing the words ''Third Edition'', and adding in its place, ''Fourth Edition, Text Revision''.

The revision reads as follows:

§ 412.27 Excluded psychiatric units: Additional requirements.

In order to be excluded from the prospective payment system as specified in § 412.1(a)(1), and paid under the prospective payment system as specified in § 412.1(a)(2), a psychiatric unit must meet the following requirements:

* * * * *

§ 412.29 [Amended]

■ 8. In § 412.29, the introductory text is amended by removing the reference ''§ 412.1(a)(2)'' and adding the reference ''§ 412.1(a)(3)'' in its place.
■ 9. Section 412.116 is amended as follows:

■ a. Redesignating paragraphs (a)(3) and (a)(4) as paragraphs (a)(4) and (a)(5).
■ b. Adding a new paragraph (a)(3).
The addition reads as follows:

§ 412.116 Method of payment.

(a) * * *

(3) For cost reporting periods beginning on or after January 1, 2005, payments for inpatient hospital services furnished by an inpatient psychiatric facility that meets the conditions of § 412.404 are made as described in § 412.432.

* * * * *

§ 412.130 [Amended]

■ 10. In § 412.130, paragraphs (a)(1) and (a)(2) are amended by removing the reference ''§ 412.1(a)(2)'' and adding the reference ''§ 412.1(a)(3)'' in its place.
■ 11. A new subpart N is added to read as follows:

Subpart N—Prospective Payment System for Hospital Inpatient Services of Inpatient Psychiatric Facilities

Sec.

Subpart N—Prospective Payment System for Inpatient Hospital Services of Inpatient Psychiatric Facilities

§ 412.400 Basis and scope of subpart.

(a) *Basis.* This subpart implements section 124 of Public Law 106–113, which provides for the implementation of a per diem-based prospective payment system for inpatient hospital services of inpatient psychiatric facilities.

(b) *Scope.* This subpart sets forth the framework for the prospective payment system for the inpatient hospital services of inpatient psychiatric facilities, including the methodology used for the development of the Federal per diem rate, payment adjustments, implementation issues, and related rules. Under this system, for cost reporting periods beginning on or after January 1, 2005, payment for the operating and capital-related costs of inpatient hospital services furnished by inpatient psychiatric facilities to Medicare Part A fee-for-service beneficiaries is made on the basis of prospectively determined payment amount applied on a per diem basis.

§ 412.402 Definitions.

As used in this subpart—

Comorbidity means all specific patient conditions that are secondary to the patient's primary diagnosis and that coexist at the time of admission, develop subsequently, or that affect the treatment received or the length of stay or both. Diagnoses that relate to an earlier episode of care that have no bearing on the current hospital stay are excluded.

Federal per diem base rate means the payment based on the average routine operating, ancillary, and capital-related cost of 1 day of hospital inpatient services in an inpatient psychiatric facility.

Federal per diem payment amount means the Federal per diem base rate with all applicable adjustments.

Fixed dollar loss threshold means a dollar amount by which the costs of a case exceed payment in order to qualify for an outlier payment.

Inpatient psychiatric facilities means hospitals that meet the requirements as specified in § 412.22, § 412.23(a), § 482.60, § 482.61, and § 482.62, and units that meet the requirements as specified in § 412.22, § 412.25, and § 412.27.

Interrupted stay means a Medicare inpatient is discharged from an inpatient psychiatric facility and is admitted to any inpatient psychiatric facility within 3 consecutive calendar days following discharge. The 3 consecutive calendar days begins with the day of discharge from the inpatient psychiatric facility and ends on midnight of the third day.

Outlier payment means an additional payment beyond the Federal per diem payment amount for cases with unusually high costs.

Principal diagnosis means the condition established after study to be chiefly responsible for occasioning the admission of the patient to the inpatient psychiatric facility also referred to as primary diagnosis. Principal diagnosis is also referred to as primary diagnosis.

Qualifying emergency department means an emergency department that is staffed and equipped to furnish a comprehensive array of emergency services and meting the definitions of a dedicated emergency department as specified in § 489.24(b).

Rural area means any area outside an urban area.

Urban area means an area as defined in § 412.62(f)(1)(ii).

§ 412.404 Conditions for payment under the prospective payment system for inpatient hospital services of psychiatric facilities.

(a) *General requirements.* (1) Effective for cost reporting periods beginning on or after January 1, 2005, an inpatient psychiatric facility must meet the conditions of this section to receive payment under the prospective payment system described in this subpart for inpatient hospital services furnished in to Medicare Part A fee-for-service beneficiaries.

(2) If an inpatient psychiatric facility fails to comply fully with these conditions, CMS may, as appropriate—

(i) Withhold (in full or in part) or reduce Medicare payment to the inpatient psychiatric facility until the facility provides adequate assurances of compliance; or

(ii) Classify the inpatient psychiatric facility as an inpatient hospital that is subject to the conditions of subpart C of this part and is paid under the prospective payment system as specified in § 412.1(a)(1).

(b) *Inpatient psychiatric facilities subject to the prospective payment system.* Subject to the special payment provisions of § 412.22(c), an inpatient psychiatric facility must meet the general criteria set forth in § 412.22. In order to be excluded from the hospital inpatient prospective payment system as specified in § 412.1(a)(1), a psychiatric hospital must meet the criteria set forth in § 412.23(a), § 482.60, § 482.61, and § 482.62 and psychiatric units must meet the criteria set forth in § 412.25 and § 412.27.

(c) *Limitations on charges to beneficiaries*—(1) *Prohibited charges.* Except as permitted in paragraph (c)(2) of this section, an inpatient psychiatric facility may not charge a beneficiary for any services for which payment is made by Medicare, even if the facility's cost of furnishing services to that beneficiary are greater than the amount the facility is paid under the prospective payment system.

(2) *Permitted charges.* An inpatient psychiatric facility receiving payment under this subpart for a covered hospital stay (that is, a stay that included at least one covered day) may charge the Medicare beneficiary or other person only the applicable deductible and coinsurance amounts under § 409.82, § 409.83, and § 409.87 of this chapter and for items or services as specified under § 489.20(a) of this chapter.

(d) *Furnishing of inpatient hospital services directly or under arrangement.*

(1) Subject to the provisions of § 412.422, the applicable payments made under this subpart are payment in full for all inpatient hospital services, as specified in § 409.10 of this chapter. Hospital inpatient services do not include the following:

(i) Physicians' services that meet the requirements of § 415.102(a) of this chapter for payment on a fee schedule basis.

(ii) Physician assistant services, as specified in section 1861(s)(2)(K)(i) of the Act.

(iii) Nurse practitioners and clinical nurse specialist services, as specified in section 1861(s)(2)(K)(ii) of the Act.

(iv) Certified nurse midwife services, as specified in section 1861(gg) of the Act.

(v) Qualified psychologist services, as specified in section 1861(ii) of the Act.

(vi) Services of a certified registered nurse anesthetist, as specified in section 1861(bb) of the Act and defined in § 410.69 of this subchapter.

(2) CMS does not pay providers or suppliers other than inpatient psychiatric facilities for services furnished to a Medicare beneficiary who is an inpatient of the inpatient psychiatric facility, except for services described in paragraphs (d)(1)(i) through (d)(1)(vi) of this section

(3) The inpatient psychiatric facility must furnish all necessary covered services to a Medicare beneficiary who is an inpatient of the inpatient psychiatric facility, either directly or under arrangements (as specified in § 409.3 of this chapter).

(e) *Reporting and recordkeeping requirements.* All inpatient psychiatric facilities participating in the prospective payment system under this subpart must meet the recordkeeping and cost reporting requirements as specified in § 412.27(c), § 413.20, § 413.24, and § 482.61 of this chapter.

§ 412.422 Basis of payment.

(a) *Method of Payment.* (1) Under the inpatient psychiatric facility prospective payment system, inpatient psychiatric facilities receive a predetermined Federal per diem base rate for inpatient hospital services furnished to Medicare Part A fee-for-service beneficiaries.

(2) The Federal per diem payment amount is based on the Federal per diem base rate plus applicable adjustments as specified in § 412.424.

(3) During the transition period, payment is based on a blend of the Federal per diem payment amount as specified in § 412.424, and the facility-specific payment rate as specified in § 412.426.

(b) *Payment in full.* (1) The payment made under this subpart represents payment in full (subject to applicable deductibles and coinsurance as specified in subpart G of part 409 of this chapter) for inpatient operating and capital-related costs associated with furnishing Medicare covered services in an inpatient psychiatric facility, but not the cost of an approved medical education program as specified in § 413.79 through § 413.75 of this chapter.

(2) In addition to the Federal per diem payment amounts, inpatient psychiatric facilities receive payment for bad debts of Medicare beneficiaries, as specified in § 413.80 of this chapter.

§ 412.424 Methodology for calculating the Federal per diem payment amount.

(a) *Data sources.* (1) To calculate the Federal per diem base rate (as specified in paragraph (b) of this section for inpatient psychiatric facilities, as specified in paragraph (b) of this section, CMS uses the following data sources:

(2) The best Medicare data available to estimate the average inpatient operating and capital-related costs per day made as specified in part 413 of this chapter.

(i) Patient and facility cost report data capturing routine and ancillary costs.

(ii) An appropriate wage index to adjust for wage differences.

(iii) An increase factor to adjust for the most recent estimate of increases in the prices of an appropriate market basket of goods and services provided by inpatient psychiatric facilities.

(b) *Determining the average per diem cost of inpatient psychiatric facilities for FY 2002.* CMS determines the average inpatient operating, ancillary, and capital-related per diem cost for which payment is made to each inpatient psychiatric facility, using the available data described in paragraph (a) of this section.

(c) *Determining the Federal per diem base rate for cost reporting periods beginning on or after January 1, 2005 through June 30, 2006.* (1) *General.* Payment under the inpatient psychiatric facility prospective payment system is based on a standardized per diem payment referred to as the Federal per diem base rate. The Federal per diem base rate is the unadjusted cost for 1 day of inpatient hospital services in an inpatient psychiatric facility in a base year as described in paragraph (b) of this section. The unadjusted cost per day is adjusted in accordance with paragraphs (c)(2) through (c)(5) of this section.

(2) *Update of the average per diem cost.* CMS applies the increase factor described in paragraph (a)(2)(iii) of this section to the updated average per diem cost to the midpoint of the January 1, 2005 through June 30, 2006, under the update methodology described in section 1886(b)(3)(B)(ii) of the Act.

(3) *Budget neutrality.* (i) CMS adjusts the updated average per diem cost so that the aggregate payments in the first 18 months (for January 1, 2005 through June 30, 2006) under the inpatient psychiatric facility prospective payment system are estimated to equal the amount that would have been made to the inpatient psychiatric facilities under part 413 of this chapter if the inpatient psychiatric facility prospective payment system described in this subpart were not implemented.

(ii) CMS evaluates the accuracy of the budget-neutrality adjustment within the first 5 years after implementation of the inpatient psychiatric facility prospective payment system. CMS may make a one-time prospective adjustment to the Federal per diem base rate to account for significant differences between the historical data on cost-based TEFRA payments (the basis of the budget-neutrality adjustment at the time of implementation) and estimates of TEFRA payments based on actual data from the first year of the prospective payment system.

(4) *Outlier payments.* CMS determines a reduction factor equal to the estimated proportion of outlier payments described in paragraph (d)(3)(i) of this section.

(5) *Standardization.* CMS determines a reduction factor to reflect estimated increases in the Federal per diem base rate as defined in § 412.402 resulting from the facility-level and patient-level adjustments described in paragraph (d) of this section.

(6) *Computation of the Federal per diem base rate.* The Federal per diem base rate is computed as follows:

(i) For cost reporting periods beginning on or after January 1, 2005 and on or before June 30, 2006, the Federal per diem base rate is computed in accordance with paragraph (c) of this section.

(ii) For inpatient psychiatric facilities beginning on or after July 1, 2006, the Federal per diem base rate will be the Federal per diem base rate for the previous year, updated by an increase factor described in paragraph (a)(2)(iii) of this section.

(d) Determining the Federal per diem payment amount. The Federal per diem payment amount is the product of the Federal per diem base rate established under paragraph (c) of this section, the facility-level adjustments applicable to the inpatient psychiatric facility, and the patient-level adjustments applicable to the case.

(1) *Facility-level adjustments.* (i) *Adjustment for wages.* CMS adjusts the labor portion of the Federal per diem base rate to account for geographic differences in the area wage levels using an appropriate wage index. The application of the wage index is made on the basis of the location of the inpatient psychiatric facility in an urban or rural area as defined in § 412.402.

(ii) *Rural location.* CMS adjusts the Federal per diem base rate for inpatient psychiatric facilities located in a rural area as defined in § 412.402.

(iii) *Teaching adjustment.* CMS adjusts the Federal per diem base rate by a factor to account for indirect medical education costs.

(A) An inpatient psychiatric facility's teaching adjustment is based on the ratio of the number of residents training in the inpatient psychiatric facility divided by the facility's average daily census.

(B) The number of full-time equivalent residents used in calculating the teaching adjustment cannot exceed the number of full-time equivalent residents in a base year.

(1) The base year is the inpatient psychiatric facility's most recently filed cost report filed with its fiscal intermediary before November 15, 2004. Residents with less than full-time status and residents rotating through the inpatient psychiatric facility for less than a full year will be counted in proportion to the time they spend in the inpatient psychiatric facility.

(*2*) The teaching status adjustment for new inpatient psychiatric facilities as defined in § 412.426 is made in accordance with § 413.79(e)(1)(i) and (ii).

(C) If an inpatient psychiatric facility has fewer full-time equivalent residents than in its base year payment of the teaching adjustment will be based on the actual number of full-time equivalent residents. The inpatient psychiatric facility may add residents in subsequent years up to its resident cap established under section (1)(iii)(B) of this paragraph.

(iv) *Inpatient psychiatric facilities located in Alaska and Hawaii.* CMS adjusts the non-labor portion of the Federal per diem base rate to reflect the higher cost of living of inpatient psychiatric facilities located in Alaska and Hawaii.

(v) *Adjustment for IPF with qualifying emergency departments.* (A) CMS adjusts the Federal per diem base rate to account for the costs associated with maintaining a qualifying emergency department. A qualifying emergency department is staffed and equipped to furnish a comprehensive array of emergency services and meets the requirements of § 489.24(b) and § 413.65.

(B) Where the inpatient psychiatric facility is part of an acute care hospital that has a qualifying emergency department as described in paragraph (d)(1)(v)(A) of this section and an individual patient is discharged to the inpatient psychiatric facility from that acute care hospital, CMS would not apply the emergency adjustment.

(2) *Patient-level adjustments.* (i) *Age.* CMS adjusts the Federal per diem base rate to account for patient age based on age groupings specified by CMS.

(ii) *Diagnosis-related group assignment.* The inpatient psychiatric facility must identify a principal diagnosis as specified in § 412.27(a) for each patient. CMS adjusts the Federal per diem base rate by a factor to account for the CMS inpatient psychiatric facility prospective payment system recognized diagnosis-related group assignment associated with each patient's principal diagnosis.

(iii) *Principal diagnosis.* The inpatient psychiatric facility must identify a principal psychiatric diagnosis as specified in § 412.27(a) for each patient. CMS adjusts the Federal per diem base rate by a factor to account for the diagnosis-related group assignment associated with the principal diagnosis, as specified by CMS.

(iv) *Comorbidities.* CMS adjusts the Federal per diem base rate by a factor to account for certain comorbidities as specified by CMS.

(v) *Variable per diem adjustments.* CMS adjusts the Federal per diem base rate by factors as specified by CMS to account for the cost of each day of inpatient psychiatric care relative to the cost of the median length of stay.

(3) *Other adjustments.* (i) *Outlier payments.* CMS provides an additional payment if an inpatient psychiatric facility's estimated total cost for a case exceeds a fixed dollar loss threshold as defined in § 412.402 plus the Federal per diem payment amount for the case.

(A) The fixed dollar loss threshold is adjusted for the inpatient psychiatric facility's adjustments for wage area, teaching, rural location, and cost of living adjustment for facilities located in Alaska and Hawaii.

(B) The outlier payment equals 80 percent of the difference between the IPF's estimated cost for the case and the adjusted threshold amount for days 1 through 9, and 60 percent for day 10 and thereafter.

(C) For discharges occurring in cost reporting periods beginning on or after January 1, 2005, outlier payments are subject to the adjustments specified at § 412.84(i) and § 412.84(m) of this part, except that national urban and rural median cost-to-charge ratios would be used instead of statewide average cost-to-charge ratios.

(ii) *Stop-loss payments.* CMS will provide additional payments during the transition period, specified in § 412.426(a)(1) through (3), to an inpatient psychiatric facility to ensure that aggregate payments under the prospective payment system are at least 70 percent of the amount the inpatient psychiatric facility would have received under reasonable cost reimbursement had the prospective payment system not been implemented.

(iii) *Special payment provision for interrupted stays.* If a patient is discharged from an inpatient psychiatric facility and is admitted to the same or another inpatient psychiatric facility within 3 consecutive calendar days following the discharge, the case is considered to be continuous for the purposes listed below. The 3 consecutive calendar days begins with the day of discharge from the inpatient psychiatric facility and ends on midnight of day 3.

(A) Determining the appropriate variable per diem adjustment, as specified in paragraph (d)(2)(v) of this section, applicable to the case.

(B) Determining whether the total cost for a case meets the criteria for outlier payments, as specified in paragraph (d)(3)(i)(C) of this section.

(iv) Payment for electroconvulsive therapy treatments. CMS provides an additional payment to reflect the cost of electroconvulsive therapy treatments received by a patient during an inpatient psychiatric facility stay in a manner specified by CMS.

(v) *Adjustment for high-cost cases.* CMS provides for an additional payment if the estimated total cost for a case exceeds a fixed dollar loss threshold plus the total per diem payment amount for the case.

(A) The fixed dollar loss threshold is adjusted for area wage levels, teaching status, and rural location.

(B) The additional payment equals 80 percent of the difference between the estimated cost of the case and the Federal per diem payment amount for days 1 through 9, and 60 percent for days 10 and beyond.

(C) Effective for discharges occurring in cost reporting periods beginning on or after January 1, 2005, additional payments made under this section would be subject to the adjustments at § 412.84(i) and § 412.84(m) of this part, except that the national urban and rural median cost-to-charge ratios would be

used instead of statewide averages, and at § 412.84(m) of this part.

§ 412.426 Transition period.

(a) *Duration of transition period and composition of the blended transition payment.* Except as provided in paragraph (c) of this section, for cost reporting periods beginning on or after January 1, 2005 through June 30, 2008, an inpatient psychiatric facility receives a payment comprised of a blend of the estimated Federal per diem payment amount, as specified in § 412.424(c) and a facility-specific payment as specified under paragraph (b).

(1) For cost reporting periods beginning on or after January 1, 2005 and on or before June 30, 2006, payment is based on 75 percent of the facility-specific payment and 25 percent is based on the Federal per diem payment amount.

(2) For cost reporting periods beginning on or after July 1, 2006 and on or before June 30, 2007, payment is based on 50 percent of the facility-specific payment and 50 percent is based on the Federal per diem payment amount.

(3) For cost reporting periods beginning on or after July 1, 2007 and on or before June 30, 2008, payment is based on 25 percent of the facility-specific payment and 75 percent is based on the Federal per diem payment amount.

(4) For cost reporting periods beginning on or after July 1, 2008, payment is based entirely on the Federal per diem payment amount.

(b) *Calculation of the facility-specific payment.* The facility-specific payment is equal to the estimated payment for each cost reporting period in the transition period that would have been made without regard to this subpart. The facility's Medicare fiscal intermediary calculates the facility-specific payment for inpatient operating costs and capital costs in accordance with part 413 of this chapter.

(c) *Treatment of new inpatient psychiatric facilities.* New inpatient psychiatric facilities, are facilities that under present or previous ownership or both have their first cost reporting period as an IPF beginning on or after January 1, 2005. New IPFs are paid based on 100 percent of the Federal per diem payment amount.

§ 412.428 Publication of Updates to the inpatient psychiatric facility prospective payment system.

CMS will publish annually in the **Federal Register** information pertaining to updates to the inpatient psychiatric facility prospective payment system. This information includes:

(a) A description of the methodology and data used to calculate the updated Federal per diem base payment amount.

(b) The rate of increase factor as described in 412.424(a)(2)(iii), which is based on the excluded hospital with capital market basket under the update methodology of 1886(b)(3)(B)(ii) of the Act for each year.

(c) The best available hospital wage index and information regarding whether an adjustment to the Federal per diem base rate is needed to maintain budget neutrality.

(d) Updates to the fixed dollar loss threshold in order to maintain the appropriate outlier percentage.

(e) Describe the ICD–9–CM coding changes and DRG classification changes discussed in the annual update to the hospital inpatient prospective payment system regulations.

(f) Update the electroconvulsive therapy adjustment by a factor specified by CMS.

§ 412.432 Method of payment under the inpatient psychiatric facility prospective payment system.

(a) *General rule.* Subject to the exceptions in paragraphs (b) and (c) of this section, an inpatient psychiatric facility receives payment under this subpart for inpatient operating cost and capital-related costs for each inpatient stay following submission of a bill.

(b) *Periodic interim payments (PIP).* (1) Criteria for receiving PIP.

(i) An inpatient psychiatric facility receiving payment under this subpart may receive PIP for Part A services under the PIP method subject to the provisions of § 413.64(h) of this chapter.

(ii) To be approved for PIP, the inpatient psychiatric facility must meet the qualifying requirements in § 413.64(h)(3) of this chapter.

(iii) A hospital that is receiving periodic interim payments also receives payment under this subpart for applicable services furnished by its excluded psychiatric unit.

(iv) As provided in § 413.64(h)(5) of this chapter, intermediary approval is conditioned upon the intermediary's best judgment as to whether payment can be made under the PIP method without undue risk of resulting in an overpayment to the provider.

(2) *Frequency of payment.* For facilities approved for PIP, the intermediary estimates the annual inpatient psychiatric facility's Federal per diem prospective payments, net of estimated beneficiary deductibles and coinsurance, and makes biweekly payments equal to 1/26 of the total estimated amount of payment for the year. If the inpatient psychiatric facility has payment experience under the prospective payment system, the intermediary estimates PIP based on that payment experience, adjusted for projected changes supported by substantiated information for the current year. Each payment is made 2 weeks after the end of a biweekly period of service as specified in § 413.64(h)(6) of this chapter. The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if an inpatient psychiatric facility receives interim payments for less than a full reporting period. These payments are subject to final settlement.

(3) *Termination of PIP.* (i) *Request by the inpatient psychiatric facility.* Subject to the provisions of paragraph (b)(1)(iii) of this section, an inpatient psychiatric facility receiving PIP may convert to receiving prospective payments on a non-PIP basis at any time.

(ii) *Removal by the intermediary.* An intermediary terminates PIP if the inpatient psychiatric facility no longer meets the requirements of § 413.64(h) of this chapter.

(c) *Interim payments for Medicare bad debts and for costs of an approved education program and other costs paid outside the prospective payment system.* For Medicare bad debts and for costs of an approved education program and other costs paid outside the prospective payment system, the intermediary determines the interim payments by estimating the reimbursable amount for the year based on the previous year's experience, adjusted for projected changes supported by substantiated information for the current year, and makes biweekly payments equal to 1/26 of the total estimated amount. Each payment is made 2 weeks after the end of the biweekly period of service as specified in § 413.64(h)(6) of this chapter. The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if an inpatient psychiatric facility receives interim payments for less than a full reporting period. These payments are subject to final cost settlement.

(d) *Outlier payments.* Additional payments for outliers are not made on an interim basis. Outlier payments are made based on the submission of a discharge bill and represents final payment subject to the cost report settlement specified in § 412.84(i) and § 412.84(m).

(e) *Accelerated payments.* (1) *General rule.* Upon request, an accelerated payment may be made to an inpatient psychiatric facility that is receiving

payment under this subpart and is not receiving PIP under paragraph (b) of this section if the inpatient psychiatric facility is experiencing financial difficulties because of the following:

(i) There is a delay by the intermediary in making payment to the inpatient psychiatric facility.

(ii) Due to an exceptional situation, there is a temporary delay in the inpatient psychiatric facility's preparation and submittal of bills to the intermediary beyond the normal billing cycle.

(2) *Approval of accelerated payment.* An inpatient psychiatric facility's request for an accelerated payment must be approved by the intermediary and CMS.

(3) *Amount of accelerated payment.* The amount of the accelerated payment is computed as a percent of the net payment for unbilled or unpaid covered services.

(4) *Recovery of accelerated payment.* Recovery of the accelerated payment is made by recoupment as inpatient psychiatric facility bills are processed or by direct payment by the inpatient psychiatric facility.

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT FOR SKILLED NURSING FACILITIES

■ 1. The authority citation for part 413 is revised to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1861 (v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww) Sec 124 of Pub. L. 106–113, 113 Stat. 1515.

■ 2. Section 413.1 is amended as follows:

■ a. Revising paragraph (d)(2)(ii).

■ b. Redesignating paragraphs (d)(2)(iv), (d)(2)(v), (d)(2)(vi), and (d)(2)(vii) as paragraphs (d)(2)(vi), (d)(2)(vii), (d)(2)(viii), and (d)(2)(ix).

■ (c) Adding new paragraphs (d)(2)(iv) and (d)(2)(v).

The revision and additions read as follows:

§ 413.1 Introduction.

* * * * *

(d) * * *

(2) * * *

(ii) Payment to children's hospitals that are excluded from the prospective payment systems under subpart B of part 412 of this chapter, and hospitals outside the 50 States and the District of Columbia is on a reasonable cost basis, subject to the provisions of § 413.40.

* * * * *

(iv) For cost reporting periods beginning before January 1, 2005, payment to psychiatric hospitals (as well as separate psychiatric units (distinct parts) of short-term general hospitals) that are excluded under subpart B of part 412 of this chapter from the prospective payment system is on a reasonable cost basis, subject to the provisions of § 413.40.

(v) For cost reporting periods beginning on or after January 1, 2005, payment to inpatient psychiatric facilities that meet the conditions of § 412.404 of this chapter, is made under the prospective payment system described in subpart N of part 412 of this chapter.

* * * * *

■ 3. Section 413.40 is amended as follows:

■ a. Redesignating paragraphs (a)(2)(i)(C) and (a)(2)(i)(D) as paragraphs (a)(2)(i)(D) and (a)(2)(i)(E).

■ b. Adding a new paragraph (a)(2)(i)(C).

■ c. Republishing paragraph (a)(2)(ii) introductory text.

■ d. Revising paragraph (a)(2)(ii)(B).

■ e. Amending paragraph (a)(2)(ii)(C) by removing reference to ''paragraph (a)(2)(iv)'' and adding the reference ''paragraph (a)(2)(v)'' in its place.

■ f. Redesignating paragraphs (a)(2)(iii) and (a)(2)(iv) as paragraphs (a)(2)(iv) and (a)(2)(v).

■ g. Adding a new paragraph (a)(2)(iii).

The revision and additions read as follows:

§ 413.40 Ceiling on the rate of increase in hospital inpatient costs.

(a) * * *

(2) * * *

(i) * * *

(C) Psychiatric hospitals and psychiatric units that are paid under the prospective payment system for inpatient psychiatric facilities described in subpart N of part 412 of this chapter for cost reporting periods beginning on or after January 1, 2005.

* * * * *

(ii) For cost reporting periods beginning on or after October 1, 1983, this section applies to—

* * * * *

(B) Psychiatric and rehabilitation units excluded from the prospective payment systems, as specified in § 412.1(a)(1) of this chapter and in accordance with § 412.25 through § 412.30 of this chapter, except as limited by paragraphs (a)(2)(iii) and (a)(2)(iv) of this section with respect to psychiatric and rehabilitation hospitals and psychiatric and rehabilitation units as specified in § 412.22, § 412.23, § 412.25, § 412.27, § 412.29 and § 412.30 of this chapter.

* * * * *

(iii) For cost reporting periods beginning on or after October 1, 1983 and before January 1, 2005 this section applies to psychiatric hospitals and psychiatric units that are excluded from the prospective payment systems as specified in § 412.1(a)(1) of this chapter and paid under the prospective payment system as specified in § 412.1(a)(2) of this chapter.

* * * * *

■ 4. Section 413.64 is amended by revising paragraph (h)(2)(i) to read as follows:

§ 413.64 Payment to providers: Specific rules.

* * * * *

(h) * * *

(2) * * *

(i) Part A inpatient services furnished in hospitals that are excluded from the prospective payment systems, as specified in § 412.1(a)(1) of this chapter under subpart B of part 412 of this subchapter, or are paid under the prospective payment systems described in subpart N, O, and P of part 412 of this chapter.

* * * * *

■ 5. Section 413.70 is amended by revising paragraph (e) to read as follows:

§ 413.70 Payment for services of a CAH.

* * * * *

(e) *Payment for service of distinct part psychiatric and rehabilitation units of CAHS.* Payment for inpatient services of distinct part psychiatric units of CAHs—

(1) For cost reporting periods beginning before January 1, 2005, payment is made on a reasonable cost basis, subject to the provisions of § 413.40.

(2) For cost reporting periods beginning on or after January 1, 2005, payment is made in accordance with regulations governing inpatient psychiatric facilities at subpart N (§ 412.400 through § 412.432) of Part 412 of this subchapter.

(3) Payment for inpatient services of distinct part rehabilitation units of CAHs is made in accordance with regulations governing the inpatient rehabilitation facilities prospective payment system at Subpart P (§ 412.600 through § 412.632) of Part 412 of this subchapter.

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: October 26, 2004.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Approved: November 2, 2004.

Tommy G. Thompson,

Secretary.

Note: The following Addenda will not appear in the Code of Federal Regulations

Addendum A—Psychiatric Prospective Payment Adjustment Rate and Adjustment Factors

BILLING CODE 4120–01–P

Rate and Adjustment Factors

Per Diem Rate:

Federal Per Diem Base Rate	$575.95
Labor Share (0.72528)	$417.73
Non-Labor Share (0.27472)	$158.22

Facility Adjustments:

Rural Adjustment Factor	1.17
Teaching Adjustment Factor	0.5150
Wage Index	Same as IPPS

Cost of Living Adjustments (COLAs):

Alaska	1.25
Hawaii	
Honolulu County	1.25
Hawaii County	1.165
Kauai County	1.2325
Maui County	1.2375
Kalawao County	1.2375

Patient Adjustments:

ECT – Per Treatment	$247.96

Variable Per Diem Adjustments:

	Adjustment Factor
Day 1 -- Facility Without a 24/7 Full-service Emergency Department	1.19
Day 1 -- Facility With a 24/7 Full-service Emergency Department	1.31
Day 2	1.12
Day 3	1.08
Day 4	1.05
Day 5	1.04
Day 6	1.02
Day 7	1.01
Day 8	1.01
Day 9	1.00

Day 10	1.00
Day 11	0.99
Day 12	0.99
Day 13	0.99
Day 14	0.99
Day 15	0.98
Day 16	0.97
Day 17	0.97
Day 18	0.96
Day 19	0.95
Day 20	0.95
Day 21	0.95
After Day 21	0.92

Age Adjustments:

Age (in years)	Adjustment Factor
Under 45	1.00
45 and under 50	1.01
50 and under 55	1.02
55 and under 60	1.04
60 and under 65	1.07
65 and under 70	1.10
70 and under 75	1.13
75 and under 80	1.15
80 and over	1.17

DRG Adjustments:

DRG	DRG Definition	Adjustment Factor
DRG 424	Procedure with principal diagnosis of mental illness	1.22
DRG 425	Acute adjustment reaction	1.05
DRG 426	Depressive neurosis	0.99
DRG 427	Neurosis, except depressive	1.02
DRG 428	Disorders of personality	1.02
DRG 429	Organic disturbances	1.03
DRG 430	Psychosis	1.00
DRG 431	Childhood disorders	0.99
DRG 432	Other mental disorders	0.92
DRG 433	Alcohol/Drug use Leave against Medical Advice (LAMA)	0.97
DRG 521	Alcohol/Drug use with comorbid conditions	1.02
DRG 522	Alcohol/Drug use without comorbid conditions	0.98
DRG 523	Alcohol/Drug use without rehabilitation	0.88
DRG 12	Degenerative nervous system disorders	1.05
DRG 23	Non-traumatic stupor & coma	1.07

Comorbidity Adjustments:

Comorbidity	Adjustment Factor
Developmental Disabilities	1.04
Coagulation Factor Deficit	1.13
Tracheostomy	1.06
Eating and Conduct Disorders	1.12
Infectious Diseases	1.07
Renal Failure, Acute	1.11
Renal Failure, Chronic	1.11
Oncology Treatment	1.07
Uncontrolled Type I Diabetes Mellitus	1.05
Severe Protein Malnutrition	1.13
Drug/Alcohol Induced Mental Disorders	1.03
Cardiac Conditions	1.11
Gangrene	1.10
Chronic Obstructive Pulmonary Disease	1.12
Artificial Openings – Digestive & Urinary	1.08
Musculoskeletal & Connective Tissue Diseases	1.09
Poisoning	1.11

ADDENDUM B1—WAGE INDEX FOR URBAN AREAS

MSA	Urban Area (Constituent Counties or County Equivalents)	Wage Index
0040	Abilene, TX Taylor, TX	0.8009
0060	Aguadilla, PR Aguada, PR Aguadilla, PR Moca, PR	0.4294
0080	Akron, OH Portage, OH Summit, OH	0.9055
0120	Albany, GA Dougherty, GA Lee, GA	1.1266
0160	Albany-Schenectady-Troy, NY Albany, NY Montgomery, NY Rensselaer, NY Saratoga, NY Schenectady, NY Schoharie, NY	0.8570
0200	Albuquerque, NM Bernalillo, NM Sandoval, NM Valencia, NM	1.0485
0220	Alexandria, LA Rapides, LA	0.8171
0240	Allentown-Bethlehem-Easton, PA Carbon, PA Lehigh, PA Northampton, PA	0.9536
0280	Altoona, PA Blair, PA	0.8462
0320	Amarillo, TX Potter, TX Randall, TX	0.9178
0380	Anchorage, AK Anchorage, AK	1.2109
0440	Ann Arbor, MI Lenawee, MI Livingston, MI Washtenaw, MI	1.0816
0450	Anniston,AL Calhoun, AL	0.7881

MSA	Urban Area (Constituent Counties or County Equivalents)	Wage Index
0460	Appleton-Oshkosh-Neenah, WI Calumet, WI Outagamie, WI Winnebago, WI	0.9115
0470	Arecibo, PR Arecibo, PR Camuy, PR Hatillo, PR	0.3757
0480	Asheville, NC Buncombe, NC Madison, NC	0.9501
0500	Athens, GA Clarke, GA Madison, GA Oconee, GA	1.0202
0520	Atlanta, GA Barrow, GA Bartow, GA Carroll, GA Cherokee, GA Clayton, GA Cobb, GA Coweta, GA De Kalb, GA Douglas, GA Fayette, GA Forsyth, GA Fulton, GA Gwinnett, GA Henry, GA Newton, GA Paulding, GA Pickens, GA Rockdale, GA Spalding, GA Walton, GA	0.9971
0560	Atlantic City-Cape May, NJ Atlantic City, NJ Cape May, NJ	1.0907
0580	Auburn-Opelika, AL Lee, AL	0.8215

MSA	Urban Area (Constituent Counties or County Equivalents)	Wage Index
0600	Augusta-Aiken, GA-SC Columbia, GA McDuffie, GA Richmond, GA Aiken, SC Edgefield, SC	0.9208
0640	Austin-San Marcos, TX Bastrop, TX Caldwell, TX Hays, TX Travis, TX Williamson, TX	0.9595
0680	Bakersfield, CA Kern, CA	1.0036
0720	Baltimore, MD Anne Arundel, MD Baltimore, MD Baltimore City, MD Carroll, MD Harford, MD Howard, MD Queen Annes, MD	0.9907
0733	Bangor, ME Penobscot, ME	0.9955
0743	Barnstable-Yarmouth, MA Barnstable, MA	1.2335
0760	Baton Rouge, LA Ascension, LA East Baton Rouge Livingston, LA West Baton Rouge, LA	0.8354
0840	Beaumont-Port Arthur, TX Hardin, TX Jefferson, TX Orange, TX	0.8616
0860	Bellingham, WA Whatcom, WA	1.1642
0870	Benton Harbor, MI Berrien, MI	0.8847
0875	Bergen-Passaic, NJ Bergen, NJ Passaic, NJ	1.1967
0880	Billings, MT Yellowstone, MT	0.8961

MSA	Urban Area (Constituent Counties or County Equivalents)	Wage Index
0920	Biloxi-Gulfport-Pascagoula, MS Hancock, MS Harrison, MS Jackson, MS	0.8649
0960	Binghamton, NY Broome, NY Tioga, NY	0.8447
1000	Birmingham, AL Blount, AL Jefferson, AL St. Clair, AL Shelby, AL	0.9198
1010	Bismarck, ND Burleigh, ND Morton, ND	0.7505
1020	Bloomington, IN Monroe, IN	0.8587
1040	Bloomington-Normal, IL McLean, IL	0.9111
1080	Boise City, ID Ada, ID Canyon, ID	0.9352
1123	Boston-Worcester-Lawrence-Lowell- Brockton, MA-NH Bristol, MA Essex, MA Middlesex, MA Norfolk, MA Plymouth, MA Suffolk, MA Worcester, MA Hillsborough, NH Merrimack, NH Rockingham, NH Strafford, NH	1.1290
1125	Boulder-Longmont, CO Boulder, CO	1.0046
1145	Brazoria, TX Brazoria, TX	0.8524
1150	Bremerton, WA Kitsap, WA	1.0614
1240	Brownsville-Harlingen-San Benito, TX Cameron, TX	1.0125
1260	Bryan-College Station, TX Brazos, TX	0.9243

MSA	Urban Area (Constituent Counties or County Equivalents)	Wage Index
1280	Buffalo-Niagara Falls, NY Erie, NY Niagara, NY	0.9339
1303	Burlington, VT Chittenden, VT Franklin, VT Grand Isle, VT	0.9322
1310	Caguas, PR Caguas, PR Cayey, PR Cidra, PR Gurabo, PR San Lorenzo, PR	0.4061
1320	Canton-Massillon, OH Carroll, OH Stark, OH	0.8895
1350	Casper, WY Natrona, WY	0.9243
1360	Cedar Rapids, IA Linn, IA	0.8975
1400	Champaign-Urbana, IL Champaign, IL	0.9527
1440	Charleston-North Charleston, SC Berkeley, SC Charleston, SC Dorchester, SC	0.9420
1480	Charleston, WV Kanawha, WV Putnam, WV	0.8876
1520	Charlotte-Gastonia-Rock Hill, NC-SC Cabarrus, NC Gaston, NC Lincoln, NC Mecklenburg, NC Rowan, NC Stanly, NC Union, NC York, SC	0.9711
1540	Charlottesville, VA Albemarle, VA Charlottesville City, VA Fluvanna, VA Greene, VA	1.0294

MSA	Urban Area (Constituent Counties or County Equivalents)	Wage Index
1560	Chattanooga, TN-GA Catoosa, GA Dade, GA Walker, GA Hamilton, TN Marion, TN	0.9207
1580	Cheyenne, WY Laramie, WY	0.8980
1600	Chicago, IL Cook, IL De Kalb, IL Du Page, IL Grundy, IL Kane, IL Kendall, IL Lake, IL McHenry, IL Will, IL	1.0851
1620	Chico-Paradise, CA Butte, CA	1.0542
1640	Cincinnati, OH-KY-IN Dearborn, IN Ohio, IN Boone, KY Campbell, KY Gallatin, KY Grant, KY Kenton, KY Pendleton, KY Brown, OH Clermont, OH Hamilton, OH Warren, OH	0.9595
1660	Clarksville-Hopkinsville, TN-KY Christian, KY Montgomery, TN	0.8022
1680	Cleveland-Lorain-Elyria, OH Ashtabula, OH Geauga, OH Cuyahoga, OH Lake, OH Lorain, OH Medina, OH	0.9626
1720	Colorado Springs, CO El Paso, CO	0.9792

MSA	Urban Area (Constituent Counties or County Equivalents)	Wage Index
1740	Columbia MO Boone, MO	0.8396
1760	Columbia, SC Lexington, SC Richland, SC	0.9450
1800	Columbus, GA-AL Russell, AL Chattanoochee, GA Harris, GA Muscogee, GA	0.8690
1840	Columbus, OH Delaware, OH Fairfield, OH Franklin, OH Licking, OH Madison, OH Pickaway, OH	0.9753
1880	Corpus Christi, TX Nueces, TX San Patricio, TX	0.8647
1890	Corvallis, OR Benton, OR	1.0545
1900	Cumberland, MD-WV Allegany MD Mineral WV	0.8662
1920	Dallas, TX Collin, TX Dallas, TX Denton, TX Ellis, TX Henderson, TX Hunt, TX Kaufman, TX Rockwall, TX	1.0054
1950	Danville, VA Danville City, VA Pittsylvania, VA	0.8643
1960	Davenport-Moline-Rock Island, IA-IL Scott, IA Henry, IL Rock Island, IL	0.8773
2000	Dayton-Springfield, OH Clark, OH Greene, OH Miami, OH Montgomery, OH	0.9231

MSA	Urban Area (Constituent Counties or County Equivalents)	Wage Index
2020	Daytona Beach, FL Flagler, FL Volusia, FL	0.8900
2030	Decatur, AL Lawrence, AL Morgan, AL	0.8894
2040	Decatur, IL Macon, IL	0.8122
2080	Denver, CO Adams, CO Arapahoe, CO Broomfield, CO Denver, CO Douglas, CO Jefferson, CO	1.0904
2120	Des Moines, IA Dallas, IA Polk, IA Warren, IA	0.9266
2160	Detroit, MI Lapeer, MI Macomb, MI Monroe, MI Oakland, MI St. Clair, MI Wayne, MI	1.0227
2180	Dothan, AL Dale, AL Houston, AL	0.7596
2190	Dover, DE Kent, DE	0.9825
2200	Dubuque, IA Dubuque, IA	0.8748
2240	Duluth-Superior, MN-WI St. Louis, MN Douglas, WI	1.0356
2281	Dutchess County, NY Dutchess, NY	1.1657
2290	Eau Claire, WI Chippewa, WI Eau Claire, WI	0.9139
2320	El Paso, TX El Paso, TX	0.9181
2330	Elkhart-Goshen, IN Elkhart, IN	0.9278

MSA	Urban Area (Constituent Counties or County Equivalents)	Wage Index
2335	Elmira, NY Chemung, NY	0.8445
2340	Enid, OK Garfield, OK	0.9001
2360	Erie, PA Erie, PA	0.8699
2400	Eugene-Springfield, OR Lane, OR	1.0940
2440	Evansville-Henderson, IN-KY Posey, IN Vanderburgh, IN Warrick, IN Henderson, KY	0.8395
2520	Fargo-Moorhead, ND-MN Clay, MN Cass, ND	0.9114
2560	Fayetteville, NC Cumberland, NC	0.9363
2580	Fayetteville-Springdale-Rogers, AR Benton, AR Washington, AR	0.8636
2620	Flagstaff, AZ-UT Coconino, AZ Kane, UT	1.0611
2640	Flint, MI Genesee, MI	1.1178
2650	Florence, AL Colbert, AL Lauderdale, AL	0.7883
2655	Florence, SC Florence, SC	0.8960
2670	Fort Collins-Loveland, CO Larimer, CO	1.0218
2680	Ft. Lauderdale, FL Broward, FL	1.0165
2700	Fort Myers-Cape Coral, FL Lee, FL	0.9371
2710	Fort Pierce-Port St. Lucie, FL Martin, FL St. Lucie, FL	1.0046
2720	Fort Smith, AR-OK Crawford, AR Sebastian, AR Sequoyah, OK	0.8303
2750	Fort Walton Beach, FL Okaloosa, FL	0.8786

MSA	Urban Area (Constituent Counties or County Equivalents)	Wage Index
2760	Fort Wayne, IN Adams, IN Allen, IN De Kalb, IN Huntington, IN Wells, IN Whitley, IN	0.9737
2800	Forth Worth-Arlington, TX Hood, TX Johnson, TX Parker, TX Tarrant, TX	0.9520
2840	Fresno, CA Fresno, CA Madera, CA	1.0407
2880	Gadsden, AL Etowah, AL	0.8049
2900	Gainesville, FL Alachua, FL	0.9459
2920	Galveston-Texas City, TX Galveston, TX	0.9403
2960	Gary, IN Lake, IN Porter, IN	0.9342
2975	Glens Falls, NY Warren, NY Washington, NY	0.8467
2980	Goldsboro, NC Wayne, NC	0.8778
2985	Grand Forks, ND-MN Polk, MN Grand Forks, ND	0.9091
2995	Grand Junction, CO Mesa, CO	0.9900
3000	Grand Rapids-Muskegon-Holland, MI Allegan, MI Kent, MI Muskegon, MI Ottawa, MI	0.9519
3040	Great Falls, MT Cascade, MT	0.8810
3060	Greeley, CO Weld, CO	0.9444
3080	Green Bay, WI Brown, WI	0.9586

MSA	Urban Area (Constituent Counties or County Equivalents)	Wage Index
3120	Greensboro-Winston-Salem-High Point, NC Alamance, NC Davidson, NC Davie, NC Forsyth, NC Guilford, NC Randolph, NC Stokes, NC Yadkin, NC	0.9312
3150	Greenville, NC Pitt, NC	0.9183
3160	Greenville-Spartanburg-Anderson, SC Anderson, SC Cherokee, SC Greenville, SC Pickens, SC Spartanburg, SC	0.9400
3180	Hagerstown, MD Washington, MD	0.9940
3200	Hamilton-Middletown, OH Butler, OH	0.9066
3240	Harrisburg-Lebanon-Carlisle, PA Cumberland, PA Dauphin, PA Lebanon, PA Perry, PA	0.9286
3283	Hartford, CT Hartford, CT Litchfield, CT Middlesex, CT Tolland, CT	1.1054
3285	Hattiesburg, MS Forrest, MS Lamar, MS	0.7362
3290	Hickory-Morganton-Lenoir, NC Alexander, NC Burke, NC Caldwell, NC Catawba, NC	0.9502
3320	Honolulu, HI Honolulu, HI	1.1013
3350	Houma, LA Lafourche, LA Terrebonne, LA	0.7721

MSA	Urban Area (Constituent Counties or County Equivalents)	Wage Index
3360	Houston, TX Chambers, TX Fort Bend, TX Harris, TX Liberty, TX Montgomery, TX Waller, TX	1.0117
3400	Huntington-Ashland, WV-KY-OH Boyd, KY Carter, KY Greenup, KY Lawrence, OH Cabell, WV Wayne, WV	0.9564
3440	Huntsville, AL Limestone, AL Madison, AL	0.8851
3480	Indianapolis, IN Boone, IN Hamilton, IN Hancock, IN Hendricks, IN Johnson, IN Madison, IN Marion, IN Morgan, IN Shelby, IN	1.0039
3500	Iowa City, IA Johnson, IA	0.9654
3520	Jackson, MI Jackson, MI	0.9146
3560	Jackson, MS Hinds, MS Madison, MS Rankin, MS	0.8406
3580	Jackson, TN Chester, TN Madison, TN	0.8900
3600	Jacksonville, FL Clay, FL Duval, FL Nassau, FL St. Johns, FL	0.9548
3605	Jacksonville, NC Onslow, NC	0.8401

MSA	Urban Area (Constituent Counties or County Equivalents)	Wage Index
3610	Jamestown, NY Chautaqua, NY	0.7589
3620	Janesville-Beloit, WI Rock, WI	0.9583
3640	Jersey City, NJ Hudson, NJ	1.0923
3660	Johnson City-Kingsport-Bristol, TN-VA Carter, TN Hawkins, TN Sullivan, TN Unicoi, TN Washington, TN Bristol City, VA Scott, VA Washington, VA	0.8202
3680	Johnstown, PA Cambria, PA Somerset, PA	0.7980
3700	Jonesboro, AR Craighead, AR	0.8144
3710	Joplin, MO Jasper, MO Newton, MO	0.8721
3720	Kalamazoo-Battlecreek, MI Calhoun, MI Kalamazoo, MI Van Buren, MI	1.0350
3740	Kankakee, IL Kankakee, IL	1.0603
3760	Kansas City, KS-MO Johnson, KS Leavenworth, KS Miami, KS Wyandotte, KS Cass, MO Clay, MO Clinton, MO Jackson, MO Lafayette, MO Platte, MO Ray, MO	0.9641
3800	Kenosha, WI Kenosha, WI	0.9772
3810	Killeen-Temple, TX Bell, TX Coryell, TX	0.9242

MSA	Urban Area (Constituent Counties or County Equivalents)	Wage Index
3840	Knoxville, TN Anderson, TN Blount, TN Knox, TN Loudon, TN Sevier, TN Union, TN	0.8508
3850	Kokomo, IN Howard, IN Tipton, IN	0.8986
3870	La Crosse, WI-MN Houston, MN La Crosse, WI	0.9289
3880	Lafayette, LA Acadia, LA Lafayette, LA St. Landry, LA St. Martin, LA	0.8105
3920	Lafayette, IN Clinton, IN Tippecanoe, IN	0.9067
3960	Lake Charles, LA Calcasieu, LA	0.7972
3980	Lakeland-Winter Haven, FL Polk, FL	0.8930
4000	Lancaster, PA Lancaster, PA	0.9883
4040	Lansing-East Lansing, MI Clinton, MI Eaton, MI Ingham, MI	0.9658
4080	Laredo, TX Webb, TX	0.8747
4100	Las Cruces, NM Dona Ana, NM	0.8784
4120	Las Vegas, NV-AZ Mohave, AZ Clark, NV Nye, NV	1.1121
4150	Lawrence, KS Douglas, KS	0.8644
4200	Lawton, OK Comanche, OK	0.8212
4243	Lewiston-Auburn, ME Androscoggin, ME	0.9562

MSA	Urban Area (Constituent Counties or County Equivalents)	Wage Index
4280	Lexington, KY Bourbon, KY Clark, KY Fayette, KY Jessamine, KY Madison, KY Scott, KY Woodford, KY	0.9219
4320	Lima, OH Allen, OH Auglaize, OH	0.9258
4360	Lincoln, NE Lancaster, NE	1.0208
4400	Little Rock-North Little, AR Faulkner, AR Lonoke, AR Pulaski, AR Saline, AR	0.8826
4420	Longview-Marshall, TX Gregg, TX Harrison, TX Upshur, TX	0.8739
4480	Los Angeles-Long Beach, CA Los Angeles, CA	1.1732
4520	Louisville, KY-IN Clark, IN Floyd, IN Harrison, IN Scott, IN Bullitt, KY Jefferson, KY Oldham, KY	0.9162
4600	Lubbock, TX Lubbock, TX	0.8777
4640	Lynchburg, VA Amherst, VA Bedford City, VA Bedford, VA Campbell, VA Lynchburg City, VA	0.9017
4680	Macon, GA Bibb, GA Houston, GA Jones, GA Peach, GA Twiggs, GA	0.9596

MSA	Urban Area (Constituent Counties or County Equivalents)	Wage Index
4720	Madison, WI Dane, WI	1.0395
4800	Mansfield, OH Crawford, OH Richland, OH	0.9105
4840	Mayaguez, PR Anasco, PR Cabo Rojo, PR Hormigueros, PR Mayaguez, PR Sabana Grande, PR San German, PR	0.4769
4880	McAllen-Edinburg-Mission, TX Hidalgo, TX	0.8602
4890	Medford-Ashland, OR Jackson, OR	1.0534
4900	Melbourne-Titusville-Palm Bay, FL Brevard, FL	0.9633
4920	Memphis, TN-AR-MS Crittenden, AR De Soto, MS Fayette, TN Shelby, TN Tipton, TN	0.9234
4940	Merced, CA Merced, CA	1.0575
5000	Miami, FL Dade, FL	0.9870
5015	Middlesex-Somerset-Hunterdon, NJ Hunterdon, NJ Middlesex, NJ Somerset, NJ	1.1360
5080	Milwaukee-Waukesha, WI Milwaukee, WI Ozaukee, WI Washington, WI Waukesha, WI	1.0076

MSA	Urban Area (Constituent Counties or County Equivalents)	Wage Index
5120	Minneapolis-St. Paul, MN-WI Anoka, MN Carver, MN Chisago, MN Dakota, MN Hennepin, MN Isanti, MN Ramsey, MN Scott, MN Sherburne, MN Washington, MN Wright, MN Pierce, WI St. Croix, WI	1.1066
5140	Missoula, MT Missoula, MT	0.9618
5160	Mobile, AL Baldwin, AL Mobile, AL	0.7932
5170	Modesto, CA Stanislaus, CA	1.1966
5190	Monmouth-Ocean, NJ Monmouth, NJ Ocean, NJ	1.0888
5200	Monroe, LA Ouachita, LA	0.7913
5240	Montgomery, AL Autauga, AL Elmore, AL Montgomery, AL	0.8300
5280	Muncie, IN Delaware, IN	0.8580
5330	Myrtle Beach, SC Horry, SC	0.9022
5345	Naples, FL Collier, FL	1.0558
5360	Nashville, TN Cheatham, TN Davidson, TN Dickson, TN Robertson, TN Rutherford, TN Sumner, TN Williamson, TN Wilson, TN	1.0108

MSA	Urban Area (Constituent Counties or County Equivalents)	Wage Index
5380	Nassau-Suffolk, NY Nassau, NY Suffolk, NY	1.2907
5483	New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT Fairfield, CT New Haven, CT	1.2254
5523	New London-Norwich, CT New London, CT	1.1596
5560	New Orleans, LA Jefferson, LA Orleans, LA Plaquemines, LA St. Bernard, LA St. Charles, LA St. James, LA St. John The Baptist, LA St. Tammany, LA	0.9103
5600	New York, NY Bronx, NY Kings, NY New York, NY Putnam, NY Queens, NY Richmond, NY Rockland, NY Westchester, NY	1.3586
5640	Newark, NJ Essex, NJ Morris, NJ Sussex, NJ Union, NJ Warren, NJ	1.1625
5660	Newburgh, NY-PA Orange, NY Pike, PA	1.1170

MSA	Urban Area (Constituent Counties or County Equivalents)	Wage Index
5720	Norfolk-Virginia Beach-Newport News, VA-NC Currituck, NC Chesapeake City, VA Gloucester, VA Hampton City, VA Isle of Wight, VA James City, VA Mathews, VA Newport News City, VA Norfolk City, VA Poquoson City, VA Portsmouth City, VA Suffolk City, VA Virginia Beach City, VA Williamsburg City, VA York, VA	0.8894
5775	Oakland, CA Alameda, CA Contra Costa, CA	1.5220
5790	Ocala, FL Marion, FL	0.9153
5800	Odessa-Midland, TX Ector, TX Midland, TX	0.9632
5880	Oklahoma City, OK Canadian, OK Cleveland, OK Logan, OK McClain, OK Oklahoma, OK Pottawatomie, OK	0.8966
5910	Olympia, WA Thurston, WA	1.1006
5920	Omaha, NE-IA Pottawattamie, IA Cass, NE Douglas, NE Sarpy, NE Washington, NE	0.9754
5945	Orange County, CA Orange, CA	1.1611
5960	Orlando, FL Lake, FL Orange, FL Osceola, FL Seminole, FL	0.9742

MSA	Urban Area (Constituent Counties or County Equivalents)	Wage Index
5990	Owensboro, KY Daviess, KY	0.8434
6015	Panama City, FL Bay, FL	0.8124
6020	Parkersburg-Marietta, WV-OH Washington, OH Wood, WV	0.8288
6080	Pensacola, FL Escambia, FL Santa Rosa, FL	0.8306
6120	Peoria-Pekin, IL Peoria, IL Tazewell, IL Woodford, IL	0.8886
6160	Philadelphia, PA-NJ Burlington, NJ Camden, NJ Gloucester, NJ Salem, NJ Bucks, PA Chester, PA Delaware, PA Montgomery, PA Philadelphia, PA	1.0824
6200	Phoenix-Mesa, AZ Maricopa, AZ Pinal, AZ	0.9982
6240	Pine Bluff, AR Jefferson, AR	0.8673
6280	Pittsburgh, PA Allegheny, PA Beaver, PA Butler, PA Fayette, PA Washington, PA Westmoreland, PA	0.8756
6323	Pittsfield, MA Berkshire, MA	1.0439
6340	Pocatello, ID Bannock, ID	0.9601

MSA	Urban Area (Constituent Counties or County Equivalents)	Wage Index
6360	Ponce, PR Guayanilla, PR Juana Diaz, PR Penuelas, PR Ponce, PR Villalba, PR Yauco, PR	0.4954
6403	Portland, ME Cumberland, ME Sagadahoc, ME York, ME	1.0112
6440	Portland-Vancouver, OR-WA Clackamas, OR Columbia, OR Multnomah, OR Washington, OR Yamhill, OR Clark, WA	1.1403
6483	Providence-Warwick-Pawtucket, RI Bristol, RI Kent, RI Newport, RI Providence, RI Washington, RI	1.1061
6520	Provo-Orem, UT Utah, UT	0.9613
6560	Pueblo, CO Pueblo, CO	0.8752
6580	Punta Gorda, FL Charlotte, FL	0.9441
6600	Racine, WI Racine, WI	0.9045
6640	Raleigh-Durham-Chapel Hill, NC Chatham, NC Durham, NC Franklin, NC Johnston, NC Orange, NC Wake, NC	1.0258
6660	Rapid City, SD Pennington, SD	0.8912
6680	Reading, PA Berks, PA	0.9215
6690	Redding, CA Shasta, CA	1.1835

MSA	Urban Area (Constituent Counties or County Equivalents)	Wage Index
6720	Reno, NV Washoe, NV	1.0456
6740	Richland-Kennewick-Pasco, WA Benton, WA Franklin, WA	1.0520
6760	Richmond-Petersburg, VA Charles City County, VA Chesterfield, VA Colonial Heights City, VA Dinwiddie, VA Goochland, VA Hanover, VA Henrico, VA Hopewell City, VA New Kent, VA Petersburg City, VA Powhatan, VA Prince George, VA Richmond City, VA	0.9397
6780	Riverside-San Bernardino, CA Riverside, CA San Bernardino, CA	1.0970
6800	Roanoke, VA Botetourt, VA Roanoke, VA Roanoke City, VA Salem City, VA	0.8428
6820	Rochester, MN Olmsted, MN	1.1504
6840	Rochester, NY Genesee, NY Livingston, NY Monroe, NY Ontario, NY Orleans, NY Wayne, NY	0.9196
6880	Rockford, IL Boone, IL Ogle, IL Winnebago, IL	0.9626
6895	Rocky Mount, NC Edgecombe, NC Nash, NC	0.8998

MSA	Urban Area (Constituent Counties or County Equivalents)	Wage Index
6920	Sacramento, CA El Dorado, CA Placer, CA Sacramento, CA	1.1848
6960	Saginaw-Bay City-Midland, MI Bay, MI Midland, MI Saginaw, MI	0.9696
6980	St. Cloud, MN Benton, MN Stearns, MN	1.0215
7000	St. Joseph, MO Andrews, MO Buchanan, MO	1.0013
7040	St. Louis, MO-IL Clinton, IL Jersey, IL Madison, IL Monroe, IL St. Clair, IL Franklin, MO Jefferson, MO Lincoln, MO St. Charles, MO St. Louis, MO St. Louis City, MO Warren, MO Sullivan City, MO	0.9081
7080	Salem, OR Marion, OR Polk, OR	1.0556
7120	Salinas, CA Monterey, CA	1.3823
7160	Salt Lake City-Ogden, UT Davis, UT Salt Lake, UT Weber, UT	0.9487
7200	San Angelo, TX Tom Green, TX	0.8167
7240	San Antonio, TX Bexar, TX Comal, TX Guadalupe, TX Wilson, TX	0.9023
7320	San Diego, CA San Diego, CA	1.1267

MSA	Urban Area (Constituent Counties or County Equivalents)	Wage Index
7360	San Francisco, CA Marin, CA San Francisco, CA San Mateo, CA	1.4712
7400	San Jose, CA Santa Clara, CA	1.4744
7440	San Juan-Bayamon, PR Aguas Buenas, PR Barceloneta, PR Bayamon, PR Canovanas, PR Carolina, PR Catano, PR Ceiba, PR Comerio, PR Corozal, PR Dorado, PR Fajardo, PR Florida, PR Guaynabo, PR Humacao, PR Juncos, PR Los Piedras, PR Loiza, PR Luguillo, PR Manati, PR Morovis, PR Naguabo, PR Naranjito, PR Rio Grande, PR San Juan, PR Toa Alta, PR Toa Baja, PR Trujillo Alto, PR Vega Alta, PR Vega Baja, PR Yabucoa, PR	0.4802
7460	San Luis Obispo-Atascadero-Paso Robles, CA San Luis Obispo, CA	1.1118
7480	Santa Barbara-Santa Maria-Lompoc, CA Santa Barbara, CA	1.0771
7485	Santa Cruz-Watsonville, CA Santa Cruz, CA	1.4779
7490	Santa Fe, NM Los Alamos, NM Santa Fe, NM	1.0590

MSA	Urban Area (Constituent Counties or County Equivalents)	Wage Index
7500	Santa Rosa, CA Sonoma, CA	1.2961
7510	Sarasota-Bradenton, FL Manatee, FL Sarasota, FL	0.9629
7520	Savannah, GA Bryan, GA Chatham, GA Effingham, GA	0.9460
7560	Scranton--Wilkes-Barre--Hazleton, PA Columbia, PA Lackawanna, PA Luzerne, PA Wyoming, PA	0.8522
7600	Seattle-Bellevue-Everett, WA Island, WA King, WA Snohomish, WA	1.1479
7610	Sharon, PA Mercer, PA	0.7881
7620	Sheboygan, WI Sheboygan, WI	0.8948
7640	Sherman-Denison, TX Grayson, TX	0.9617
7680	Shreveport-Bossier City, LA Bossier, LA Caddo, LA Webster, LA	0.9111
7720	Sioux City, IA-NE Woodbury, IA Dakota, NE	0.9094
7760	Sioux Falls, SD Lincoln, SD Minnehaha, SD	0.9441
7800	South Bend, IN St. Joseph, IN	0.9447
7840	Spokane, WA Spokane, WA	1.0660
7880	Springfield, IL Menard, IL Sangamon, IL	0.8738
7920	Springfield, MO Christian, MO Greene, MO Webster, MO	0.8597

MSA	Urban Area (Constituent Counties or County Equivalents)	Wage Index
8003	Springfield, MA Hampden, MA Hampshire, MA	1.0173
8050	State College, PA Centre, PA	0.8461
8080	Steubenville-Weirton, OH-WV Jefferson, OH Brooke, WV Hancock, WV	0.8280
8120	Stockton-Lodi, CA San Joaquin, CA	1.0564
8140	Sumter, SC Sumter, SC	0.8520
8160	Syracuse, NY Cayuga, NY Madison, NY Onondaga, NY Oswego, NY	0.9394
8200	Tacoma, WA Pierce, WA	1.1078
8240	Tallahassee, FL Gadsden, FL Leon, FL	0.8655
8280	Tampa-St. Petersburg-Clearwater, FL Hernando, FL Hillsborough, FL Pasco, FL Pinellas, FL	0.9024
8320	Terre Haute, IN Clay, IN Vermillion, IN Vigo, IN	0.8582
8360	Texarkana, AR-Texarkana, TX Miller, AR Bowie, TX	0.8413
8400	Toledo, OH Fulton, OH Lucas, OH Wood, OH	0.9524
8440	Topeka, KS Shawnee, KS	0.8904
8480	Trenton, NJ Mercer, NJ	1.0276
8520	Tucson, AZ Pima, AZ	0.8926

MSA	Urban Area (Constituent Counties or County Equivalents)	Wage Index
8560	Tulsa, OK Creek, OK Osage, OK Rogers, OK Tulsa, OK Wagoner, OK	0.8729
8600	Tuscaloosa, AL Tuscaloosa, AL	0.8440
8640	Tyler, TX Smith, TX	0.9502
8680	Utica-Rome, NY Herkimer, NY Oneida, NY	0.8295
8720	Vallejo-Fairfield-Napa, CA Napa, CA Solano, CA	1.3517
8735	Ventura, CA Ventura, CA	1.1105
8750	Victoria, TX Victoria, TX	0.8469
8760	Vineland-Millville-Bridgeton, NJ Cumberland, NJ	1.0573
8780	Visalia-Tulare-Porterville, CA Tulare, CA	0.9975
8800	Waco, TX McLennan, TX	0.8146

MSA	Urban Area (Constituent Counties or County Equivalents)	Wage Index
8840	Washington, DC-MD-VA-WV District of Columbia, DC Calvert, MD Charles, MD Frederick, MD Montgomery, MD Prince Georges, MD Alexandria City, VA Arlington, VA Clarke, VA Culpepper, VA Fairfax, VA Fairfax City, VA Falls Church City, VA Fauquier, VA Fredericksburg City, VA King George, VA Loudoun, VA Manassas City, VA Manassas Park City, VA Prince William, VA Spotsylvania, VA Stafford, VA Warren, VA Berkeley, WV Jefferson, WV	1.0971
8920	Waterloo-Cedar Falls, IA Black Hawk, IA	0.8633
8940	Wausau, WI Marathon, WI	0.9570
8960	West Palm Beach-Boca Raton, FL Palm Beach, FL	1.0362
9000	Wheeling, OH-WV Belmont, OH Marshall, WV Ohio, WV	0.7449
9040	Wichita, KS Butler, KS Harvey, KS Sedgwick, KS	0.9468
9080	Wichita Falls, TX Archer, TX Wichita, TX	0.8395
9140	Williamsport, PA Lycoming, PA	0.8485

MSA	Urban Area (Constituent Counties or County Equivalents)	Wage Index
9160	Wilmington-Newark, DE-MD New Castle, DE Cecil, MD	1.1121
9200	Wilmington, NC New Hanover, NC Brunswick, NC	0.9237
9260	Yakima, WA Yakima, WA	1.0322
9270	Yolo, CA Yolo, CA	0.9378
9280	York, PA York, PA	0.9150
9320	Youngstown-Warren, OH Columbiana, OH Mahoning, OH Trumbull, OH	0.9517
9340	Yuba City, CA Sutter, CA Yuba, CA	1.0363
9360	Yuma, AZ Yuma, AZ	0.8871

ADDENDUM B2—WAGE INDEX FOR RURAL AREAS

Nonurban Area	Wage Index
Alabama	0.7637
Alaska	1.1637
Arizona	0.9140
Arkansas	0.7703
California	1.0297
Colorado	0.9368
Connecticut	1.1917
Delaware	0.9503
Florida	0.8721
Georgia	0.8247
Guam	0.9611
Hawaii	1.0522
Idaho	0.8826
Illinois	0.8340
Indiana	0.8736
Iowa	0.8550
Kansas	0.8087
Kentucky	0.7844
Louisiana	0.7290

Nonurban Area	Wage Index
Maine	0.9039
Maryland	0.9179
Massachusetts	1.0216
Michigan	0.8740
Minnesota	0.9339
Mississippi	0.7583
Missouri	0.7829
Montana	0.8701
Nebraska	0.9035
Nevada	0.9832
New Hampshire	0.9940
New Jersey [1/]	------
New Mexico	0.8529
New York	0.8403
North Carolina	0.8500
North Dakota	0.7743
Ohio	0.8759
Oklahoma	0.7537
Oregon	1.0049
Pennsylvania	0.8348
Puerto Rico	0.4047
Rhode Island [1/]	------
South Carolina	0.8640
South Dakota	0.8393
Tennessee	0.7876
Texas	0.7910
Utah	0.8843
Vermont	0.9375
Virginia	0.8479
Virgin Islands	0.7456
Washington	1.0072
West Virginia	0.8083
Wisconsin	0.9498
Wyoming	0.9182

[1/] All counties within the State are classified urban.

ADDENDUM C--CODE FIRST

Code	Code First Instruction as of 2005 (Effective October 1, 2004) ICD-9-CM Disease Tabulary
290.0	Code First the Associated neurological condition
290.10	Code First the Associated neurological condition
290.11	Code First the Associated neurological condition

Code	Code First Instruction as of 2005 (Effective October 1, 2004) ICD-9-CM Disease Tabulary
290.12	Code First the Associated neurological condition
290.13	Code First the Associated neurological condition
290.20	Code First the Associated neurological condition
290.21	Code First the Associated neurological condition
290.3	Code First the Associated neurological condition
290.40	Code First the Associated neurological condition
290.41	Code First the Associated neurological condition
290.42	Code First the Associated neurological condition
290.43	Code First the Associated neurological condition
290.8	Code First the Associated neurological condition
290.9	Code First the Associated neurological condition
293	Code First Associated physical or neurological condition
293.0	Code First Underlying Physical condition as: Dementia in: 331.0, 330.1, 331.82, 345.0 though 345.9, 331.19, 094.1, 275.1, 333.4, 046.1, 340, 331.1, 446.0, 094.1,
293.1,	Code First Underlying Physical condition as: Dementia in: 331.0
293.81,	Code First Underlying Physical condition as: Dementia in: 331.0
293.82	Code First Underlying Physical condition as: Dementia in: 331.0
293.83	Code First Underlying Physical condition as: Dementia in: 331.0
293.84	Code First Underlying Physical condition as: Dementia in: 331.0
293.89	Code First Underlying Physical condition as: Dementia in: 331.0
293.9	Code First Underlying Physical condition as: Dementia in: 331.0
294.10	Code First Underlying Physical condition as: Dementia in: 331.0, 330.1, 331.82, 345.0 through 345.9, 331.19, 094.1, 275.1, 333.4, 046.1, 340, 331.1, 446.0, 094.1,
294.11	Code First Underlying Physical condition as: Dementia in: 331.0, 330.1, 331.82, 345.0 through 345.9, 331.19, 094.1, 275.1, 333.4, 046.1, 340, 331.1, 446.0, 094.1,
307.89	Code First Site of Pain
320.7	Code First Underlying disease as: 039.8, 027.0, 002.0, 033.0 through 033.9

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November 15, 2004

Part VI

Social Security Administration

20 CFR Part 404

Revised Medical Criteria for Evaluating Hematological Disorders and Malignant Neoplastic Diseases; Final Rule and Proposed Rule

SOCIAL SECURITY ADMINISTRATION

20 CFR Part 404

[Regulations No. 4]

RIN 0960–AD67

Revised Medical Criteria for Evaluating Malignant Neoplastic Diseases

AGENCY: Social Security Administration.

ACTION: Final rules.

SUMMARY: We are revising the criteria in the Listing of Impairments (the listings) that we use to evaluate claims involving malignant neoplastic diseases. We apply these criteria when you claim benefits based on disability under title II and title XVI of the Social Security Act (the Act). The revisions reflect advances in medical knowledge, treatment, and methods of evaluating malignant neoplastic diseases.

DATES: These rules are effective December 15, 2004.

Electronic Version

The electronic file of this document is available on the date of publication in the **Federal Register** at *http://www.gpoaccess.gov/fr/index.html.* It is also available on the Internet site for SSA (*i.e.*, Social Security Online): *http://policy.ssa.gov/pnpublic.nsf/LawsRegs.*

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SUPPLEMENTARY INFORMATION: We are revising and making final the rules we proposed for evaluating malignant neoplastic diseases in the Notice of Proposed Rulemaking (NPRM) published in the **Federal Register** on November 27, 2001 (66 FR 59306). In that NPRM, we proposed revisions to both the listings for hematological disorders and the listings for malignant neoplastic diseases. We proposed to make revisions to the listings for these two body systems in order to update their medical criteria and to provide more information about how we evaluate disorders in these body systems. We initially provided a 60-day comment period that ended on January 28, 2002. Subsequently, on April 18, 2002, we reopened the comment period for an additional 60 days, until June 17, 2002 (67 FR 19138). For the reasons explained below, we have decided to publish only revisions to the malignant neoplastic diseases body system in this final rule. We are publishing separately, in today's edition of the **Federal Register**, a notice withdrawing the proposed rules that would have revised the hematological disorders listings. We plan to publish a new NPRM for the hematological disorders listings at a later date.

We provide a summary of the provisions of the final rules below, with an explanation of the changes we have made from the text in the NPRM. We then provide summaries of the public comments and our reasons for adopting or not adopting the recommendations in those comments in the section ''Public Comments.'' The final rule language follows the public comments section.

What Programs Do These Final Regulations Affect?

These final regulations affect disability determinations and decisions that we make under title II and title XVI of the Act. In addition, to the extent that Medicare entitlement and Medicaid eligibility are based on whether you qualify for disability benefits under title II and title XVI, these final regulations also affect the Medicare and Medicaid programs.

Who Can Get Disability Benefits?

Under title II of the Act, we provide for the payment of disability benefits if you are disabled and belong to one of the following three groups:

- Workers insured under the Act.
- Children of insured workers.
- Widows, widowers, and surviving divorced spouses (*see* § 404.336) of insured workers.

Under title XVI of the Act, we provide for Supplemental Security Income (SSI) payments on the basis of disability if you are disabled and have limited income and resources.

How Do We Define Disability?

Under both the title II and title XVI programs, disability must be the result of any medically determinable physical or mental impairment or combination of impairments that is expected to result in death or which has lasted or can be expected to last for a continuous period of at least 12 months. Our definitions of disability are shown in the following table:

If you file a claim under * * *	And you are * * *	Disability means you have a medically determinable impairment(s) as described above and that results in * * *
title II	an adult or a child	the inability to do any substantial gainful activity (SGA).
title XVI	an individual age 18 or older	the inability to do any SGA.
title XVI	an individual under age 18	marked and severe functional limitations.

How Do We Decide Whether You Are Disabled?

If you are seeking benefits under title II of the Act, or if you are an adult seeking benefits under title XVI of the Act, we use a five-step ''sequential evaluation process'' to decide whether you are disabled. We describe this five-step process in our regulations at §§ 404.1520 and 416.920. We follow the five steps in order and stop as soon as we can make a determination or decision. The steps are:

1. Are you working and is the work you are doing substantial gainful activity? If you are working and the work you are doing is substantial gainful activity, we will find that you are not disabled, regardless of your medical condition or your age, education, and work experience. If you are not, we will go on to step 2.

2. Do you have a ''severe'' impairment? If you do not have an impairment or combination of impairments that significantly limits your physical or mental ability to do basic work activities, we will find that you are not disabled. If you do, we will go on to step 3.

3. Do you have an impairment(s) that meets or medically equals the severity of an impairment in the listings? If you do, and the impairment(s) meets the duration requirement, we will find that you are disabled. If you do not, we will go on to step 4.

4. Do you have the residual functional capacity to do your past relevant work? If you do, we will find that you are not disabled. If you do not, we will go on to step 5.

5. Does your impairment(s) prevent you from doing any other work that exists in significant numbers in the

national economy, considering your residual functional capacity, age, education, and work experience? If it does, and it meets the duration requirement, we will find that you are disabled. If it does not, we will find that you are not disabled.

We use a different sequential evaluation process for children who apply for payments based on disability under title XVI of the Act. We describe that sequential evaluation process in § 416.924 of our regulations. If you are already receiving benefits, we also use a different sequential evaluation process when we decide whether your disability continues. *See* §§ 404.1594, 416.924, 416.994, and 416.994a of our regulations. However, all of these processes include steps at which we consider whether your impairment meets or medically equals one of our listings.

What Are the Listings?

The listings are examples of impairments that we consider severe enough to prevent you as an adult from doing any gainful activity. If you are a child seeking SSI benefits based on disability, the listings describe impairments that we consider severe enough to result in marked and severe functional limitations. Although the listings are contained only in appendix 1 to subpart P of part 404 of our regulations we incorporate them by reference in the SSI program in § 416.925 of our regulations, and apply them to claims under both title II and title XVI of the Act.

How Do We Use the Listings?

The listings are in two parts. There are listings for adults (part A) and for children (part B). If you are an individual age 18 or over, we apply the listings in part A when we assess your claim, and we do not use the listings in part B.

If you are an individual under age 18, we first use the criteria in part B of the listings. If the listings in part B do not apply, and the specific disease process(es) has a similar effect on adults and children, we then use the criteria in part A. (*See* §§ 404.1525 and 416.925.)

If your impairment(s) does not meet any listing, we will also consider whether it medically equals any listing; that is, whether it is as medically severe as an impairment in the listings. (*See* §§ 404.1526 and 416.926.)

What if You Do Not Have an Impairment(s) That Meets or Medically Equals a Listing?

We use the listings only to decide that individuals are disabled or that they are still disabled. We will not deny your claim because your impairment(s) does not meet or medically equal a listing. If you are not doing work that is substantial gainful activity, and you have a severe impairment(s) that does not meet or medically equal any listing, we may still find you disabled based on other rules in the ''sequential evaluation process'' described above. Likewise, we will not decide that your disability has ended only because your impairment(s) does not meet or medically equal a listing.

Also, when we conduct reviews to determine whether your disability continues, we will not find that your disability has ended because we have changed a listing. Our regulations explain that, when we change our listings, we continue to use our prior listings when we review your case, if you had qualified for disability benefits or SSI payments based on our determination or decision that your impairment(s) met or medically equaled a listing. In these cases, we determine whether you have experienced medical improvement, and if so, whether the medical improvement is related to the ability to work. If your condition(s) has medically improved so that you no longer meet or medically equal the prior listing, we evaluate your case further to determine whether you are currently disabled. We may find that you are currently disabled, depending on the full circumstances of your case. *See* §§ 404.1594(c)(3)(i) and 416.994(b)(2)(iv)(A). If you are a child who is eligible for SSI payments, we follow a similar rule when we decide whether you have experienced medical improvement in your condition(s). *See* § 416.994a(b)(2).

Why Are We Revising the Listings for Malignant Neoplastic Diseases?

We are revising these listings to update our medical criteria for evaluating malignant neoplastic diseases and to provide more information about how we evaluate such diseases. On April 24, 2002, we published final rules in the **Federal Register** (67 FR 20018) that included technical revisions to some of the listings for malignant neoplastic diseases. Prior to this, we last published final rules making comprehensive revisions to the listings for malignant neoplastic diseases in the **Federal Register** on December 6, 1985 (50 FR 50068). Because we have not comprehensively revised the listings for this body system since 1985, we believe that we need to update the rules.

What Do We Mean by ''Final Rules'' and ''Prior Rules''?

Even though these rules will not go into effect until 30 days after publication of this notice, for clarity, we refer to the changes we are making here as the ''final rules'' and to the rules that will be changed by these final rules as the ''prior rules.''

When Will We Start To Use These Final Rules?

We will start to use these final rules on their effective date. We will continue to use our prior rules until the effective date of these final rules. When the final rules become effective, we will apply them to new applications filed on or after the effective date of these rules and to claims pending before us, as we describe below.

As is our usual practice when we make changes to our regulations, we will apply these final rules on or after their effective date when we make a determination or decision, including those claims in which we make a determination or decision after remand to us from a Federal court. With respect to claims in which we have made a final decision, and that are pending judicial review in Federal court, we expect that the court's review of the Commissioner's final decision would be made in accordance with the rules in effect at the time of the administrative law judge's (ALJ) decision, if the ALJ's decision is the final decision of the Commissioner. If the court determines that the Commissioner's final decision is not supported by substantial evidence, or contains an error of law, we would expect that the court would reverse the final decision, and remand the case for further administrative proceedings pursuant to the fourth sentence of section 205(g) of the Act, except in those few instances in which the court determines that it is appropriate to reverse the final decision and award benefits without remanding the case for further administrative proceedings. In those cases decided by a court after the effective date of the rules, where the court reverses the Commissioner's final decision and remands the case for further administrative proceedings, on remand, we will apply the provisions of these final rules to the entire period at issue in the claim.

How Long Will These Final Rules Be Effective?

These rules will no longer be effective 5 years after the date on which they become effective, unless we extend them or revise and issue them again.

Why Are We Not Publishing Final Rules for Evaluating Hematological Disorders in This Notice?

The public comments we received on the NPRM raised significant issues about the proposed listings for some of the hematological disorders, and we have not finished resolving these issues. The public comments did not raise similar issues with respect to the listings for malignant neoplastic diseases. Therefore, we are issuing these final regulations to implement changes to the listings for malignant neoplastic diseases, and we summarize and respond here only to the significant public comments that we received about the proposed changes regarding those diseases.

As noted above, we are publishing separately in today's edition of the **Federal Register** a notice withdrawing the proposed rules for the hematological disorders listings. We plan to issue a new NPRM for the hematological disorders listings at a later date.

What General Changes Are We Making That Affect Both the Adult and Childhood Listings for Malignant Neoplastic Diseases?

To present the listings in a more logical order, and make them easier to use, we are:

- Redesignating the listings in part A and part B. To the extent possible, the listings in part B correspond with listings addressing the same or similar impairments in part A.
- Placing all listings for malignant neoplastic diseases in this body system, with the exception of certain ones associated with human immunodeficiency virus (HIV) infection. To do this, we are moving the criteria for acute leukemia, chronic leukemia, myeloma, and malignant brain tumors, prior listings 7.11, 7.12, 7.16, 11.05, 107.11, and 111.05, to final listings 13.06, 13.07, 13.13, 113.06 and 113.13, respectively. We are also moving the guidance for evaluating macroglobulinemia or heavy chain disease, prior listing 7.14, to 13.00K3 of the introductory text because the prior listing for this disorder was a reference listing. As noted below, we are eliminating reference listings and providing guidance in the introductory text.
- Removing reference listings from this body system. Reference listings are listings that are met by satisfying the criteria of another listing. For example, prior listing 7.16B, for myeloma with evidence of renal impairment, was a reference listing that requires evaluation under listing 6.02, for impairment of renal function. Instead of using reference listings, we are providing guidance in the introductory text stating that these impairments should be evaluated under the criteria for the affected body system. Where appropriate, we also provide references to specific listings. For example, in 13.00K3 we indicate that macroglobulinemia or heavy chain disease should be evaluated under the criteria of 7.02, 7.06, or 7.08, or under the criteria of any other affected body system.

How Are We Changing the Introductory Text to the Listings for Evaluating Malignant Neoplastic Diseases in Adults?

13.00 Malignant Neoplastic Diseases

We are expanding and reorganizing the introductory text to these listings to provide additional guidance and reflect the new listings. The following is a detailed explanation of this material.

13.00A—What Impairments Do These Listings Cover?

In this section, we explain that we use these listings to evaluate all malignant neoplasms, except certain neoplasms associated with human immunodeficiency virus (HIV) infection. We use the criteria in listing 14.08E to evaluate carcinoma of the cervix, Kaposi's sarcoma, lymphoma, and squamous cell carcinoma of the anus if you also have HIV infection.

13.00B—What Do We Consider When We Evaluate Malignant Neoplastic Diseases Under These Listings?

This section corresponds to prior 13.00A, ''Introduction.'' For clarity, we are using the phrase ''origin of the malignancy'' instead of the prior language, ''the site of the lesion, the histogenesis of the tumor'' to describe one of the factors we consider when we evaluate malignant neoplastic diseases. We also changed the phrase ''apparent adequacy and response to therapy'' in the prior section to ''[r]esponse to antineoplastic therapy'' to eliminate any misunderstanding concerning who can make judgments about the appropriateness of the treatment regimen. ''Apparent adequacy'' was intended to mean effectiveness of the therapy. Judgments about its appropriateness must be left entirely to the treating source. We added the word ''antineoplastic'' to be consistent with the language in the listing criteria. We also specifically identify the types of antineoplastic therapy referred to in the listings.

13.00C—How Do We Apply the Listings?

In this section, we explain that we apply the criteria in a specific listing to a malignancy originating from that specific site.

In this section of the NPRM (66 FR at 59321), we stated that metastatic carcinoma to the brain or spinal cord was an exception to the guidance above. We received a public comment questioning this exception. In response to this comment, we determined that this exception was unnecessary and have removed it. We will evaluate metastatic carcinoma to the brain or spinal cord under the site of origin for the primary tumor or, if this is unknown, under final listing 13.27.

13.00D—What Evidence Do We Need?

We are expanding the guidance in prior 13.00B, ''Documentation,'' by:

- Explaining that when the primary site cannot be identified, we will use evidence documenting the site(s) of metastasis to evaluate the impairment under listing 13.27.
- Clarifying that we consider biopsies and needle aspirations to be ''operative procedures.''
- Using the more general term ''pathology report'' instead of ''the report of the gross and microscopic examination of the surgical specimen.'' We made this change to recognize that a report of the gross examination is not always required and to recognize that a microscopic examination of appropriate body fluids may be used as an alternative to the gross and microscopic examination of the surgical specimen.

13.00E—When Do We Need Longitudinal Evidence?

We are incorporating and expanding the guidance in the fourth paragraph of prior 13.00C, ''Evaluation.'' We explain when we need longitudinal evidence, and the time period such evidence should cover. We also explain when we may need to defer adjudication.

13.00F—How Do We Evaluate Impairments That Do Not Meet One of the Malignant Neoplastic Diseases Listings?

This paragraph corresponds to the first sentence in the second paragraph of prior 13.00D, ''Effects of Therapy.'' We state our basic adjudicative principle that, if your impairment(s) does not meet or medically equal the requirements of a listing, we will continue the sequential evaluation process to determine whether you are disabled.

13.00G—How Do We Consider the Effects of Therapy?

We are reorganizing the guidance in prior 13.00D, ''Effects of Therapy.'' In final 13.00G2a, we are adding ''extent of surgery'' and ''schedule and fields of radiation therapy'' to the list of the elements of therapy for which we will request a description noted in the second paragraph of prior 13.00D. In final 13.00G2b, we are adding ''neurological complications'' and ''cardiovascular complications'' to the list of examples of complications or adverse effects for which we will request a description. We are also clarifying that we will not delay adjudication to determine whether the therapy has achieved its intended effect if we can make a fully favorable determination or decision based on the evidence in the case record.

13.00H—How Long Do We Consider Your Impairment To Be Disabling?

We are incorporating and expanding the guidance contained in the third paragraph of prior 7.00E, ''Acute leukemia,'' and the fifth paragraph of prior 13.00C, ''Evaluation.'' In some of the listings, we specify that we consider an impairment to be disabling until a particular point in time; for example, at least 18 months from the date of diagnosis. If you have an impairment(s) that meets or equals a listing in this body system that does not contain such a specification, we provide that we will consider the impairment(s) to be disabling until at least 3 years after onset of complete remission. We also explain what we do when the appropriate time period has passed.

For those listings in which we specify that the impairment is considered disabling until a particular point in time, such as listing 13.28, the beginning date specified is not related to the onset date. We can establish an earlier onset date if the evidence in your case record supports the earlier onset date, as we explain in final 13.00J.

13.00I—What Do These Terms in the Listings Mean?

We are revising the first two paragraphs and the first sentence of the third paragraph of prior 13.00C, ''Evaluation,'' and providing additional definitions. The prior section contained an adjudicative definition of ''distant metastases'' and ''metastases beyond the regional lymph nodes.'' We are not retaining this definition because our use of these terms in the final listings is consistent with current clinical practice. We are also adding definitions in order to differentiate between the terms ''inoperable'' and ''unresectable.''

13.00J—Can We Establish the Existence of a Disabling Impairment Prior to the Date of the Evidence That Shows the Malignancy Satisfies the Criteria of a Listing?

This section corresponds to prior 13.00E, ''Onset.'' We are making no substantive changes.

13.00K—How Do We Evaluate Specific Malignant Neoplastic Diseases?

We are incorporating and clarifying prior 7.00E, ''Acute leukemia,'' and the last sentence of the third paragraph in prior 13.00C, ''Evaluation,'' and providing guidance for evaluating additional malignant neoplastic disorders. The following is a detailed discussion of the information provided.

13.00K1—Lymphoma

In paragraphs K1a and K1b of this section, we discuss the evaluation of low grade or indolent (non-aggressive) lymphomas. We explain that we may defer adjudication of these cases for an appropriate period after the initiation of therapy to determine whether the therapy will achieve its intended effect. We do not specify a particular time for this deferral because it will vary from case to case. We also explain that changes in therapy based solely on patient or physician preference are not indicative of a failure to stabilize the disease. We also explain how the disease should be evaluated when stability has been achieved.

Final paragraphs 13.00K1a and 13.00K1b reflect nonsubstantive editorial corrections made to the corresponding proposed paragraphs in the NPRM (66 FR at 59322). Proposed paragraph K1a referred to indolent lymphoma. We added a reference to low grade lymphoma to final paragraph K1a to be consistent with the listing language. We also added a reference to low grade or indolent lymphoma in final paragraph K1b for clarity.

We have not retained the last sentence of the third paragraph of prior 13.00C, ''Evaluation.'' This sentence stated, ''In the evaluation of lymphomas, the tissue type and site of involvement are not necessarily indicators of the degree of impairment.'' We do not believe this guidance provided useful information for applying the criteria in final listing 13.05.

In paragraph K1c, we provide that Hodgkin's disease that recurs more than 12 months after completing initial antineoplastic therapy will be evaluated as a new disease rather than as a recurrence.

13.00K2—Leukemia

In paragraph K2a, we expand the guidance in the first paragraph of prior 7.00E, ''Acute leukemia,'' to indicate sources of additional diagnostic information. We clarify that recurrent disease must be documented by peripheral blood, bone marrow, or cerebrospinal fluid examination. We also clarify that the initial and follow-up pathology reports should be included.

In paragraph K2b, we provide guidance on documenting chronic myelogenous leukemia (CML). We have not included in this paragraph the guidance in the second paragraph of prior 7.00E, which provided that the acute phase of CML should be considered under the requirements for acute leukemia. Instead, we have provided a separate listing for the acute phase (more appropriately called the accelerated or blast phase) of CML, final listing 13.06B1, that uses the same criteria as the listing for acute leukemia (final listing 13.06A).

In paragraph K2c, we provide guidance for documenting and evaluating chronic lymphocytic leukemia (CLL). Consistent with our effort to eliminate reference listings, this guidance incorporates the cross-references from prior listing 7.12 that are appropriate for evaluating CLL.

In paragraph K2d, we explain that, in cases of chronic leukemia (either myelogenous or lymphocytic), an elevated white cell count, in itself, is not ordinarily a factor in determining the severity of the impairment.

13.00K3—Macroglobulinemia or Heavy Chain Disease

This section replaces prior listing 7.14, which was a reference listing. We are making no substantive changes in how we evaluate these disorders.

13.00K4—Bilateral Primary Breast Cancer

We are clarifying the statement in prior listing 13.09D, ''bilateral breast carcinoma, synchronous or metachronous is *usually* primary in each breast'' (emphasis added) by removing the suggestion that there are exceptions to this rule. *See* the discussion of final listing 13.10B, below.

13.00K5—Carcinoma-in-situ

In this section, we explain that this type of carcinoma usually responds to treatment and is not included when we use the term ''carcinoma'' in these listings.

13.00K6—Brain Tumors

In this section, we explain that malignant tumors are evaluated under final listing 13.13, while benign tumors continue to be evaluated under listing 11.05. We also explain that we evaluate any complications of malignant brain tumors, such as resultant neurological or psychological impairments, under the criteria for the affected body system.

13.00L—How Do We Evaluate Malignant Neoplastic Diseases Treated by Bone Marrow or Stem Cell Transplantation?

In paragraphs L1 and L2, we discuss how long we consider you disabled if you have leukemia, lymphoma, or multiple myeloma and you undergo bone marrow or stem cell transplantation.

In paragraph L3, we provide that any other malignant neoplastic diseases treated with bone marrow or stem cell transplantation must be evaluated under final listing 13.28, regardless of whether there is another listing that addresses that impairment. We explain that under final listing 13.28, the length of time we will consider you disabled will depend on whether you undergo allogeneic or autologous transplantation. We also define ''allogeneic'' and ''autologous'' in paragraphs L3a and L3b.

In paragraph L4, we discuss some of the factors we consider when we evaluate any residual impairment(s) that results from transplantation.

How Are We Changing the Listings for Evaluating Malignant Neoplastic Diseases in Adults?

13.01—Category of Impairments, Malignant Neoplastic Diseases

We are removing prior listing 13.15, ''Abdomen,'' because disorders covered by this listing can be evaluated under other final listings. Prior listings 13.15A, ''Generalized carcinomatosis,'' and 13.15C, ''Ascites with demonstrated malignant cells,'' represent malignancies that have spread to the abdomen from another site. We will evaluate these conditions under final listing 13.27, ''Primary site unknown after appropriate search for primary.'' We will evaluate ''Retroperitoneal cellular sarcoma not controlled by prescribed therapy,'' the impairment in prior listing 13.15B, under final listing 13.04, ''Soft tissue sarcoma.''

In the final listings, we:

- Take into account medical advances in the detection, treatment, control, and cure of malignant neoplastic diseases.
- Recognize that in some situations the effects of therapy for these disorders can be disabling.
- Provide for the evaluation of residual impairments.

The following is a detailed explanation of the final listings.

Listing 13.02—Soft Tissue Tumors of the Head and Neck (Except Salivary Glands—13.06—and Thyroid Gland—13.07)

This listing corresponds to prior listing 13.02, ''Head and neck.'' We are revising the listing heading to ensure that only tumors of the soft tissue of the head and neck are considered under this listing. This change allows us to delete the last two exceptions in the prior heading (orbit or temporal fossa), as these are not soft tissue tumors. In response to a comment, we are also removing prior listing 13.02E, ''Epidermoid carcinoma occurring in the pyriform sinus or posterior third of the tongue,'' as these conditions can be evaluated under other sections of the final listing. We had proposed to evaluate epidermoid carcinoma occurring in the pyriform sinus under proposed listing 13.02E. We explain our reasons for this change in more detail in the public comments section of this preamble.

Final listing 13.02A is substantively the same as prior listing 13.02A. We are updating the terminology to reflect the definitions used in the final listings.

In final listing 13.02B, which corresponds to prior listing 13.02B, we are replacing ''[n]ot controlled by prescribed therapy'' with ''[p]ersistent disease following initial multimodal antineoplastic therapy'' to clarify our intent.

Final listing 13.02C corresponds to prior listing 13.02C. We are replacing ''after radical surgery or irradiation'' with ''following initial antineoplastic therapy'' to recognize that other therapeutic modalities may be used. We are also excluding local vocal cord recurrences, because these recurrences have a good response to therapy.

Final listing 13.02D corresponds to prior listing 13.02D. We are making no substantive change.

Final listing 13.02E corresponds to proposed listing 13.02F in the NPRM. As we have already noted, we removed prior and proposed listing 13.02E in response to a comment. Therefore, we are redesignating proposed listing 13.02F as final listing 13.02E. It recognizes the length and debilitating effects of multimodal treatment for soft tissue tumors of the head and neck.

Listing 13.03—Skin

We are combining prior listing 13.03, ''Sarcoma of skin,'' and prior listing 13.05, ''Malignant melanoma,'' so that all malignancies originating in the skin are evaluated under this listing. Accordingly, we are revising the heading by removing the reference to sarcoma.

Final listing 13.03A corresponds to prior listing 13.03A, ''Angiosarcoma with metastases to regional lymph nodes or beyond.'' We are expanding the provision to include all skin sarcomas and carcinomas because other skin malignancies of the severity described would also be disabling.

Final listing 13.03B corresponds to prior listing 13.05. We clarify that an additional primary melanoma at a different site is not considered recurrent disease. We are also adding a criterion for palpable nodal metastases. Prior listing 13.05B addressed only metastases to the regional lymph nodes or beyond, and not palpable nodal metastases.

We are moving prior listing 13.03B, ''Mycosis fungoides'' (a type of lymphoma), to final listing 13.05, ''Lymphoma,'' so that all lymphomas will be evaluated under the same listing.

Listing 13.04—Soft Tissue Sarcoma

We are updating the heading of prior listing 13.04, ''Sarcoma of soft parts,'' to recognize that ''soft tissue'' is a more common term than ''soft parts.'' We are adding a criterion for regional or distant metastases, final listing 13.04A, to be consistent with the criteria for other malignant neoplastic diseases and to recognize the grave prognosis for these conditions. In final listing 13.04B, we define the prior criterion ''not controlled by prescribed therapy'' similarly to the way we defined it in other listings, such as final listing 13.02B.

Listing 13.05—Lymphoma (Including Mycosis Fungoides, But Excluding T-cell Lymphoblastic Lymphoma—13.06)

This listing corresponds to prior listing 13.06. We are changing the heading from ''Lymph nodes'' to ''Lymphoma'' to more accurately reflect the disease. We also provide a cross-reference to the explanatory paragraphs in 13.00K1 and 13.00K2c. This listing also replaces prior listing 7.13, ''Lymphomas.''

We evaluated both Hodgkin's disease and non-Hodgkin's lymphoma under prior listing 13.06A. We are separating and clarifying the criteria for each of these diseases. Final listing 13.05A provides criteria for evaluating non-Hodgkin's lymphoma; final listing 13.05B provides criteria for Hodgkin's disease. For each of these disorders, we clarify the prior criteria by replacing the phrase ''progressive disease not

controlled by prescribed therapy'' in the prior listing with clearer language.

In the final rules, we are making a minor editorial revision to proposed listing 13.05A2 for clarity. We amended the proposed listing by adding the words ''at least'' between ''from'' and ''the'' in the last sentence to clarify that the individual can be found disabled prior to the date specified in the listing.

In final listing 13.05C, we provide that a lymphoma treated by bone marrow or stem cell transplantation is considered disabling until at least 12 months from the date of transplantation. After this period, we will evaluate any residual impairment(s) under the criteria for the affected body system.

We are removing prior listing 13.06B, ''Metastatic carcinoma in a lymph node (except for epidermoid carcinoma in a lymph node in the neck) where the primary site is not determined after adequate search.'' We will evaluate this impairment under final listing 13.27, ''Primary site unknown after appropriate search for primary.'' We are also removing prior listing 13.06C. We will evaluate epidermoid carcinoma in a lymph node in the neck under final listing 13.02, ''Soft tissue tumors of the head and neck.''

Listing 13.06—Leukemia

This final listing replaces prior listing 7.11, ''Acute leukemia,'' and prior listing 7.12, ''Chronic leukemia.''

Final listing 13.06A replaces prior listing 7.11. We provide that acute leukemia (including T-cell lymphoblastic lymphoma) will be considered disabling until at least 24 months from the date of diagnosis or relapse, or at least 12 months from the date of bone marrow or stem cell transplantation, whichever is later. After the appropriate period, we will evaluate any residual impairment(s) under the criteria for the affected body system.

Under the prior listing, we considered acute leukemia disabling for 2½ years from the time of the initial diagnosis. We are shortening this period to 2 years because of improvement in the treatment of this disorder. However, as with other final listings, and unlike the prior listing, we permit a longer period when the facts warrant it. We also recognize that a relapse of acute leukemia is as significant as the initial diagnosis.

The criterion for bone marrow or stem cell transplantation in cases of acute leukemia is similar to the transplantation criteria for other diseases. Unlike those diseases, however, we will not reevaluate cases of acute leukemia 12 months after transplantation if that date is earlier than 24 months after onset or relapse. We provide this option for this disease because of the disease course and the high rate of infection and other complications that occur when this disease is treated with bone marrow or stem cell transplantation.

Final listing 13.06B, ''Chronic myelogenous leukemia,'' replaces prior listing 7.12. The prior listing was a reference listing. Rather than replace the entire listing with guidance in the preface, we are providing separate evaluation criteria for CML. Consistent with our guidance in the second paragraph of prior 7.00E, the listing for the accelerated or blast phase of CML is the same as final listing 13.06A.

We are retaining references to the listings that are appropriate for evaluating chronic lymphocytic leukemia in 13.00K2c.

Listing 13.07—Multiple Myeloma (Confirmed by Appropriate Serum or Urine Protein Electrophoresis and Bone Marrow Findings)

This listing replaces prior listing 7.16. In this listing, we remove the specific findings in prior listings 7.16A–D and substitute the criterion ''[f]ailure to respond or progressive disease following initial antineoplastic therapy.'' Our intent is to clarify that this listing includes all listing-level manifestations of this disease. We also clarify that we consider multiple myeloma treated with bone marrow or stem cell transplantation to be disabling until at least 12 months from the date of transplantation. After that time, we will evaluate any residual impairment(s) under the criteria for the affected body system.

Listing 13.08—Salivary Glands

This listing redesignates prior listing 13.07. There are no substantive changes.

Listing 13.09—Thyroid Gland

In the NPRM, we proposed to amend current listing 13.08, for malignancies of the thyroid gland, by:

- Redesignating the current listing as proposed listing 13.09.
- Adding a separate criterion for anaplastic (undifferentiated) carcinoma in proposed listing 13.09A.
- Redesignating the criterion in current listing 13.08, ''carcinoma with metastases beyond the regional lymph nodes, not controlled by prescribed therapy,'' as proposed listing 13.09B.
- Replacing the term ''not controlled by prescribed therapy'' used in current listing 13.08 with ''progressive despite radioactive iodine therapy'' to clarify our intent.

On April 24, 2002, we published final rules in the **Federal Register** (67 FR 20018, 20026) that made technical revisions to the listings. Those rules added the criterion for anaplastic (undifferentiated) carcinoma and redesignated the criterion in prior listing 13.08 as final listing 13.08B.

In these final rules, we are redesignating prior listing 13.08 as final listing 13.09, and are clarifying the language as indicated in the fourth bullet above.

Listing 13.10—Breast

This listing corresponds to prior listing 13.09. In final listing 13.10A, we are amending the criterion in prior listing 13.09B, ''Inflammatory carcinoma,'' by adding other types of locally advanced carcinoma.

In final listing 13.10B, ''Carcinoma with distant metastases,'' we are revising prior listing 13.09D by removing the parenthetical statement ''bilateral breast carcinoma, synchronous or metachronous, is usually primary in each breast.'' Instead, we provide guidance about evaluating bilateral breast cancer in final 13.00K4. As indicated in our discussion of that section, we are clarifying this guidance by removing the suggestion that there are exceptions to this rule.

In final listing 13.10C, which replaces prior listing 13.09C, we are replacing the term ''controlled by prescribed therapy'' used in the prior listing with ''that remits with antineoplastic therapy'' to clarify our intent.

We are removing prior listing 13.09A, ''inoperable carcinoma,'' to avoid confusion about what this term means for this malignancy. We can evaluate cases in which breast cancer is inoperable under other criteria in final listing 13.10. We are also removing prior listing 13.09E, ''Sarcoma with metastases anywhere.'' We will evaluate this impairment under final listing 13.04, ''Soft tissue sarcoma.''

Listing 13.11—Skeletal System

This listing replaces prior listing 13.10. We are expanding the listing to include tumors of the mandible that were evaluated under prior listing 13.11. In final listings 13.11A, 13.11B, and 13.11C, we revise prior listing 13.10A to clarify when these tumors are of listing-level severity. In final listing 13.11D, we provide that we consider all other malignant tumors originating in bone with multimodal antineoplastic therapy to be disabling for 12 months from the date of diagnosis. Consistent with the changes we have made for other listings, any residual impairment(s) will be evaluated under

the criteria for the affected body system after that period. With this criterion, we recognize the length and debilitating effects of multimodal treatment for these tumors.

Listing 13.12—Maxilla, Orbit, or Temporal Fossa

This listing corresponds to prior listing 13.11. As noted above, we evaluate tumors of the mandible under final listing 13.11. Final listings 13.12A and 13.12B reorganize the criteria in prior listings 13.11A and 13.11B by moving the criterion for carcinoma with regional or distant metastases (part of prior listing 13.11B) to final listing 13.12A. We did this so that all tumors of the maxilla, orbit, or temporal fossa with regional or distant metastases would be covered in the same listing. The final listings do not make any substantive changes.

In the NPRM, we inadvertently changed the word ''temporal'' in the heading of current listing 13.11 to ''infratemporal'' in the heading of proposed listing 13.12 (66 FR at 59323). We are correcting the heading in these final rules. Additionally, although we moved the criterion for carcinoma with regional or distant metastases to proposed listing 13.12A, we failed to remove the criterion from proposed listing 13.12B. We are removing the criterion from final listing 13.12B in response to a public comment indicating that retaining the criterion in listing 13.12B was redundant.

In final listing 13.12C, we consolidate the disease sites in prior listings 13.11C, 13.11D, 13.11E, and 13.11F.

Listing 13.13—Nervous System

This listing incorporates the criteria for malignant brain tumors from listing 11.05, ''Brain tumors,'' in the neurological body system, and replaces prior listing 13.12, ''Brain or spinal cord.'' We are expanding the listings to include tumors of the spinal cord, spinal nerve roots, and the peripheral nervous system. We are also including tumors of the central nervous system that are not specifically named.

Under final listing 13.13A, we evaluate central nervous system malignant neoplasms; that is, those affecting the brain or spinal cord. In final listing 13.13A1, we list and revise the criteria for the impairments named in prior listing 11.05A. We are revising the reference to medulloblastoma to include other primitive neuroectodermal tumors (PNETs) and to require documented metastases for this type of tumor. Advances in treatment have significantly improved the overall prognosis of this disease, so that, in the absence of metastases, many individuals do well. We can evaluate medulloblastomas or other PNETs that have not metastasized, as well as the malignant brain tumors listed in prior listing 11.05B, under final listing 13.13A2.

We are also adding diffuse intrinsic brain stem gliomas in final listing 13.13A1. We are requiring that the impairment be ''diffuse'' and ''intrinsic'' because progress in medical diagnostic tools has now allowed for effective treatment of individuals with localized brain stem tumors.

In the NPRM, the criteria in proposed listing 13.13A were preceded by the phrase, ''Central nervous system neoplasms (brain and spinal cord), including * * *.'' In final listing 13.13A, we are changing the word ''including'' to the phrase ''as described in 1 or 2'' to be consistent with other listings.

In final listing 13.13B, we provide criteria for evaluating malignant tumors of peripheral nerves and spinal roots.

In the NPRM, we had proposed a listing, listing 13.13C, to correspond to prior listing 13.12A for metastatic carcinoma to brain or spinal cord. In response to a public comment, we have determined that this listing is unnecessary. These malignancies will be evaluated under the criteria for the site of origin, or under listing 13.27 if the primary site is unknown. Therefore, we are removing prior listing 13.12A and proposed listing 13.13C. We are also removing prior listing 13.12B, which was a reference listing.

Listing 13.14—Lungs

This listing corresponds to prior listing 13.13. In final listing 13.14A, we consolidate prior listings 13.13A, 13.13B, 13.13D, and 13.13E. This change is consistent with current medical terminology, which no longer distinguishes between the types of non-small-cell carcinoma.

In the NPRM, proposed listing 13.14A covered metastatic disease to or beyond the mediastinal or subcarinal lymph nodes. A public comment pointed out that this criterion would exclude cases of non-small-cell carcinomas with metastases to the hilar lymph nodes that had been included under prior listing 13.13E. The comment also indicated that, even when the involved hilar nodes are excised, the prognosis for this disease is unfavorable. In response to this comment, we have revised final listing 13.14A to include metastases to the hilar nodes.

We are redesignating prior listing 13.13C as final listing 13.14B. We are making no substantive changes.

Listing 13.15—Pleura or Mediastinum

This listing corresponds to prior listing 13.14. Final listing 13.15A is the same as prior listing 13.14A. In final listing 13.15B, which corresponds to prior listing 13.14C, we provide new language that clarifies the phrase ''not controlled by prescribed therapy'' used in the prior listing.

In the NPRM, the criterion in proposed listing 13.15B1 was ''Metastatic.'' In final listing 13.15B1, we revise this criterion to ''With metastases to or beyond the regional lymph nodes'' to be consistent with the other listings in these rules.

We are removing prior listing 13.14B, ''Malignant tumors, metastatic to pleura.'' We will evaluate this malignancy under final listing 13.27, ''Primary site unknown.''

Listing 13.16—Esophagus or Stomach

This listing corresponds to prior listing 13.16. Final listing 13.16A is the same as prior listing 13.16A. In final listing 13.16B, we consolidate prior listings 13.16B through 13.16E to clarify that all of those criteria relate to carcinoma or sarcoma of the stomach. We also provide new language to clarify the phrase ''not controlled by prescribed therapy'' used in prior listing 13.16C.

Listing 13.17—Small Intestine

This listing corresponds to prior listing 13.17. In final listing 13.17A, we expand the criterion in prior listing 13.17B, for recurrent malignancies, to indicate that inoperable and unresectable malignancies are also of listing-level severity. We also provide new language to clarify the phrase ''not controlled by prescribed therapy'' used in prior listing 13.17C. Final listing 13.17B corresponds to prior listing 13.17A, and is substantively unchanged.

Listing 13.18—Large Intestine (From Ileocecal Valve to and Including Anal Canal)

This listing corresponds to prior listing 13.18. We are removing the phrase ''carcinoma or sarcoma'' from the heading of this listing because sarcomas of the large intestine are extremely rare. In final listing 13.18A, we consolidate prior listings 13.18A and 13.18C and clarify that these criteria apply to adenocarcinoma. In final listing 13.18B, we provide that squamous cell carcinoma of the anus will not be found to meet the listing unless it is recurrent after surgery. Advances in treatment have made chemotherapy and radiation the treatment of choice for this disorder. However, good results can be achieved through surgery if the preferred treatment is not effective. Final listing

13.18C is the same as prior listing 13.18B.

Listing 13.19—Liver or Gallbladder

This listing corresponds to prior listing 13.19. We are clarifying that the listing applies only to malignancies that originate in the liver, gallbladder, or bile ducts. We evaluate metastases to the liver from other sites under the criteria for the site of origin, or under the criteria of final listing 13.27 when the primary site is unknown.

Listing 13.20—Pancreas

This listing corresponds to prior listing 13.20. We are not making any substantive changes, other than adding ''inoperable'' conditions to the second listing criterion. We are making this change to reflect the revised definitions used in these listings.

Listing 13.21—Kidneys, Adrenal Glands, or Ureters

This listing corresponds to prior listing 13.21. In final listing 13.21A, we expand the criteria of unresectable tumors in prior listing 13.21A to include inoperable and recurrent tumors. Final listing 13.21B consolidates prior listings 13.21B and 13.21C. We are eliminating the modifier ''hematogenous'' used in prior listing 13.21B because metastases by lymphatic spread or by direct extension carry the same poor prognosis.

Listing 13.22—Urinary Bladder

This listing corresponds to prior listing 13.22. We are removing prior listing 13.22E, which provided for the evaluation of renal impairment following total cystectomy under the criteria in listing 6.02, because it was a reference listing.

Listing 13.23—Cancers of the Female Genital Tract

In this listing, we incorporate and revise prior listings 13.25, ''Uterus,'' 13.26, ''Ovaries,'' 13.28, ''Uterine (Fallopian) tubes,'' and 13.30, ''Vulva.''

In final listings 13.23A, ''Uterus (corpus),'' and 13.23B ''Uterine cervix,'' we replace the prior criteria in listings 13.25B, ''Recurrent after total hysterectomy,'' and 13.25C, ''Total pelvic exenteration,'' with ''Persistent or recurrent following initial antineoplastic therapy.'' With this revision, we recognize changes in treatment for these disorders. In final listing 13.23C, ''Vulva,'' we provide criteria in addition to the criteria for distant metastases used in the prior listing.

We are making several changes in final listing 13.23D, ''Fallopian tubes.'' In final listing 13.23D1, ''Extending to the serosa or beyond,'' we replace the criteria in prior listings 13.28A, ''Unresectable,'' and 13.28B, ''Metastases to regional lymph nodes.'' Tumors extending to the serosa are considered to be unresectable for the purposes of this listing; tumors extending beyond the serosa equate to tumors that have metastasized to the regional lymph nodes. In final listing 13.23D2, we are also adding criteria to evaluate fallopian tube tumors when the initial antineoplastic therapy has not achieved the desired effect.

In final listing 13.23E, ''Ovaries,'' we separate germ-cell and non-germ-cell tumors. In final listing 13.23E1, which provides the criteria for evaluating non-germ-cell tumors, we expand the criteria in prior listing 13.26 to reflect advances in diagnostic techniques and treatment. We provide criteria for evaluating germ-cell tumors in final listing 13.23E2.

Listing 13.24—Prostate Gland

In this listing, which corresponds to prior listing 13.23, we provide new language to clarify the phrase ''not controlled by prescribed therapy'' used in the prior listing.

Listing 13.25—Testicles

This listing corresponds to prior listing 13.24. We are removing prior listing 13.24A, for choriocarcinoma because the literature we consulted does not separate choriocarcinoma from other forms of nonseminomatous germ-cell tumors with regard to staging or treatment. (*See* 67 FR 19138 for a list of the literature we consulted.)

Listing 13.26—Penis

This listing corresponds to prior listing 13.29. We have clarified the listing to explicitly include metastases to or beyond the regional lymph nodes.

Listing 13.27—Primary Site Unknown After Appropriate Search for Primary

We are providing a listing for the occasional case in which metastases have been appropriately verified but the site of the primary malignancy cannot be determined. The final listing specifically excludes solitary squamous cell carcinoma in the neck, as this type of metastasis is often amenable to treatment.

Listing 13.28—Malignant Neoplastic Diseases Treated by Bone Marrow or Stem Cell Transplantation

As we have already noted in our discussion of final 13.00L above, final listing 13.28 is a listing for bone marrow or stem cell transplantation in any malignant neoplastic disease other than acute leukemia, CML, lymphoma, or multiple myeloma, which we evaluate under final listings 13.05, 13.06 and 13.07. In final listing 13.28A, we provide that allogeneic transplantation is disabling until at least 12 months from the date of transplantation. In final listing 13.28B, we provide that autologous transplantation is disabling until at least 12 months from the date of the first treatment under the treatment plan that includes transplantation. We use an earlier date to begin the 12-month period for autologous transplantation because the recovery period after this type of transplantation is generally shorter than for allogeneic transplantation. In both cases, we will evaluate any residual impairment(s) after the applicable period under the criteria for the affected body system.

How Are We Changing the Introductory Text to the Listings for Evaluating Malignant Neoplastic Diseases in Children?

113.00 Malignant Neoplastic Diseases

Except for minor changes to refer to children, we are repeating much of the introductory text in 13.00 in the introductory text in 113.00. This is because the same basic rules for establishing and evaluating the existence and severity of malignant neoplastic diseases in adults also apply to children. Because we have already described these provisions under the explanation of 13.00, the following discussions describe only those provisions that are unique to the childhood rules or that require further explanation.

113.00B—What Do We Consider When We Evaluate Malignant Neoplastic Diseases Under These Listings?

In this section, which is the same as final 13.00B, we replace the guidance in prior 113.00A1.

113.00D—What Evidence Do We Need?

In this section, we replace and expand prior 113.00B. This section is substantively the same as final 13.00D. We are not including a childhood listing to correspond to final listing 13.27, primary site unknown after appropriate search for primary, because the inability to determine the primary site is an extremely rare occurrence in childhood malignancies. Instead, we indicate that, in these rare situations, we will use final listing 13.27.

113.00E—When Do We Need Longitudinal Evidence?

This section is similar to final 13.00E. We are adding a general description of most malignant childhood tumors.

113.00F—How Do We Evaluate Impairments That Do Not Meet One of the Malignant Neoplastic Diseases Listings?

In this section, we repeat the guidance in final 13.00F, but use the definition of disability for children who claim SSI payments.

113.00G—How Do We Consider the Effects of Therapy?

This section replaces prior 113.00A2 and the last paragraph of prior 113.00A. We repeat the guidance in final 13.00G but use the definition of disability for children who claim SSI payments.

113.00H—How Long Do We Consider Your Impairment To Be Disabling?

This section corresponds to final 13.00H. It also replaces prior 113.00D, ''Duration of disability,'' which referred to the specific time periods that we included in prior listings 113.02 and 113.03. Although we do not cite specific listings, we indicate that some listings specify that the impairment should be considered disabling until a particular point in time. In final 113.00H2, we state that, when the listing does not contain such a specification, we will consider an impairment that meets or medically equals the listings in this body system to be disabling until at least 3 years after onset of complete remission. We added this section to ensure consistency between the adult and childhood rules.

113.00I—What Do These Terms in the Listings Mean?

This section corresponds to final 13.00I. As we explain below, we are retaining our listings for malignant solid tumors. Because of this, there are no listings in part B of these final rules that include the terms ''inoperable'' and ''unresectable.'' Therefore, in these final rules, we revised proposed 113.00I to remove the definitions of those terms.

113.00K—How Do We Evaluate Specific Malignant Neoplastic Diseases?

In this section, we incorporate the discussion in prior 107.00C, ''Acute leukemia,'' and provide guidance for other childhood malignancies. Except for minor changes to refer to children, final 113.00K4, ''Brain Tumors,'' is the same as final 13.00K6. The following is a discussion of the other malignant neoplastic diseases addressed in this section.

113.00K1—Lymphoma

In this section, we indicate that final listing 113.05 should not be used for evaluating low grade or indolent lymphomas because they are rare in children. We will evaluate these lymphomas under final listing 13.05. We also indicate that many children with lymphoma are treated according to a long-term protocol that can result in significant adverse medical, social, and emotional consequences. We provide a reference to final 113.00G to evaluate those consequences.

113.00K2—Leukemia

In final 113.00K2c, we provide a description of juvenile CML (JCML) and explain that we will evaluate it under final listing 113.06A.

Final 113.00K2d is similar to final 13.00K2d. We did not include a discussion about chronic lymphocytic leukemia, as in final 13.00K2c, because the disorder is extremely rare in children.

113.00K3—Malignant Solid Tumors

In this section, we incorporate the guidance in prior 113.00C, ''Malignant solid tumors.'' We have revised the reference to the listing for brain tumors because that listing is now in this body system. As we have added a listing for the thyroid gland, we no longer need guidance in the introductory text explaining how thyroid tumors should be evaluated.

113.00K5—Retinoblastoma

In this section, we state that treatment for bilateral retinoblastoma usually results in a visual impairment and that we will evaluate any resulting visual impairment under listing 102.02.

113.00L—How Do We Evaluate Malignant Neoplastic Diseases Treated by Bone Marrow or Stem Cell Transplantation?

In this section, we provide the same guidance as in final 13.00L1, 13.00L2, and 13.00L4. We have added JCML to the heading of 13.00L1 to reflect that JCML is included in final listing 113.06A. We do not refer to multiple myeloma in final 113.00L2 because this impairment is not included in the final childhood listings. Multiple myeloma is extremely rare in children.

In the NPRM, we had also proposed a section in part B, similar to final 13.00L3, that contained guidance on how to evaluate bone marrow or stem cell transplantation for other disorders in children. That section, proposed 113.00L3, indicated that malignant neoplastic diseases treated with bone marrow or stem cell transplantation should be evaluated under proposed listing 113.28. Proposed listing 113.28 was one of several listings that we proposed as a replacement for prior listing 113.03, ''Malignant solid tumors.'' As we explain in the public comments section of this preamble, we have decided not to change our prior criteria for malignant solid tumors in these final rules. Therefore, we do not need the guidance we included in proposed section 113.00L3, and we are not including it in these final rules. As we indicate in response to a public comment on bone marrow or stem cell transplantation in chidren, final listing 13.28 can be used in those few cases in which the end of the 2-year period provided by final listing 113.03 is earlier than the end of the period that the impairment would be considered disabling based on the bone marrow or stem cell transplantation.

How Are We Changing the Listings for Evaluating Malignant Neoplastic Diseases in Children?

113.01 Category of Impairments, Malignant Neoplastic Diseases

We are redesignating the childhood listings to maintain consistency with the adult rules for those malignancies that are addressed in both the adult and childhood rules. Because of this, the numbers of the final childhood listings are not consecutive.

Listing 113.03—Malignant Solid Tumors

This listing corresponds to prior listing 113.03, ''Malignant Solid Tumors.'' We are making minor editorial changes to make the language consistent with that used in other listings and to indicate that, after the appropriate time period has passed, any residual impairment should be evaluated under criteria for the affected body system.

In the NPRM, we proposed removing prior listing 113.03 and providing separate listings for specific types of malignant solid tumors and a listing for malignant neoplastic diseases treated by bone marrow or stem cell transplantation. In response to a comment, we have decided to retain prior listing 113.03 as we further consider how to include solid tumors in children in our listings. Because we are retaining prior listing 113.03 in these final rules, we are not incorporating the proposed listings that would have replaced it: Proposed listing 113.04, ''Soft Tissue Sarcoma (including Ewing's Sarcoma, Primitive Neuroectodermal Tumors (PNETs)''; proposed listing 113.11, ''Osteogenic Sarcoma''; proposed listing 113.13A2,

for any central nervous system neoplasm progressive or recurrent following initial antineoplastic therapy; proposed listing 113.13B, for peripheral nerve or spinal root neoplasm; proposed listing 113.21B, for Wilms' tumor persistent or recurrent following initial Antineoplastic therapy; proposed listing 113.25, ''Testicles—Tumor With Metastatic Disease Progressive of Recurrent Following Initial Chemotherapy''; proposed listing 113.26, ''Germ Cell Tumors—Gonadal or Extragonadal''; and proposed listing 113.28, ''Malignant Neoplastic Diseases Treated by Bone Marrow or Stem Cell Transplantation.''

Listing 113.05—Lymphoma (Excluding T-cell Lymphoblastic Lymphoma—113.06)

This listing corresponds to prior listing 113.02, ''Lymphoreticular malignant neoplasms.'' We are revising the listing to make it more consistent with final listing 13.05.

Final listing 113.05A replaces the criteria for non-Hodgkin's lymphoma in prior listing 113.02B. Currently, there are several treatment regimens for this disease, and they vary in the amount of time needed to complete them. Many are of sufficiently short duration that the impairment may be disabling for less than 12 months. Due to these advances in treatment, it is no longer appropriate to assume that the impairment will meet the statutory duration requirement. Instead, we will find the impairment disabling under this listing when it is persistent or recurrent following initial antineoplastic therapy. We also clarify that non-Hodgkins lymphoma includes Burkitt's and anaplastic large cell.

Final listing 113.05B replaces the criteria for Hodgkin's disease in prior listing 113.02A. With the final criterion, we clarify what we meant by ''progressive disease not controlled by prescribed therapy'' in the prior listing.

In final listing 113.05C, we add a criterion for bone marrow or stem cell transplantation.

Listing 113.06—Leukemia

This listing replaces prior listing 107.11, ''Acute leukemia.'' In final listing 113.06A, for ''acute leukemia,'' we also include T-cell lymphoblastic lymphoma and JCML. JCML is an aggressive leukemia that responds poorly to therapy and is, therefore, more appropriately evaluated like an acute leukemia. The criteria in this listing are the same as in final listing 13.06A, and are explained in the discussion of that listing.

In final listing 113.06B, which is the same as final listing 13.06B, we added criteria for evaluating CML other than JCML.

Listing 113.09—Thyroid Gland

This listing is the same as final listing 13.09 and incorporates the guidance contained in prior 113.00C. The listing criteria define when the malignancy is not controlled by prescribed therapy.

Listing 113.12—Retinoblastoma

This final listing revises prior listing 113.05. We are removing prior listing 113.05A, for bilateral involvement, because with advances in treatment this malignancy is often treated successfully. As we indicate in final 113.00K4, we will evaluate the resulting visual impairment under listing 102.02. If treatment is not successful, we will evaluate the impairment under the other criteria in the final listing.

Final listing 113.12A corresponds to prior listing 113.05C. We are making no substantive changes.

Final listing 113.12B corresponds to prior listing 113.05D. We are revising the criteria to recognize that persistence after treatment, as well as recurrence, indicates a poor prognosis.

Final listing 113.12C corresponds to prior listing 113.05B. We are revising the description to make it clear that any metastatic disease is included under the listing.

Listing 113.13—Brain Tumors

This listing revises the criteria for malignant brain tumors in prior listing 111.05, ''Brain tumors.'' We use the same criteria for evaluating brain tumors in children as in final listing 13.13A1.

In the NPRM, we proposed to expand the criteria in this listing to address other tumors of the nervous system. As explained above, we have decided to retain our prior criteria for evaluating malignant solid tumors, and these additional criteria are not needed. Because we are not including the additional criteria, we have revised the heading of this listing to reflect the types of tumors evaluated under it.

Listing 113.21—Neuroblastoma

Final listing 113.21A corresponds to prior listing 113.04, ''Neuroblastoma.'' We have made minor editorial revisions to be consistent with other listings.

In the NPRM, we proposed changing the criteria for neuroblastoma. As explained above, we have decided to retain our prior criteria for malignant solid tumors as we further consider how to include solid tumors in children in our listings. Similarly, we have decided to retain our prior criteria for neuroblastoma.

We also proposed to expand the criteria in this listing to address Wilms' tumors. Because we are retaining our prior criteria for malignant solid tumors, this additional criterion is not needed. Therefore, we have revised the heading of this listing to reflect the types of tumors evaluated under it.

What Other Revisions Are We Making?

Consistent with the changes explained above, we are also:

- Changing the name of 7.00 and 107.00 from Hemic and Lymphatic System to Hematological Disorders. We are making this change because we are moving the lymphatic impairments now contained in these body systems to 13.00 and 113.00.
- Revising the heading of listing 7.17 to remove the reference to hematologic malignancies. We are making this change because we are moving the listings for hematological malignancies to 13.00 and 113.00.
- Revising 11.00B to indicate that malignant brain tumors should be evaluated under the criteria in listing 13.13.
- Adding 111.00E to provide the same guidance as final 11.00B.
- Revising prior listings 11.05 and 111.05 by removing the criteria for malignant brain tumors. In the NPRM, proposed listing 11.05 indicated that benign brain tumors would be evaluated under 11.02, 11.03, 11.04A or B, or 12.02. Proposed listing 111.05 indicated that these tumors would be evaluated under the criteria for the resulting neurological impairment. As we reviewed these criteria, we realized that these listings should be the same. We also realized that they should allow for the evaluation of all complications of benign brain tumors. Therefore, we have replaced the reference to 12.02 with ''the criteria of the affected body system'' and revised final listing 111.05 for consistency between the adult and childhood listings.
- Making nonsubstantive editorial changes throughout these rules to reflect the technical changes that were implemented by the final regulation we published in the **Federal Register** on April 24, 2002, (67 FR 20018), to correct typographical errors and omissions, to make the language clearer, and to be consistent with other rules.

Public Comments

In the NPRM we published in the **Federal Register** on November 27, 2001 (66 FR 59306), we provided the public with a 60-day comment period that ended on January 28, 2002. Due to some significant issues raised by commenters, we provided an additional 60-day

public comment period by publishing a notice in the **Federal Register** on April 18, 2002 (67 FR 19138). The additional comment period ended on June 17, 2002.

In response to the two notices, we received comments from 61 commenters, 16 of whom addressed the proposed criteria for malignant neoplastic diseases. These 16 commenters included medical organizations, legal services organizations, State agencies that make disability determinations for us, and individuals. Many of the commenters raised more than one issue. We carefully considered all of the comments.

A number of the comments were quite long and detailed, requiring us to condense, summarize, or paraphrase them. We have tried to accurately present all views of the commenters and have tried to respond to all of the significant issues raised by the commenters. We provide our reasons for adopting or not adopting the comments in our responses below.

General Comments

Extend the Comment Period and Provide the Medical and Scientific Justification for the Proposed Listings.

Comment: During the initial comment period, several commenters asked us to extend the 60-day comment period due to the length and complexity of the proposed rules. Commenters also asked us to provide the medical and scientific justification for these changes.

Response: As we reviewed the initial comments, we realized that significant issues were being raised, and we determined that it would be appropriate to reopen the comment period in order to get additional input on those and other issues. Therefore, on April 18, 2002, we published a notice in the **Federal Register** (67 FR 19138) reopening the comment period and providing an additional 60-day period within which to comment. The additional comment period ended on June 17, 2002. The notice that reopened the comment period included references to the medical and scientific sources we consulted when developing the NPRM, and invited comment on those references as well.

The Proposed Listings are More Restrictive Than the Prior Listings

Comment: Some commenters believed that these criteria reflect a trend toward an increased level of severity in the listings. One commenter noted that, although good arguments may be made for these changes, the criteria in the childhood listings for non-Hodgkin's lymphoma, chronic granulocytic leukemia, thyroid carcinoma, medulloblastoma, Wilms' tumor, testicular cancer, and germ-cell tumors were more restrictive.

Response: As we reviewed our proposed listings to respond to the public comments, we realized that we need to consider further how to address childhood malignant solid tumors in our listings. In the interim, we are retaining our prior criteria that provide that malignant solid tumors, other than brain tumors or thyroid tumors, are disabling for 2 years from the date of initial diagnosis or from the date of recurrence of active disease. We are also retaining our prior criteria for neuroblastoma.

Impact of the Changes

Comment: Two commenters stated that the proposed rules would result in a considerable reduction in the number of individuals eligible for disability benefits and requested that we provide an estimate of the impact of these changes.

Response: Based on our assessment of these rules, we do not believe that a considerable number of individuals will be adversely affected by the changes we are making in these final rules. We believe that these final rules appropriately reflect advances in medical knowledge, treatment, and methods for evaluating malignant neoplastic diseases.

Comment: One commenter expressed concern that these rules would result in fewer claims being allowed at step 3 of the sequential evaluation process, and that a functional assessment would be required in more cases.

Response: Based on our assessment of these rules, we do not believe that fewer claims will be allowed at step 3 of the sequential evaluation process.

The Proposed Listings May Result in Delays

Comment: Several commenters expressed concern that it will take longer to evaluate some malignancies because the proposed listings for these malignancies require that the treatment has not been effective. Some of these commenters believed that evaluation of these malignancies would need to be delayed until treatment was completed. One commenter thought that we would not evaluate cases at other steps in the sequential evaluation process while we were waiting to determine the effectiveness of the treatment. One commenter thought that deferring adjudication in these cases would result in more informed decisions and prevent us from denying some cases in error.

Response: While we agree that these final rules may delay the adjudication of some cases, we do not believe the number of affected cases will be significantly more than under the prior rules. The prior listings for most of these malignancies also included a requirement that the impairments not be controlled by prescribed therapy. To make this determination under the prior rules, we also had to allow sufficient time to determine whether the impairments would be controlled.

When we can determine whether treatment will be effective before the treatment regimen is completed, we will make the decision about whether the malignancy is of listing-level severity at that point. Additionally, as we state in final 13.00E3 and 113.00E3, we will not defer adjudication to determine whether the therapy will achieve its intended effect if we can make a fully favorable determination or decision based on the length and effects of therapy, or the residuals of the malignancy or therapy.

Focus on the Individual's Particular Situation

Comment: One commenter stressed the importance of focusing on an individual's particular situation, especially when he or she has significant limitations past the listed disability time period. The commenter stated that cancer patients typically incur short-term impairments resulting from toxicities associated with chemotherapy and other treatment, and from the disease itself. The commenter also noted that impairments from treatment, such as cardiotoxicity and infertility, can manifest several years later, and that a tumor may cause disability to a patient for a period of time far surpassing that which has been allocated by the proposed regulations for certain malignant neoplastic diseases. The commenter believed that it is essential that the new regulations maintain sufficient flexibility to adequately adjust disability time periods based on the individualized nature of cancer and patient responses to treatment of the disease.

Another commenter believed that the proposed rules did not adequately address problems with fatigue, energy levels and ability to sustain work for normal periods of time. The commenter also requested that we consider the lack of immunity to infection from which many individuals with cancer suffer.

Response: We believe these final regulations do allow sufficient flexibility to adjust the period of time the individual is considered disabled and stress the importance of considering residual impairment(s) or symptoms

caused by the disease or the treatment. However, the severity of any residual impairment(s) or symptom can vary greatly, and must be evaluated on an individualized, case-by-case basis. If a severe residual impairment(s) does not meet or medically equal any listing, we will evaluate the impact of the impairment(s), as well as the impact of any symptoms caused by the disease or the treatment, at later steps in the sequential evaluation process.

The Listings Need Timely Review

Comment: Two commenters stated that these listings will need timely review in the future to keep up with advances in treatment and to ensure that they reflect current medical knowledge.

Response: We agree that the listings should continue to reflect the latest medical knowledge and advances in treatment. We intend to monitor these listings and to update the criteria for any impairment contained in these listings as the need arises. For this reason, we are indicating that these rules will be in effect for 5 years after they become effective, unless we extend them or revise and issue them again.

Comments on the Introductory Text

Provide Additional Definitions

Comment: Two commenters asked us to include definitions of ''regional lymph nodes'' and ''distant metastases'' in the introductory text.

Response: As we indicated in our explanation of 13.00I, our intent is to use these terms as they are used in current clinical practice. In clinical practice, these terms are defined in relation to the site of the primary malignancy. To define these terms in our listings, we would need a separate definition for each primary site specified in the listings. Our adjudicative experience has shown that the medical evidence usually indicates whether the malignancy has spread to the regional lymph nodes or beyond. Therefore, we do not believe it is practicable or necessary to add these definitions to the introductory text. Instead, we will rely on the description of the malignancy contained in the medical records.

Documenting Complete Remission

Comment: One commenter requested that we add a discussion of the documentation required to establish a ''complete remission.''

Response: We partially adopted this comment by revising final 13.00H2 and 113.00H2 to clarify that ''complete remission'' occurs when the original tumor and any metastases are no longer evident. However, we did not add a discussion about the documentation we require to establish a complete remission. The treating source will determine the methods of evaluating complete remission for the particular malignancy for each individual patient. We will usually rely on the documentation provided by the treating source.

13.00 K2c—Chronic Lymphocytic Leukemia

Comment: One commenter noted that chronic lymphocytic leukemia (CLL) is mentioned only in the introductory text and believed that this is a potential source of confusion. The commenter requested that CLL be added to the heading of proposed listing 13.05, Lymphoma, and included in the criteria in proposed listings 13.05A1 and 13.05A2, which address non-Hodgkin's lymphoma.

Response: We partially adopted the comment. The complications of CLL are diverse and, because of this, it is not always appropriate to evaluate CLL using the criteria for lymphoma. By maintaining the references in the introductory text, we provide the flexibility needed to evaluate this disorder. We have, however, included a reference to 13.00K2c in the heading of final listing 13.05 as a reminder that CLL may be evaluated under this listing when appropriate.

Evaluation of Hodgkin's Disease That Recurs More Than 1 Year After Completion of Therapy

Comment: One commenter disagreed with our proposed rule in 13.00K1c to consider Hodgkin's disease that recurs more than 12 months after the completion of initial antineoplastic therapy as new disease under the listings, rather than a recurrence. The commenter indicated that oncologists would consider such patients as having relapsed, rather than as having developed a new disease.

Response: We agree that, for treatment purposes, Hodgkin's disease that recurs more than 12 months after the completion of therapy should not be considered as new disease. However, Hodgkin's disease frequently remits within 12 months of the initiation of treatment, and the period of remission is often longer than 12 months. In these instances, the impairment would not satisfy the statutory duration requirement. If the disease then recurs, we have to consider it as a new disease for purposes of determining whether the duration requirement will be met. Additionally, secondary treatment for a recurrence after 12 months can result in complete remission or cure.

Comments on the Listing Criteria

Add Additional Criteria

Comment: Several commenters suggested that we add specific additional malignancies to the listings. One commenter expressed concern that malignancies that are not contained in the listings because they are rare or because they are often amenable to treatment will not be properly evaluated. The commenter indicated that there are no instructions as to how to adjudicate the cases of individuals who do not respond well to treatment, and believed that there was no guidance for evaluating any cases on a case-by-case basis. The commenter also believed it is not acceptable to rely on the sequential evaluation process, since that process is often difficult to enforce and apply uniformly to people of all age groups. The commenter said this is especially true for children. The commenter suggested that these regulations include a full listing of any malignancy that is of listing-level severity.

Response: We have not added the specific malignancies suggested by the commenters. In some instances, we believe the malignancies are already included in the final rules. For example, one commenter suggested we add nasopharyngeal cancer. This malignancy will be evaluated under final listing 13.02, for soft tissue tumors of the head and neck. Another commenter suggested we add an adult listing for germ-cell tumors. These malignancies will be evaluated under the criteria in listing 13.15B or listing 13.23E2, depending on the site of the malignancy.

In other instances, such as prostate cancer with bone metastases or earlier stages of multiple myeloma, we believe that there are effective therapies that, even considering their length and effects, generally do not result in an impairment of listing-level severity. In these situations, we believe that the impairment should not be considered to be of listing-level severity until it is demonstrated that therapy is not effective.

We did not add the other suggested additions, such as granulocytic sarcoma, because these malignancies are rare. As noted in sections 13.00F and 113.00F of these rules, the listings contain examples of impairments that we consider severe enough to prevent an adult from doing any gainful activity, or that cause marked and severe functional limitations in a child. The listings are

not intended to be all-inclusive. The purpose of the listings—to allow us to readily identify individuals with common impairments of listing-level severity—would be defeated if we tried to identify every malignancy that could be of listing-level severity.

However, we believe that our regulations do provide adequate guidance about how to evaluate malignancies that do not respond to treatment or that are unlisted. Many of these final listings address situations in which treatment is not successful. For example, final listing 13.02B addresses the situation in which the malignancy is persistent following initial multimodal antineoplastic treatment and final listing 13.09B addresses the situation in which the malignancy is progressive despite radioactive iodine therapy. We also have other rules that discuss how to evaluate impairments that are not listed. These other rules are not included in this notice, as we are not making any changes to them. We believe that malignancies that are not listed can be properly and uniformly evaluated under these other rules.

Also, and as we have already noted, as we reviewed our proposed listings to respond to the last comment, we realized that we need to consider further how to include childhood malignant solid tumors in our listings. In the interim, we have decided to retain our prior criteria for these impairments.

Comment: One commenter recommended that all cases of lymphoma should be determined to be of listing-level severity and that cases not covered by the proposed rules should be allowed with a short reexamination diary.

Response: We have not included criteria for additional lymphoma cases. It would not be appropriate to include lymphomas that do not satisfy the criteria in these final rules because we cannot presume that these impairments will meet the statutory duration requirement. Other lymphomas may respond more readily to therapy.

Use Staging Systems

Comment: Two commenters suggested we incorporate accepted classifications and staging in the listings. One indicated we should use clinical classifications and stagings that are tied to ongoing tumor registries that are matched with survival rates.

Response: As in the NPRM, these final rules incorporate staging criteria where appropriate. In these instances, we list the criteria for the stage rather than refer to the stage number. For example, the criteria in final listing 13.10A, for locally advanced breast carcinoma, correspond to stage IIIB.

We decided not to include staging numbers for two reasons. The first is that there are different staging classifications and these different classifications are not necessarily consistent. The second is that staging classifications change. If we used the staging number as the criterion, these rules may no longer be appropriate if a change in staging classifications is made.

Listings With Time Limits

Comment: Several commenters noted that several of the proposed listings included language about time limits after which the adjudicator was advised to evaluate any residual impairment(s) under the relevant body system, but that these listings did not refer to the medical improvement review standard in §§ 404.1594, 416.994, and 416.994a. They believed that failure to apply the medical improvement review standard at the end of the specified period would be contrary to the statute. One of these commenters believed that a time limit should, at most, result in a date for reviewing the individual's continuing eligibility for disability benefits.

Response: As in the prior listings and in a number of listings in other body systems, some of the listings in these final rules contain time limits in their criteria to explain the period for which we will presume that the individuals are disabled based on the nature of their impairments, the duration and effects of therapy, and the expected course of the impairments. After the therapy is completed and the relevant time period has passed, we can no longer presume that these individuals are disabled. When we review these claims to determine if these individuals continue to be disabled, we will apply the appropriate medical improvement review standard set forth in our regulations in §§ 404.1594, 416.994, or 416.994a.

Final Listing 13.02

Comment: One commenter noted that we replaced the phrase ''not controlled by prescribed therapy'' in prior listing 13.02B with ''[p]ersistent disease following initial multimodal antineoplastic therapy'' in proposed listing 13.02B. The commenter expressed concern that this criterion would exclude patients who are treated with radiation alone (uni-modal therapy), have persistent disease, and who cannot undergo surgery because of the medical condition or because the tumor remains unresectable. The commenter indicated the prognosis for these individuals seems to fit the intent of the listing. The commenter recommended we use the phrase ''therapy for curative intent'' instead of ''initial multimodal antineoplastic therapy.''

Response: We did not adopt the comment because individuals described in the comment have impairments that meet final listing 13.02A. That listing describes individuals who have tumors that are inoperable or unresectable. The definitions of the terms ''inoperable'' and ''unresectable'' in final 13.00I1 and 13.00I2 include the individuals described by the commenter.

Comment: One commenter noted the criterion for epidermoid carcinoma occurring in the pyriform sinus in proposed listing 13.02E and questioned why this site was singled out. The commenter indicated this impairment would be covered under the criteria for soft tissue tumors with multimodal therapy in proposed listing 13.02F.

Response: We agree with the commenter and have deleted the criterion for epidermoid carcinoma occurring in the pyriform sinus in final listing 13.02. Due to this deletion, we redesignated proposed listing 13.02F, for soft tissue tumors of the head and neck treated with multimodal therapy, as final listing 13.02E.

Final Listing 13.05

Comment: One commenter believed that the language in proposed listing 13.05A2, for low-grade or indolent lymphoma requiring initiation of more than 1 antineoplastic treatment regimen within a consecutive 12-month period, was confusing. The commenter indicated that we should specify that concurrent treatments would not apply and that the treatments must occur on separate occasions.

Response: The listing refers to a treatment regimen that may consist of more than one modality of treatment. The modalities used in the treatment regimen may be administered concurrently or sequentially, depending on the regimen. Regardless of the way the modalities are administered, they are still considered to be one treatment regimen. Therefore, we have not adopted the commenter's suggested changes.

However, in reviewing the proposed listing in response to this comment, we realized that some clarification of the introductory text to the listings was needed. The heading of final listing 13.05 cross-refers to 13.00K1 in the introductory text. However, proposed 13.00K1a discussed only ''indolent'' lymphoma, and did not refer to ''low grade'' lymphoma even though the

listing refers to both. This was an oversight. To be consistent with the listing criteria, we have amended final 13.00K1a to refer to both low grade and indolent lymphomas.

Final Listing 13.10

Comment: One commenter noted the criterion for breast cancer in proposed listing 13.10C, for recurrent carcinoma, except local recurrence that remits with antineoplastic therapy. The commenter believed that this criterion should be interpreted to mean a recurrence that remits with therapy subsequent to initial treatment and that adjudicators would therefore be looking at two separate events. The commenter asked whether this interpretation was correct.

Response: The commenter's interpretation is correct. Breast carcinoma that had previously remitted with initial antineoplastic treatment, that has now recurred locally, and that remits with the antineoplastic therapy given for the recurrence does not represent an impairment of listing-level severity. An example is breast cancer that initially remits following a lumpectomy and radiation, but later recurs at the site of the incision, and is successfully treated with mastectomy.

Final Listing 13.12

Comment: One commenter noted that the phrase ''or with regional or distant metastases'' in proposed listing 13.12B was unnecessary as regional and distant metastases are covered in proposed listing 13.12A.

Response: We agree with the commenter and have removed the phrase from final listing 13.12B.

Final Listing 13.13

Comment: One commenter questioned why we retained the listing for metastatic carcinoma to the brain (proposed listings 13.13C and 113.13C) when all other listings refer to the site of origin of the tumor. The commenter asked if these listings apply to cases of testicular cancer with brain metastases.

Response: In response to this comment, we did not incorporate proposed listings 13.13C and 113.13C, for metastatic carcinoma to brain or spinal cord, in the final rules so that the final listings will refer to the site of origin of the tumor. We also revised the introductory text (13.00C and 113.00C) to reflect this change.

Final Listing 13.14

Comment: One commenter disagreed with the proposed deletion of the listing for non-squamous non-small-cell carcinoma with metastases to the hilar lymph nodes (prior listing 13.13E). The commenter indicated that there have not been significant treatment advances for this malignancy, nor has there been a significant improvement in prognosis. The commenter stated that excising the involved hilar nodes has not altered the unfavorable prognosis for this malignancy.

Response: We agree with the commenter and have revised listing 13.14A to include the hilar nodes.

Final Listing 13.25

Comment: One commenter objected to the deletion of prior listing 13.24A, for choriocarcinoma. The commenter indicated that choriocarcinoma is a particularly aggressive testicular cancer with frequent distant metastases and should not be evaluated in the same manner as other forms of testicular cancer.

Response: The literature we consulted did not separate choriocarcinoma from other forms of testicular nonseminomatous germ-cell tumors with regard to staging or treatment. Therefore, we did not adopt the comment.

Final Listing 113.10

Comment: One commenter questioned the proposed deletion of the criterion for bilateral retinoblastoma (prior listing 113.05A). The commenter indicated that most children with this disease are blind in one eye and have decreased vision in the other eye, resulting in significant visual impairments.

Response: We recognize that the current treatment of this disease results in significant visual impairments. While we have not retained this criterion in final listing 113.10, we have added guidance to the introductory text, final 113.00K5, providing that we will evaluate any resulting visual impairment(s) under the criteria in listing 102.02.

Final Listing 113.21

Comment: One commenter noted that prior listing 113.04, for neuroblastoma, included a criterion for recurrent disease which was not included in proposed listing 113.21A. The commenter asked if we intended to delete this criterion, as the deletion was not addressed in the explanation of the proposed listing.

Response: We did not intend to delete this criterion, and it is included in these rules as final listing 113.21C.

Final Listings 113.25 and 113.26

Comment: Two commenters noted that testicular germ-cell tumors could be evaluated under either proposed listing 113.25, for testicular malignancies, or proposed listing 113.26, for germ-cell tumors. The commenters suggested that we evaluate testicular germ-cell tumors under the listing for testicular malignancies and exclude them from the listing for germ-cell tumors.

Response: We did not adopt the comments because we decided to retain our prior criteria for malignant solid tumors in children. Under these final rules, malignant neoplasms that would have been evaluated under the proposed listings 113.25 and 113.26 will be considered to be disabling for 2 years from the date of initial diagnosis or the date of recurrence of active disease.

Final Listing 113.28

Comment: One commenter believed that a 12-month listing criterion is too short for children who have malignant neoplastic diseases treated by allogeneic bone marrow or stem cell transplantation. The commenter believed we should consider the increased risk of acute or chronic graft vs. host disease and infection in pediatric patients.

Response: As already noted, we decided to retain our prior criteria for malignant solid tumors in children. Therefore, we are not including the proposed listing that was the subject of this comment in these final rules.

Under these final rules, criteria for evaluating bone marrow or stem cell transplants in cases of leukemia or lymphoma are included in the listings for those disorders, final listings 113.05 and 113.06. Under final listing 113.03, malignant solid tumors in children will be considered disabling for 2 years from the date of initial diagnosis or the date of recurrence of active disease regardless of whether a bone marrow or stem cell transplant has been performed. The adult listing for bone marrow or stem cell transplantation, final listing 13.28, can be used to evaluate those few cases in which the end of the 2-year period is earlier than the end of the period that the impairment would be considered disabling based on the bone marrow or stem cell transplantation. Final listing 13.28A, for malignant neoplastic diseases treated by allogeneic bone marrow or stem cell transplantation, provides that the individual will be considered to be under a disability until ''at least'' 12 months from the date of transplantation. Use of the phrase ''at least'' provides us with the flexibility to set a longer time frame when appropriate.

Regulatory Procedures

Executive Order 12866

We have consulted with the Office of Management and Budget (OMB) and determined that these final rules meet the criteria for a significant regulatory action under Executive Order 12866, as amended by Executive Order 13258. Thus, they were subject to OMB review.

Regulatory Flexibility Act

We certify that these final rules do not have a significant economic impact on a substantial number of small entities because they affect only individuals. Thus, a regulatory flexibility analysis as provided in the Regulatory Flexibility Act, as amended, is not required.

Paperwork Reduction Act

These final rules contain reporting requirements at 13.00B, 13.00D, 13.00E, 13.00G, 13.00K, 113.00B, 113.00D, 113.00E, 113.00G, and 113.00K of the final rules. An Information Collection Request has been submitted to OMB. While these rules will be effective 30 days from publication, these burdens will not be effective until approved by OMB. We will publish a notice in the **Federal Register** upon OMB's approval of the information collection requirements.

List of Subjects in 20 CFR Part 404

Administrative practice and procedure, Death benefits, Blind, Disability benefits, Old-Age, Survivors, and Disability Insurance, Reporting and recordkeeping requirements, Social Security.

(Catalog of Federal Domestic Assistance Program Nos. 96.001, Social Security-Disability Insurance; 96.002, Social Security-Retirement Insurance; 96.004, Social Security-Survivors insurance; and 96.006, Supplemental Security Income)

Dated: July 19, 2004.

Jo Anne B. Barnhart,

Commissioner of Social Security.

■ For the reasons set forth in the preamble, subpart P of part 404 of chapter III of title 20 of the Code of Federal Regulations is amended as set forth below:

PART 404—FEDERAL OLD-AGE, SURVIVORS AND DISABILITY INSURANCE (1950–)

■ 1. The authority citation for subpart P of part 404 continues to read as follows:

Authority: Secs. 202, 205(a), (b), and (d)–(h), 216(i), 221(a) and (i), 222(c), 223, 225, and 702(a)(5) of the Social Security Act (42 U.S.C. 402, 405(a), (b), and (d)–(h), 416(i), 421(a) and (i), 422(c), 423, 425, and 902(a)(5)); sec. 211(b), Pub. L. 104–193, 110 Stat. 2105, 2189.

Appendix 1 to Subpart P of Part 404—[Amended]

■ 2. Appendix 1 to subpart P of part 404 is amended as follows:

■ a. Item 8 of the introductory text before part A of appendix 1 is amended by revising the body system name.

■ b. Item 14 of the introductory text before part A of appendix 1 is amended by revising the body system name and expiration date.

■ c. The Table of Contents for part A of appendix 1 is amended by revising the body system names for sections 7.00 and 13.00.

■ d. The body system name of section 7.00 of part A of appendix 1 is revised and paragraph E of the introductory text of section 7.00, Hematological Disorders, is removed.

■ e. Listings 7.11, 7.12, 7.13, 7.14, and 7.16 of part A of appendix 1 are removed.

■ f. Listing 7.17 of part A of appendix 1 is revised.

■ g. Paragraph B of the introductory text of section 11.00, Neurological, of part A of appendix 1 is revised.

■ h. Listing 11.05 of part A of appendix 1 is revised.

■ i. Section 13.00 of part A of appendix 1 is revised.

■ j. The Table of Contents for part B of appendix 1 is amended by revising the body system names for sections 107.00 and 113.00.

■ k. The body system name of section 107.00 of part B of appendix 1 is revised and paragraph C of the introductory text of section 107.00, Hematological Disorders, is removed.

■ l. Listing 107.11 of part B of appendix 1 is removed.

■ m. Paragraph E is added to the introductory text of section 111.00, Neurological, of part B of appendix 1.

■ n. Listing 111.05 of part B of appendix 1 is revised.

■ o. Section 113.00 of part B of appendix 1 is revised.

The revised text is set forth as follows:

Appendix 1 to Subpart P of Part 404—Listing of Impairments

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8. Hematological Disorders (7.00 and 107.00): July 1, 2005.

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14. Malignant Neoplastic Diseases (13.00 and 113.00): December 15, 2009.

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Part A

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7.00 Hematological Disorders

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13.00 Malignant Neoplastic Diseases

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7.00 HEMATOLOGICAL DISORDERS

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E. [removed]

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7.11 [removed]
7.12 [removed]
7.13 [removed]
7.14 [removed]

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7.16 [removed]

7.17 *Aplastic anemias* with bone marrow or stem cell transplantation. Consider under a disability for 12 months following transplantation; thereafter, evaluate according to the primary characteristics of the residual impairment.

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11.00 NEUROLOGICAL

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B. *Brain tumors.* We evaluate malignant brain tumors under the criteria in 13.13. For benign brain tumors, we determine the severity and duration of the impairment on the basis of symptoms, signs, and laboratory findings (11.05).

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11.05 *Benign brain tumors.* Evaluate under 11.02, 11.03, 11.04, or the criteria of the affected body system.

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13.00 MALIGNANT NEOPLASTIC DISEASES

A. *What impairments do these listings cover?* We use these listings to evaluate all malignant neoplasms except certain neoplasms associated with human immunodeficiency virus (HIV) infection. We use the criteria in 14.08E to evaluate carcinoma of the cervix, Kaposi's sarcoma, lymphoma, and squamous cell carcinoma of the anus if you also have HIV infection.

B. *What do we consider when we evaluate malignant neoplastic diseases under these listings?* We consider factors such as the:

1. Origin of the malignancy.

2. Extent of involvement.

3. Duration, frequency, and response to antineoplastic therapy. Antineoplastic therapy means surgery, irradiation, chemotherapy, hormones, immunotherapy, or bone marrow or stem cell transplantation. When we refer to surgery as an antineoplastic treatment, we mean surgical excision for treatment, not for diagnostic purposes.

4. Effects of any post-therapeutic residuals.

C. *How do we apply these listings?* We apply the criteria in a specific listing to a malignancy originating from that specific site.

D. *What evidence do we need?*

1. We need medical evidence that specifies the type, extent, and site of the primary, recurrent, or metastatic lesion. When the primary site cannot be identified, we will use evidence documenting the site(s) of metastasis to evaluate the impairment under 13.27.

2. For operative procedures, including a biopsy or a needle aspiration, we generally need a copy of both the:

a. Operative note.

b. Pathology report.

3. When we cannot get these documents, we will accept the summary of

hospitalization(s) or other medical reports. This evidence should include details of the findings at surgery and, whenever appropriate, the pathological findings.

4. In some situations we may also need evidence about recurrence, persistence, or progression of the malignancy, the response to therapy, and any significant residuals. (*See* 13.00G.)

E. *When do we need longitudinal evidence?*

1. *Tumors with distant metastases.* We generally do not need longitudinal evidence for tumors that have metastasized beyond the regional lymph nodes because these tumors usually meet the requirements of a listing. Exceptions are for tumors with distant metastases that are expected to respond to antineoplastic therapy. For these exceptions, we usually need a longitudinal record of 3 months after therapy starts to determine whether the intended effect of therapy has been achieved and is likely to persist.

2. *Other malignancies.* When there are no distant metastases, many of the listings require that we consider your response to initial antineoplastic therapy; that is, the initial planned treatment regimen. This therapy may consist of a single modality or a combination of modalities (multimodal) given in close proximity as a unified whole, and is usually planned before any treatment(s) is initiated. Examples of multimodal therapy include:

a. Surgery followed by chemotherapy or radiation.

b. Chemotherapy followed by surgery.

c. Chemotherapy and concurrent radiation.

3. *Types of treatment.* Whenever the initial planned therapy is a single modality, enough time must pass to allow a determination about whether the therapy will achieve its intended effect. If the treatment fails, the failure will often happen within 6 months after the treatment starts, and there will often be a change in the treatment regimen. Whenever the initial planned therapy is multimodal, a determination about the effectiveness of the therapy usually cannot be made until the effects of all the planned modalities can be determined. In some cases, we may need to defer adjudication until the effectiveness of therapy can be assessed. However, we do not need to defer adjudication to determine whether the therapy will achieve its intended effect if we can make a fully favorable determination or decision based on the length and effects of therapy, or the residuals of the malignancy or therapy (*see* 13.00G).

F. *How do we evaluate impairments that do not meet one of the malignant neoplastic diseases listings?*

1. These listings are only examples of malignant neoplastic diseases that we consider severe enough to prevent you from doing any gainful activity. If your severe impairment(s) does not meet the criteria of any of these listings, we must also consider whether you have an impairment(s) that meets the criteria of a listing in another body system.

2. If you have a severe medically determinable impairment(s) that does not meet a listing, we will determine whether your impairment(s) medically equals a listing. (*See* §§ 404.1526 and 416.926.) If your impairment(s) does not meet or medically equal a listing, you may or may not have the residual functional capacity to engage in substantial gainful activity. In that situation, we proceed to the fourth, and, if necessary, the fifth steps of the sequential evaluation process in §§ 404.1520 and 416.920. If you are an adult, we use the rules in §§ 404.1594 and 416.994, as appropriate, when we decide whether you continue to be disabled.

G. *How do we consider the effects of therapy?*

1. *How we consider the effects of therapy under the listings.* In many cases, malignancies meet listing criteria only if the therapy does not achieve the intended effect: the malignancy persists, progresses, or recurs despite treatment. However, as explained in the following paragraphs, we will not delay adjudication if we can make a fully favorable determination or decision based on the evidence in the case record.

2. *Effects can vary widely.*

a. Because the therapy and its toxicity may vary widely, we consider each case on an individual basis. We will request a specific description of the therapy, including these items:

i. Drugs given.

ii. Dosage.

iii. Frequency of drug administration.

iv. Plans for continued drug administration.

v. Extent of surgery.

vi. Schedule and fields of radiation therapy.

b. We will also request a description of the complications or adverse effects of therapy, such as the following:

i. Continuing gastrointestinal symptoms.

ii. Persistent weakness.

iii. Neurological complications.

iv. Cardiovascular complications.

v. Reactive mental disorders.

3. *Effects of therapy may change.* Because the severity of the adverse effects of antineoplastic therapy may change during treatment, enough time must pass to allow us to evaluate the therapy's effect. The residual effects of treatment are temporary in most instances. But on occasion, the effects may be disabling for a consecutive period of at least 12 months.

4. *When the initial antineoplastic therapy is effective.* We evaluate any post-therapeutic residual impairment(s) not included in these listings under the criteria for the affected body system. We must consider any complications of therapy. When the residual impairment(s) does not meet or medically equal a listing, we must consider its effect on your ability to do substantial gainful activity.

H. *How long do we consider your impairment to be disabling?*

1. In some listings, we specify that we will consider your impairment to be disabling until a particular point in time (for example, at least 18 months from the date of diagnosis). We may consider your impairment to be disabling beyond this point when the medical and other evidence justifies it.

2. When a listing does not contain such a specification, we will consider an impairment(s) that meets or medically equals a listing in this body system to be disabling until at least 3 years after onset of complete remission. When the impairment(s) has been in complete remission for at least 3 years, that is, the original tumor and any metastases have not been evident for at least 3 years, the impairment(s) will no longer meet or medically equal the criteria of a listing in this body system.

3. Following the appropriate period, we will consider any residuals, including residuals of the malignancy or therapy (see 13.00G), in determining whether you are disabled.

I. *What do these terms in the listings mean?*

1. *Inoperable:* Surgery is thought to be of no therapeutic value or the surgery cannot be performed. Examples of when surgery cannot be performed include a tumor that is too large or that invades crucial structures, or an intolerance of anesthesia or surgery due to other medical conditions. This term does not include situations in which the tumor could have been surgically removed but another method of treatment was chosen; for example, an attempt at organ preservation. The determination whether a tumor is inoperable usually occurs before attempts to shrink the tumor with chemotherapy or radiation.

2. *Unresectable:* The operation was performed, but the malignant tumor was not removed. This term includes situations in which a tumor is incompletely resected or the surgical margins are positive.

3. *Persistent:* Failure to achieve a complete remission.

4. *Progressive:* The malignancy became more extensive after treatment.

5. *Recurrent, relapse:* A malignancy that had been in complete remission or entirely removed by surgery has returned.

J. *Can we establish the existence of a disabling impairment prior to the date of the evidence that shows the malignancy satisfies the criteria of a listing?* Yes. We will consider factors such as:

1. The type of malignancy and its location.

2. The extent of involvement when the malignancy was first demonstrated.

3. Your symptoms.

K. *How do we evaluate specific malignant neoplastic diseases?*

1. *Lymphoma.*

a. Many low grade or indolent (non-aggressive) lymphomas are controlled by well-tolerated treatment modalities, although they may produce intermittent symptoms and signs. Therefore, we may defer adjudication of these cases for an appropriate period after initiation of therapy to determine whether the therapy will achieve its intended effect. (*See* 13.00E3.) For a low grade or indolent lymphoma, the intended effect of therapy is usually stability of the disease process. When stability has been achieved, we will assess severity on the basis of the extent of involvement of other organ systems and residuals from therapy.

b. A change in therapy for low grade or indolent lymphomas is usually an indicator that the therapy is not achieving its intended effect. However, it does not indicate this if the change is based on your (or your physician's) choice rather than a failure to achieve stability. If the therapy is changed

due solely to choice, the requirements of listing 13.05A2a are not met.

c. We consider Hodgkin's disease that recurs more than 12 months after completing initial antineoplastic therapy to be a new disease rather than a recurrence.

2. *Leukemia.*

a. *Acute leukemia.* The initial diagnosis of acute leukemia, including the accelerated or blast phase of chronic myelogenous (granulocytic) leukemia, is based upon definitive bone marrow examination. Additional diagnostic information is based on chromosomal analysis, cytochemical and surface marker studies on the abnormal cells, or other methods consistent with the prevailing state of medical knowledge and clinical practice. Recurrent disease must be documented by peripheral blood, bone marrow, or cerebrospinal fluid examination. The initial and follow-up pathology reports should be included.

b. *Chronic myelogenous leukemia (CML).* The diagnosis of CML should be based upon documented granulocytosis, including immature forms such as differentiated or undifferentiated myelocytes and myeloblasts, and a chromosomal analysis that demonstrates the Philadelphia chromosome. In the absence of a chromosomal analysis, or if the Philadelphia chromosome is not present, the diagnosis may be made by other methods consistent with the prevailing state of medical knowledge and clinical practice.

c. *Chronic lymphocytic leukemia.*

i. The diagnosis of chronic lymphocytic leukemia (CLL) must be documented by evidence of a chronic lymphocytosis of at least 10,000/mm ^{3} for 3 months or longer, or other acceptable diagnostic techniques consistent with the prevailing state of medical knowledge and clinical practice.

ii. We evaluate the complications and residual impairment(s) from CLL under the appropriate listings, such as 13.05A2, 7.02, and 7.15.

d. *Elevated white cell count.* In cases of chronic leukemia (either myelogenous or lymphocytic), an elevated white cell count, in itself, is not ordinarily a factor in determining the severity of the impairment.

3. *Macroglobulinemia or heavy chain disease.* The diagnosis of these diseases must be confirmed by protein electrophoresis or immunoelectrophoresis. We evaluate the resulting impairment(s) under the criteria of 7.02, 7.06, 7.08, or any other affected body system.

4. *Bilateral primary breast cancer.* We evaluate bilateral primary breast cancer (synchronous or metachronous) under 13.10A, which covers local primary disease, and not as a primary disease that has metastasized.

5. *Carcinoma-in-situ.* Carcinoma-in-situ, or preinvasive carcinoma, usually responds to treatment. When we use the term ''carcinoma'' in these listings, it does not include carcinoma-in-situ.

6. *Brain tumors.* We use the criteria in 13.13 to evaluate malignant brain tumors. We will evaluate any complications of malignant brain tumors, such as resultant neurological or psychological impairments, under the criteria for the affected body system. We evaluate benign brain tumors under 11.05.

L. *How do we evaluate malignant neoplastic diseases treated by bone marrow or stem cell transplantation?* Bone marrow or stem cell transplantation is performed for a variety of malignant neoplastic diseases.

1. *Acute leukemia (including T-cell lymphoblastic lymphoma) or accelerated or blast phase of CML.* If you undergo bone marrow or stem cell transplantation for any of these disorders, we will consider you to be disabled until at least 24 months from the date of diagnosis or relapse, or at least 12 months from the date of transplantation, whichever is later.

2. *Lymphoma, multiple myeloma, or chronic phase of CML.* If you undergo bone marrow or stem cell transplantation for any of these disorders, we will consider you to be disabled until at least 12 months from the date of transplantation.

3. *Other malignancies.* We will evaluate any other malignant neoplastic disease treated with bone marrow or stem cell transplantation under 13.28, regardless of whether there is another listing that addresses that impairment. The length of time we will consider you to be disabled depends on whether you undergo allogeneic or autologous transplantation.

a. *Allogeneic bone marrow or stem cell transplantation.* If you undergo allogeneic transplantation (transplantation from an unrelated donor or a related donor other than an identical twin), we will consider you to be disabled until at least 12 months from the date of transplantation.

b. *Autologous bone marrow or stem cell transplantation.* If you undergo autologous transplantation (transplantation of your own cells or cells from your identical twin (syngeneic transplantation)), we will consider you to be disabled until at least 12 months from the date of the first treatment under the treatment plan that includes transplantation. The first treatment usually refers to the initial therapy given to prepare you for transplantation.

4. *Evaluating disability after the appropriate time period has elapsed.* We consider any residual impairment(s), such as complications arising from:

a. Graft-versus-host (GVH) disease.

b. Immunosuppressant therapy, such as frequent infections.

c. Significant deterioration of other organ systems.

13.01 Category of Impairments, Malignant Neoplastic Diseases

13.02 *Soft tissue tumors of the head and neck (except salivary glands—13.06—and thyroid gland—13.07).*

A. Inoperable or unresectable.

OR

B. Persistent disease following initial multimodal antineoplastic therapy.

OR

C. Recurrent disease following initial antineoplastic therapy, except local vocal cord recurrence.

OR

D. With metastases beyond the regional lymph nodes.

OR

E. Soft tissue tumors of the head and neck not addressed in A-D, with multimodal antineoplastic therapy. Consider under a disability until at least 18 months from the date of diagnosis. Thereafter, evaluate any residual impairment(s) under the criteria for the affected body system.

13.03 *Skin.*

A. Sarcoma or carcinoma with metastases to or beyond the regional lymph nodes.

OR

B. Melanoma, with either 1 or 2:

1. Recurrent after wide excision (except an additional primary melanoma at a different site, which is not considered to be recurrent disease).

2. Palpable nodal metastases or metastases to adjacent skin (satellite lesions) or elsewhere.

13.04 *Soft tissue sarcoma.*

A. With regional or distant metastases.

OR

B. Persistent or recurrent following initial antineoplastic therapy.

13.05 *Lymphoma (including mycosis fungoides, but excluding T-cell lymphoblastic lymphoma—13.06).* (*See* 13.00K1 and 13.00K2c.)

A. Non-Hodgkin's lymphoma, as described in 1 or 2:

1. Intermediate or high-grade lymphoma persistent or recurrent following initial antineoplastic therapy.

2. Low-grade or indolent lymphoma requiring initiation of more than one antineoplastic treatment regimen within a consecutive 12-month period. Consider under a disability from at least the date of initiation of the treatment regimen that failed within 12 months.

OR

B. Hodgkin's disease with failure to achieve clinically complete remission, or recurrent disease within 12 months of completing initial antineoplastic therapy.

OR

C. With bone marrow or stem cell transplantation. Consider under a disability until at least 12 months from the date of transplantation. Thereafter, evaluate any residual impairment(s) under the criteria for the affected body system.

13.06 *Leukemia.* (*See* 13.00K2.)

A. Acute leukemia (including T-cell lymphoblastic lymphoma). Consider under a disability until at least 24 months from the date of diagnosis or relapse, or at least 12 months from the date of bone marrow or stem cell transplantation, whichever is later. Thereafter, evaluate any residual impairment(s) under the criteria for the affected body system.

OR

B. Chronic myelogenous leukemia, as described in 1 or 2:

1. Accelerated or blast phase. Consider under a disability until at least 24 months from the date of diagnosis or relapse, or at least 12 months from the date of bone marrow or stem cell transplantation, whichever is later. Thereafter, evaluate any residual impairment(s) under the criteria for the affected body system.

2. Chronic phase, as described in a or b:

a. Consider under a disability until at least 12 months from the date of bone marrow or stem cell transplantation. Thereafter, evaluate any residual impairment(s) under the criteria for the affected body system.

b. Progressive disease following initial antineoplastic therapy.

13.07 *Multiple myeloma (confirmed by appropriate serum or urine protein electrophoresis and bone marrow findings).*

A. Failure to respond or progressive disease following initial antineoplastic therapy.

OR

B. With bone marrow or stem cell transplantation. Consider under a disability until at least 12 months from the date of transplantation. Thereafter, evaluate any residual impairment(s) under the criteria for the affected body system.

13.08 *Salivary glands*—carcinoma or sarcoma with metastases beyond the regional lymph nodes.

13.09 *Thyroid gland.*

A. Anaplastic (undifferentiated) carcinoma.

OR

B. Carcinoma with metastases beyond the regional lymph nodes progressive despite radioactive iodine therapy.

13.10 *Breast (except sarcoma—13.04).* (*See* 13.00K4.)

A. Locally advanced carcinoma (inflammatory carcinoma, tumor of any size with direct extension to the chest wall or skin, tumor of any size with metastases to the ipsilateral internal mammary nodes).

OR

B. Carcinoma with distant metastases.

OR

C. Recurrent carcinoma, except local recurrence that remits with antineoplastic therapy.

13.11 *Skeletal system*—carcinoma or sarcoma.

A. Inoperable or unresectable.

OR

B. Recurrent tumor (except local recurrence) after initial antineoplastic therapy.

OR

C. With distant metastases.

OR

D. All other tumors originating in bone with multimodal antineoplastic therapy. Consider under a disability for 12 months from the date of diagnosis. Thereafter, evaluate any residual impairment(s) under the criteria for the affected body system.

13.12 *Maxilla, orbit, or temporal fossa.*

A. Sarcoma or carcinoma of any type with regional or distant metastases.

OR

B. Carcinoma of the antrum with extension into the orbit or ethmoid or sphenoid sinus.

OR

C. Tumors with extension to the base of the skull, orbit, meninges, or sinuses.

13.13 *Nervous system.* (*See* 13.00K6.)

A. Central nervous system neoplasms (brain and spinal cord), as described in 1 or 2:

1. Highly malignant tumors, such as Grades III and IV astrocytomas, glioblastoma multiforme, ependymoblastoma, medulloblastoma or other primitive neuroectodermal tumors (PNETs) with documented metastases, diffuse intrinsic brain stem gliomas, or primary sarcomas.

2. Any central nervous system neoplasm progressive or recurrent following initial antineoplastic therapy.

OR

B. Peripheral nerve or spinal root neoplasm, as described in 1 or 2:

1. Metastatic.

2. Progressive or recurrent following initial antineoplastic therapy.

13.14 *Lungs.*

A. Non-small-cell carcinoma—inoperable, unresectable, recurrent, or metastatic disease to or beyond the hilar nodes.

OR

B. Small-cell (oat cell) carcinoma.

13.15 *Pleura or mediastinum.*

A. Malignant mesothelioma of pleura.

OR

B. Tumors of the mediastinum, as described in 1 or 2:

1. With metastases to or beyond the regional lymph nodes.

2. Persistent or recurrent following initial antineoplastic therapy.

13.16 *Esophagus or stomach.*

A. Carcinoma or sarcoma of the esophagus.

OR

B. Carcinoma or sarcoma of the stomach, as described in 1 or 2:

1. Inoperable, unresectable, extending to surrounding structures, or recurrent.

2. With metastases to or beyond the regional lymph nodes.

13.17 *Small intestine*—carcinoma, sarcoma, or carcinoid.

A. Inoperable, unresectable, or recurrent.

OR

B. With metastases beyond the regional lymph nodes.

13.18 *Large intestine (from ileocecal valve to and including anal canal).*

A. Adenocarcinoma that is inoperable, unresectable, or recurrent.

OR

B. Squamous cell carcinoma of the anus, recurrent after surgery.

OR

C. With metastases beyond the regional lymph nodes.

13.19 *Liver or gallbladder*—tumors of the liver, gallbladder, or bile ducts.

13.20 *Pancreas.*

A. Carcinoma (except islet cell carcinoma).

OR

B. Islet cell carcinoma that is inoperable or unresectable and physiologically active.

13.21 *Kidneys, adrenal glands, or ureters*—carcinoma.

A. Inoperable, unresectable, or recurrent.

OR

B. With metastases to or beyond the regional lymph nodes.

13.22 *Urinary bladder*—carcinoma.

A. With infiltration beyond the bladder wall.

OR

B. Recurrent after total cystectomy.

OR

C. Inoperable or unresectable.

OR

D. With metastases to or beyond the regional lymph nodes.

13.23 *Cancers of the female genital tract*—carcinoma or sarcoma.

A. Uterus (corpus), as described in 1, 2, or 3:

1. Invading adjoining organs.

2. With metastases to or beyond the regional lymph nodes.

3. Persistent or recurrent following initial antineoplastic therapy.

OR

B. Uterine cervix, as described in 1 or 2:

1. Extending to the pelvic wall, lower portion of the vagina, or adjacent or distant organs.

2. Persistent or recurrent following initial antineoplastic therapy.

OR

C. Vulva, as described in 1, 2, or 3:

1. Invading adjoining organs.

2. With metastases to or beyond the regional lymph nodes.

3. Persistent or recurrent following initial antineoplastic therapy.

OR

D. Fallopian tubes, as described in 1 or 2:

1. Extending to the serosa or beyond.

2. Persistent or recurrent following initial antineoplastic therapy.

OR

E. Ovaries, as described in 1 or 2:

1. All tumors except germ-cell tumors, with at least one of the following:

a. Tumor extension beyond the pelvis; for example, tumor implants on peritoneal, omental, or bowel surfaces.

b. Metastases to or beyond the regional lymph nodes.

c. Ruptured ovarian capsule, tumor on the serosal surface of the ovary, ascites with malignant cells, or positive peritoneal washings.

d. Recurrent following initial antineoplastic therapy.

2. Germ-cell tumors—progressive or recurrent following initial antineoplastic therapy.

13.24 *Prostate gland*—carcinoma.

A. Progressive or recurrent despite initial hormonal intervention.

OR

B. With visceral metastases.

13.25 *Testicles*—tumor with metastatic disease progressive or recurrent following initial chemotherapy.

13.26 *Penis*—carcinoma with metastases to or beyond the regional lymph nodes.

13.27 *Primary site unknown after appropriate search for primary*—metastatic carcinoma or sarcoma, except for solitary squamous cell carcinoma in the neck.

13.28 *Malignant neoplastic diseases treated by bone marrow or stem cell transplantation.* (*See* 13.00L.)

A. Allogeneic transplantation. Consider under a disability until at least 12 months from the date of transplantation. Thereafter, evaluate any residual impairment(s) under the criteria for the affected body system.

OR

B. Autologous transplantation. Consider under a disability until at least 12 months from the date of the first treatment under the treatment plan that includes transplantation. Thereafter, evaluate any residual impairment(s) under the criteria for the affected body system.

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Part B

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107.00 Hematological Disorders

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113.00 Malignant Neoplastic Diseases

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107.00 HEMATOLOGICAL DISORDERS

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C. [removed]

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107.11 [removed]

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111.00 NEUROLOGICAL

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E. *Brain tumors.* We evaluate malignant brain tumors under the criteria in 113.13. For benign brain tumors, we determine the severity and duration of the impairment on the basis of symptoms, signs, and laboratory findings (111.05).

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111.05 *Benign brain tumors.* Evaluate under 111.02, 111.03, 111.06, 111.09 or the criteria of the affected body system.

* * * * *

113.00 MALIGNANT NEOPLASTIC DISEASES

A. *What impairments do these listings cover?* We use these listings to evaluate all malignant neoplasms except certain neoplasms associated with human immunodeficiency virus (HIV) infection. We use the criteria in 114.08E to evaluate carcinoma of the cervix, Kaposi's sarcoma, lymphoma, and squamous cell carcinoma of the anus if you also have HIV infection.

B. *What do we consider when we evaluate malignant neoplastic diseases under these listings?* We consider factors such as the:

1. Origin of the malignancy.

2. Extent of involvement.

3. Duration, frequency, and response to antineoplastic therapy. Antineoplastic therapy means surgery, irradiation, chemotherapy, hormones, immunotherapy, or bone marrow or stem cell transplantation. When we refer to surgery as an antineoplastic treatment, we mean surgical excision for treatment, not for diagnostic purposes.

4. Effects of any post-therapeutic residuals.

C. *How do we apply these listings?* We apply the criteria in a specific listing to a malignancy originating from that specific site.

D. *What evidence do we need?*

1. We need medical evidence that specifies the type, extent, and site of the primary, recurrent, or metastatic lesion. In the rare situation in which the primary site cannot be identified, we will use evidence documenting the site(s) of metastasis to evaluate the impairment under 13.27 in part A.

2. For operative procedures, including a biopsy or a needle aspiration, we generally need a copy of both the:

a. Operative note.

b. Pathology report.

3. When we cannot get these documents, we will accept the summary of hospitalization(s) or other medical reports. This evidence should include details of the findings at surgery and, whenever appropriate, the pathological findings.

4. In some situations we may also need evidence about recurrence, persistence, or progression of the malignancy, the response to therapy, and any significant residuals. (*See* 113.00G.)

E. *When do we need longitudinal evidence?*

1. *Tumors with distant metastases.* Most malignant tumors of childhood consist of a local lesion with metastases to regional lymph nodes and, less often, distant metastases. We generally do not need longitudinal evidence for tumors that have metastasized beyond the regional lymph nodes because these tumors usually meet the requirements of a listing. Exceptions are for tumors with distant metastases that are expected to respond to antineoplastic therapy. For these exceptions, we usually need a longitudinal record of 3 months after therapy starts to determine whether the intended effect of therapy has been achieved and is likely to persist.

2. *Other malignancies.* When there are no distant metastases, many of the listings require that we consider your response to initial antineoplastic therapy; that is, the initial planned treatment regimen. This therapy may consist of a single modality or a combination of modalities (multimodal) given in close proximity as a unified whole, and is usually planned before any treatment(s) is initiated. Examples of multimodal therapy include:

a. Surgery followed by chemotherapy or radiation.

b. Chemotherapy followed by surgery.

c. Chemotherapy and concurrent radiation.

3. *Types of treatment.* Whenever the initial planned therapy is a single modality, enough time must pass to allow a determination about whether the therapy will achieve its intended effect. If the treatment fails, the failure will often happen within 6 months after treatment starts, and there will often be a change in the treatment regimen. Whenever the initial planned therapy is multimodal, a determination about the effectiveness of the therapy usually cannot be made until the effects of all the planned modalities can be determined. In some cases, we may need to defer adjudication until the effectiveness of therapy can be assessed. However, we do not need to defer adjudication to determine whether the therapy will achieve its intended effect if we can make a fully favorable determination or decision based on the length and effects of therapy, or the residuals of the malignancy or therapy (*see* 113.00G).

F. *How do we evaluate impairments that do not meet one of the malignant neoplastic diseases listings?*

1. These listings are only examples of malignant neoplastic diseases that we consider severe enough to result in marked and severe functional limitations. If your impairment(s) does not meet the criteria of any of these listings, we must also consider whether you have an impairment(s) that meets the criteria of a listing in another body system.

2. If you have a severe medically determinable impairment(s) that does not meet a listing, we will determine whether your impairment(s) medically equals a listing. (*See* §§ 404.1526 and 416.926.) If it does not, we will also consider whether you have an impairment(s) that functionally equals the listings. (*See* § 416.926a.) We use the rules in § 416.994a when we decide whether you continue to be disabled.

G. *How do we consider the effects of therapy?*

1. *How we consider the effects of therapy under the listings.* In many cases, malignancies meet listing criteria only if the therapy does not achieve the intended effect: the malignancy persists, progresses, or recurs despite treatment. However, as explained in the following paragraphs, we will not delay adjudication if we can make a fully favorable determination or decision based on the evidence in the case record.

2. *Effects can vary widely.*

a. Because the therapy and its toxicity may vary widely, we consider each case on an individual basis. We will request a specific description of the therapy, including these items:

i. Drugs given.

ii. Dosage.

iii. Frequency of drug administration.

iv. Plans for continued drug administration.

v. Extent of surgery.

vi. Schedule and fields of radiation therapy.

b. We will also request a description of the complications or adverse effects of therapy, such as the following:

i. Continuing gastrointestinal symptoms.

ii. Persistent weakness.

iii. Neurological complications.

iv. Cardiovascular complications.

v. Reactive mental disorders.

3. *Effects of therapy may change.* Because the severity of the adverse effects of antineoplastic therapy may change during treatment, enough time must pass to allow us to evaluate the therapy's effect. The residual effects of treatment are temporary in most instances. But on occasion, the effects may be disabling for a consecutive period of at least 12 months.

4. *When the initial antineoplastic therapy is effective.* We evaluate any post-therapeutic residual impairment(s) not included in these listings under the criteria for the affected body system. We must consider any complications of therapy. When the residual impairment(s) does not meet a listed impairment, we must consider whether it medically equals a listing, or, as appropriate, functionally equals the listings.

H. *How long do we consider your impairment to be disabling?*

1. In some listings, we specify that we will consider your impairment to be disabling until a particular point in time (for example, at least 12 months from the date of diagnosis). We may consider your impairment to be disabling beyond this point

when the medical and other evidence justifies it.

2. When a listing does not contain such a specification, we will consider an impairment(s) that meets or medically equals a listing in this body system to be disabling until at least 3 years after onset of complete remission. When the impairment(s) has been in complete remission for at least 3 years, that is, the original tumor and any metastases have not been evident for at least 3 years, the impairment(s) will no longer meet or equal the criteria of a listing in this body system.

3. Following the appropriate period, we will consider any residuals, including residuals of the malignancy or therapy (*see* 113.00G), in determining whether you are disabled.

I. *What do these terms in the listings mean?*

1. *Persistent:* Failure to achieve a complete remission.

2. *Progressive:* The malignancy became more extensive after treatment.

3. *Recurrent, relapse:* A malignancy that had been in complete remission or entirely removed by surgery has returned.

J. *Can we establish the existence of a disabling impairment prior to the date of the evidence that shows the malignancy satisfies the criteria of a listing?* Yes. We will consider factors such as:

1. The type of malignancy and its location.

2. The extent of involvement when the malignancy was first demonstrated.

3. Your symptoms.

K. *How do we evaluate specific malignant neoplastic diseases?*

1. *Lymphoma.*

a. Listing 113.05 provides criteria for evaluating intermediate or high grade lymphomas that have not responded to antineoplastic therapy. Low grade or indolent lymphomas are rare in children. We will evaluate low grade or indolent lymphomas under 13.05 in part A.

b. We consider Hodgkin's disease that recurs more than 12 months after completing initial antineoplastic therapy to be a new disease rather than a recurrence.

c. Many children with lymphoma are treated according to a long-term protocol that can result in significant adverse medical, social, and emotional consequences. (*See* 113.00G.)

2. *Leukemia.*

a. *Acute leukemia.* The initial diagnosis of acute leukemia, including the accelerated or blast phase of chronic myelogenous (granulocytic) leukemia, is based upon definitive bone marrow examination. Additional diagnostic information is based on chromosomal analysis, cytochemical and surface marker studies on the abnormal cells, or other methods consistent with the prevailing state of medical knowledge and clinical practice. Recurrent disease must be documented by peripheral blood, bone marrow, or cerebrospinal fluid examination. The initial and follow-up pathology reports should be included.

b. *Chronic myelogenous leukemia (CML).* The diagnosis of CML should be based upon documented granulocytosis, including immature forms such as differentiated or undifferentiated myelocytes and myeloblasts, and a chromosomal analysis that demonstrates the Philadelphia chromosome. In the absence of a chromosomal analysis, or if the Philadelphia chromosome is not present, the diagnosis may be made by other methods consistent with the prevailing state of medical knowledge and clinical practice.

c. *Juvenile chronic myelogenous leukemia (JCML).* JCML is a rare, Philadelphia-chromosome-negative childhood leukemia that is aggressive and clinically similar to acute myelogenous leukemia. We evaluate JCML under 113.06A.

d. *Elevated white cell count.* In cases of chronic leukemia, an elevated white cell count, in itself, is not ordinarily a factor in determining the severity of the impairment.

3. *Malignant solid tumors.* The tumors we consider under 113.03 include the histiocytosis syndromes except for solitary eosinophilic granuloma. Therefore, we will not evaluate brain tumors (*see* 113.13) or thyroid tumors (*see* 113.09) under this listing.

4. *Brain tumors.* We use the criteria in 113.13 to evaluate malignant brain tumors. We will evaluate any complications of malignant brain tumors, such as resultant neurological or psychological impairments, under the criteria for the affected body system. We evaluate benign brain tumors under 111.05.

5. *Retinoblastoma.* The treatment for bilateral retinoblastoma usually results in a visual impairment. We will evaluate any resulting visual impairment under 102.02.

L. *How do we evaluate malignant neoplastic diseases treated by bone marrow or stem cell transplantation?* Bone marrow or stem cell transplantation is performed for a variety of malignant neoplastic diseases.

1. *Acute leukemia (including T-cell lymphoblastic lymphoma and JCML) or accelerated or blast phase of CML.* If you undergo bone marrow or stem cell transplantation for any of these disorders, we will consider you to be disabled until at least 24 months from the date of diagnosis or relapse, or at least 12 months from the date of transplantation, whichever is later.

2. *Lymphoma or chronic phase of CML.* If you undergo bone marrow or stem cell transplantation for any of these disorders, we will consider you to be disabled until at least 12 months from the date of transplantation.

3. *Evaluating disability after the appropriate time period has elapsed.* We consider any residual impairment(s), such as complications arising from:

a. Graft-versus-host (GVH) disease.

b. Immunosuppressant therapy, such as frequent infections.

c. Significant deterioration of other organ systems.

113.01 Category of Impairments, Malignant Neoplastic Diseases

113.03 *Malignant solid tumors.* Consider under a disability:

A. For 2 years from the date of initial diagnosis. Thereafter, evaluate any residual impairment(s) under the criteria for the affected body system.

OR

B. For 2 years from the date of recurrence of active disease. Thereafter, evaluate any residual impairment(s) under the criteria for the affected body system.

113.05 *Lymphoma (excluding T-cell lymphoblastic lymphoma—113.06).* (*See* 113.00K1.)

A. Non-Hodgkins lymphoma, including Burkitt's and anaplastic large cell. Persistent or recurrent following initial antineoplastic therapy.

OR

B. Hodgkin's disease with failure to achieve clinically complete remission, or recurrent disease within 12 months of completing initial antineoplastic therapy.

OR

C. With bone marrow or stem cell transplantation. Consider under a disability until at least 12 months from the date of transplantation. Thereafter, evaluate any residual impairment(s) under the criteria of the affected body system.

113.06 *Leukemia.* (*See* 113.00K2.)

A. Acute leukemia (including T-cell lymphoblastic lymphoma and juvenile chronic myelogenous leukemia (JCML)). Consider under a disability until at least 24 months from the date of diagnosis or relapse, or at least 12 months from the date of bone marrow or stem cell transplantation, whichever is later. Thereafter, evaluate any residual impairment(s) under the criteria for the affected body system.

OR

B. Chronic myelogenous leukemia (except JCML), as described in 1 or 2:

1. Accelerated or blast phase. Consider under a disability until at least 24 months from the date of diagnosis or relapse, or at least 12 months from the date of bone marrow or stem cell transplantation, whichever is later. Thereafter, evaluate any residual impairment(s) under the criteria for the affected body system.

2. Chronic phase, as described in a or b:

a. Consider under a disability until at least 12 months from the date of bone marrow or stem cell transplantation. Thereafter, evaluate any residual impairment(s) under the criteria for the affected body system.

b. Progressive disease following initial antineoplastic therapy.

113.09 *Thyroid gland.*

A. Anaplastic (undifferentiated) carcinoma.

OR

B. Carcinoma with metastases beyond the regional lymph nodes progressive despite radioactive iodine therapy.

113.12 *Retinoblastoma.*

A. With extension beyond the orbit.

OR

B. Persistent or recurrent following initial antineoplastic therapy.

OR

C. With regional or distant metastases.

113.13 *Brain tumors.* (*See* 113.00K4.) Highly malignant tumors, such as Grades III and IV astrocytomas, glioblastoma multiforme, ependymoblastoma, medulloblastoma or other primitive neuroectodermal tumors (PNETs) with documented metastases, diffuse intrinsic brain stem gliomas, or primary sarcomas.

113.21 *Neuroblastoma.*

A. With extension across the midline.

OR

B. With distant metastases.

OR

C. Recurrent.

OR

D. With onset at age 1 year or older.

* * * * *

[FR Doc. 04–24897 Filed 11–12–04; 8:45 am]

BILLING CODE 4191–02–P

SOCIAL SECURITY ADMINISTRATION

20 CFR Part 404

Revised Medical Criteria for Evaluating Hematological Disorders and Malignant Neoplastic Diseases

AGENCY: Social Security Administration.

ACTION: Proposed rule; partial withdrawal.

SUMMARY: We are withdrawing the rules we proposed for evaluating hematological disorders that were included in the Notice of Proposed Rulemaking (NPRM) published in the **Federal Register** on November 27, 2001 (66 FR 59306). In that NPRM, we proposed revisions to both the listings for hematological disorders and the listings for malignant neoplastic diseases. The public comments we received on the NPRM raised significant issues about the proposed listings for some of the hematological disorders, and we have decided to withdraw the proposed rules for hematological disorders while we obtain additional input to resolve these issues. We plan to publish a new NPRM for the hematological disorders listings at a later date. We are publishing separately in today's edition of the **Federal Register** final rules for evaluating malignant neoplastic diseases.

FOR FURTHER INFORMATION CONTACT: Martin Sussman, Regulations Officer, Office of Regulations, Social Security Administration, 100 Altmeyer Building, 6401 Security Boulevard, Baltimore, Maryland 21235–6401, (410) 965–1767 or TTY (410) 966–5609. For information on eligibility or filing for benefits, call our national toll-free number, 1–800–772–1213 or TTY 1–800–325–0778, or visit our Internet Web site, *Social Security Online*, at *http://www.socialsecurity.gov/*.

Dated: July 19, 2004.

Jo Anne B. Barnhart,

Commissioner of Social Security.

[FR Doc. 04–24898 Filed 11–12–04; 8:45 am]

BILLING CODE 4191–02–P

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H.R. 4381/P.L. 108–392

To designate the facility of the United States Postal Service located at 2811 Springdale Avenue in Springdale, Arkansas, as the ''Harvey and Bernice Jones Post Office Building''. (Oct. 30, 2004; 118 Stat. 2245)

H.R. 4471/P.L. 108–393

Homeownership Opportunities for Native Americans Act of 2004 (Oct. 30, 2004; 118 Stat. 2246)

H.R. 4481/P.L. 108–394

Wilson's Creek National Battlefield Boundary Adjustment Act of 2004 (Oct. 30, 2004; 118 Stat. 2247)

H.R. 4556/P.L. 108–395

To designate the facility of the United States Postal Service located at 1115 South Clinton Avenue in Dunn, North Carolina, as the ''General William Carey Lee Post Office Building''. (Oct. 30, 2004; 118 Stat. 2249)

H.R. 4579/P.L. 108–396

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H.R. 4618/P.L. 108–397

To designate the facility of the United States Postal Service located at 10 West Prospect Street in Nanuet, New York, as the ''Anthony I. Lombardi Memorial Post Office Building''. (Oct. 30, 2004; 118 Stat. 2251)

H.R. 4632/P.L. 108–398

To designate the facility of the United States Postal Service located at 19504 Linden Boulevard in St. Albans, New York, as the ''Archie Spigner Post Office Building''. (Oct. 30, 2004; 118 Stat. 2252)

H.R. 4731/P.L. 108–399

To amend the Federal Water Pollution Control Act to reauthorize the National Estuary Program. (Oct. 30, 2004; 118 Stat. 2253)

H.R. 4827/P.L. 108–400

To amend the Colorado Canyons National Conservation Area and Black Ridge Canyons Wilderness Act of 2000 to rename the Colorado Canyons National Conservation Area as the McInnis Canyons National Conservation Area. (Oct. 30, 2004; 118 Stat. 2254)

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To designate the facility of the United States Postal Service located at 411 Midway Avenue in Mascotte, Florida, as the ''Specialist Eric Ramirez Post Office''. (Oct. 30, 2004; 118 Stat. 2257)

H.R. 5039/P.L. 108–403

To designate the facility of the United States Postal Service located at United States Route 1 in Ridgeway, North Carolina, as the ''Eva Holtzman Post Office''. (Oct. 30, 2004; 118 Stat. 2258)

H.R. 5051/P.L. 108–404

To designate the facility of the United States Postal Service located at 1001 Williams Street in Ignacio, Colorado, as the ''Leonard C. Burch Post Office Building''. (Oct. 30, 2004; 118 Stat. 2259)

H.R. 5107/P.L. 108–405

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Special Olympics Sport and Empowerment Act of 2004 (Oct. 30, 2004; 118 Stat. 2294)

H.R. 5133/P.L. 108–407

To designate the facility of the United States Postal Service located at 11110 Sunset Hills Road in Reston, Virginia, as the ''Martha Pennino Post Office Building''. (Oct. 30, 2004; 118 Stat. 2297)

H.R. 5147/P.L. 108–408

To designate the facility of the United States Postal Service located at 23055 Sherman Way in West Hills, California, as the ''Evan Asa Ashcraft Post Office Building''. (Oct. 30, 2004; 118 Stat. 2298)

H.R. 5186/P.L. 108–409

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H.R. 5294/P.L. 108–410

John F. Kennedy Center Reauthorization Act of 2004 (Oct. 30, 2004; 118 Stat. 2303)

S. 129/P.L. 108–411

Federal Workforce Flexibility Act of 2004 (Oct. 30, 2004; 118 Stat. 2305)

S. 144/P.L. 108–412

To require the Secretary of Agriculture to establish a program to provide assistance to eligible weed management entities to control or eradicate noxious weeds on public and private land. (Oct. 30, 2004; 118 Stat. 2320)

S. 643/P.L. 108–413

Hibben Center Act (Oct. 30, 2004; 118 Stat. 2325)

S. 1194/P.L. 108–414

Mentally Ill Offender Treatment and Crime Reduction Act of 2004 (Oct. 30, 2004; 118 Stat. 2327)

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1–50	(869–052–00026–4)	61.00	Jan. 1, 2004
51–199	(869–052–00027–2)	58.00	Jan. 1, 2004
200–499	(869–052–00028–1)	46.00	Jan. 1, 2004
500–End	(869–052–00029–9)	62.00	Jan. 1, 2004
11	(869–052–00030–2)	41.00	Feb. 3, 2004
12 Parts:			
1–199	(869–052–00031–1)	34.00	Jan. 1, 2004
200–219	(869–052–00032–9)	37.00	Jan. 1, 2004
220–299	(869–052–00033–7)	61.00	Jan. 1, 2004
300–499	(869–052–00034–5)	47.00	Jan. 1, 2004
500–599	(869–052–00035–3)	39.00	Jan. 1, 2004
600–899	(869–052–00036–1)	56.00	Jan. 1, 2004
900–End	(869–052–00037–0)	50.00	Jan. 1, 2004
13	(869–052–00038–8)	55.00	Jan. 1, 2004
14 Parts:			
1–59	(869–052–00039–6)	63.00	Jan. 1, 2004
60–139	(869–052–00040–0)	61.00	Jan. 1, 2004
140–199	(869–052–00041–8)	30.00	Jan. 1, 2004
200–1199	(869–052–00042–6)	50.00	Jan. 1, 2004
1200–End	(869–052–00043–4)	45.00	Jan. 1, 2004
15 Parts:			
0–299	(869–052–00044–2)	40.00	Jan. 1, 2004
300–799	(869–052–00045–1)	60.00	Jan. 1, 2004
800–End	(869–052–00046–9)	42.00	Jan. 1, 2004
16 Parts:			
0–999	(869–052–00047–7)	50.00	Jan. 1, 2004
1000–End	(869–052–00048–5)	60.00	Jan. 1, 2004
17 Parts:			
1–199	(869–052–00050–7)	50.00	Apr. 1, 2004
200–239	(869–052–00051–5)	58.00	Apr. 1, 2004
240–End	(869–052–00052–3)	62.00	Apr. 1, 2004
18 Parts:			
1–399	(869–052–00053–1)	62.00	Apr. 1, 2004
400–End	(869–052–00054–0)	26.00	Apr. 1, 2004
19 Parts:			
1–140	(869–052–00055–8)	61.00	Apr. 1, 2004
141–199	(869–052–00056–6)	58.00	Apr. 1, 2004
200–End	(869–052–00057–4)	31.00	Apr. 1, 2004
20 Parts:			
1–399	(869–052–00058–2)	50.00	Apr. 1, 2004
400–499	(869–052–00059–1)	64.00	Apr. 1, 2004
500–End	(869–052–00060–9)	63.00	Apr. 1, 2004
21 Parts:			
1–99	(869–052–00061–2)	42.00	Apr. 1, 2004
100–169	(869–052–00062–1)	49.00	Apr. 1, 2004
170–199	(869–052–00063–9)	50.00	Apr. 1, 2004
200–299	(869–052–00064–7)	17.00	Apr. 1, 2004
300–499	(869–052–00065–5)	31.00	Apr. 1, 2004
500–599	(869–052–00066–3)	47.00	Apr. 1, 2004
600–799	(869–052–00067–1)	15.00	Apr. 1, 2004
800–1299	(869–052–00068–0)	58.00	Apr. 1, 2004
1300–End	(869–052–00069–8)	24.00	Apr. 1, 2004
22 Parts:			
1–299	(869–052–00070–1)	63.00	Apr. 1, 2004
300–End	(869–052–00071–0)	45.00	Apr. 1, 2004
23	(869–052–00072–8)	45.00	Apr. 1, 2004
24 Parts:			
0–199	(869–052–00073–6)	60.00	Apr. 1, 2004
200–499	(869–052–00074–4)	50.00	Apr. 1, 2004
500–699	(869–052–00075–2)	30.00	Apr. 1, 2004
700–1699	(869–052–00076–1)	61.00	Apr. 1, 2004
1700–End	(869–052–00077–9)	30.00	Apr. 1, 2004
25	(869–052–00078–7)	63.00	Apr. 1, 2004
26 Parts:			
§§ 1.0–1–1.60	(869–052–00079–5)	49.00	Apr. 1, 2004
§§ 1.61–1.169	(869–052–00080–9)	63.00	Apr. 1, 2004
§§ 1.170–1.300	(869–052–00081–7)	60.00	Apr. 1, 2004
§§ 1.301–1.400	(869–052–00082–5)	46.00	Apr. 1, 2004
§§ 1.401–1.440	(869–052–00083–3)	62.00	Apr. 1, 2004
§§ 1.441–1.500	(869–052–00084–1)	57.00	Apr. 1, 2004
§§ 1.501–1.640	(869–052–00085–0)	49.00	Apr. 1, 2004
§§ 1.641–1.850	(869–052–00086–8)	60.00	Apr. 1, 2004
§§ 1.851–1.907	(869–052–00087–6)	61.00	Apr. 1, 2004
§§ 1.908–1.1000	(869–052–00088–4)	60.00	Apr. 1, 2004
§§ 1.1001–1.1400	(869–052–00089–2)	61.00	Apr. 1, 2004
§§ 1.1401–1.1503–2A	(869–052–00090–6)	55.00	Apr. 1, 2004
§§ 1.1551–End	(869–052–00091–4)	55.00	Apr. 1, 2004
2–29	(869–052–00092–2)	60.00	Apr. 1, 2004
30–39	(869–052–00093–1)	41.00	Apr. 1, 2004
40–49	(869–052–00094–9)	28.00	Apr. 1, 2004
50–299	(869–052–00095–7)	41.00	Apr. 1, 2004
300–499	(869–052–00096–5)	61.00	Apr. 1, 2004

Title	Stock Number	Price	Revision Date
500–599	(869–052–00097–3)	12.00	[5]Apr. 1, 2004
600–End	(869–052–00098–1)	17.00	Apr. 1, 2004
27 Parts:			
1–199	(869–052–00099–0)	64.00	Apr. 1, 2004
200–End	(869–052–00100–7)	21.00	Apr. 1, 2004
28 Parts:			
0–42	(869–052–00101–5)	61.00	July 1, 2004
43–End	(869–052–00102–3)	60.00	July 1, 2004
29 Parts:			
0–99	(869–052–00103–1)	50.00	July 1, 2004
100–499	(869–052–00104–0)	23.00	July 1, 2004
500–899	(869–052–00105–8)	61.00	July 1, 2004
900–1899	(869–052–00106–6)	36.00	July 1, 2004
1900–1910 (§§ 1900 to 1910.999)	(869–052–00107–4)	61.00	July 1, 2004
1910 (§§ 1910.1000 to end)	(869–052–00108–2)	46.00	[8]July 1, 2004
1911–1925	(869–052–00109–1)	30.00	July 1, 2004
1926	(869–052–00110–4)	50.00	July 1, 2004
1927–End	(869–052–00111–2)	62.00	July 1, 2004
30 Parts:			
1–199	(869–052–00112–1)	57.00	July 1, 2004
200–699	(869–052–00113–9)	50.00	July 1, 2004
700–End	(869–052–00114–7)	58.00	July 1, 2004
31 Parts:			
0–199	(869–052–00115–5)	41.00	July 1, 2004
200–End	(869–052–00116–3)	65.00	July 1, 2004
32 Parts:			
1–39, Vol. I		15.00	[2]July 1, 1984
1–39, Vol. II		19.00	[2]July 1, 1984
1–39, Vol. III		18.00	[2]July 1, 1984
1–190	(869–052–00117–1)	61.00	July 1, 2004
191–399	(869–052–00118–0)	63.00	July 1, 2004
400–629	(869–052–00119–8)	50.00	[8]July 1, 2004
630–699	(869–052–00120–1)	37.00	[7]July 1, 2004
700–799	(869–052–00121–0)	46.00	July 1, 2004
800–End	(869–052–00122–8)	47.00	July 1, 2004
33 Parts:			
*1–124	(869–052–00123–6)	57.00	July 1, 2004
125–199	(869–052–00124–4)	61.00	July 1, 2004
200–End	(869–052–00125–2)	57.00	July 1, 2004
34 Parts:			
1–299	(869–052–00126–1)	50.00	July 1, 2004
300–399	(869–052–00127–9)	40.00	July 1, 2004
400–End	(869–052–00128–7)	61.00	July 1, 2004
35	(869–052–00129–5)	10.00	[6]July 1, 2004
36 Parts			
1–199	(869–052–00130–9)	37.00	July 1, 2004
200–299	(869–052–00131–7)	37.00	July 1, 2004
*300–End	(869–052–00132–5)	61.00	July 1, 2004
37	(869–052–00133–3)	58.00	July 1, 2004
38 Parts:			
0–17	(869–052–00134–1)	60.00	July 1, 2004
18–End	(869–052–00135–0)	62.00	July 1, 2004
39	(869–052–00136–8)	42.00	July 1, 2004
40 Parts:			
1–49	(869–052–00137–6)	60.00	July 1, 2004
50–51	(869–052–00138–4)	45.00	July 1, 2004
52 (52.01–52.1018)	(869–052–00139–2)	60.00	July 1, 2004
*52 (52.1019–End)	(869–052–00140–6)	61.00	July 1, 2004
53–59	(869–052–00141–4)	31.00	July 1, 2004
60 (60.1–End)	(869–052–00142–2)	58.00	July 1, 2004
60 (Apps)	(869–052–00143–1)	57.00	July 1, 2004
61–62	(869–052–00144–9)	45.00	July 1, 2004
63 (63.1–63.599)	(869–052–00145–7)	58.00	July 1, 2004
63 (63.600–63.1199)	(869–052–00146–5)	50.00	July 1, 2004
63 (63.1200–63.1439)	(869–052–00147–3)	50.00	July 1, 2004
63 (63.1440–63.8830)	(869–052–00148–1)	64.00	July 1, 2004
64–71	(869–052–00150–3)	29.00	July 1, 2004
72–80	(869–052–00151–1)	62.00	July 1, 2004
81–85	(869–052–00152–0)	60.00	July 1, 2004
86 (86.1–86.599–99)	(869–052–00153–8)	58.00	July 1, 2004
86 (86.600–1–End)	(869–052–00154–6)	50.00	July 1, 2004
87–99	(869–052–00155–4)	60.00	July 1, 2004
100–135	(869–052–00156–2)	45.00	July 1, 2004
136–149	(869–052–00157–1)	61.00	July 1, 2004
150–189	(869–052–00158–9)	50.00	July 1, 2004
190–259	(869–052–00159–7)	39.00	July 1, 2004
260–265	(869–052–00160–1)	50.00	July 1, 2004
266–299	(869–052–00161–9)	50.00	July 1, 2004
300–399	(869–052–00162–7)	42.00	July 1, 2004
400–424	(869–052–00163–5)	56.00	[8]July 1, 2004
425–699	(869–052–00164–3)	61.00	July 1, 2004
700–789	(869–052–00165–1)	61.00	July 1, 2004
790–End	(869–052–00166–0)	61.00	July 1, 2004
41 Chapters:			
1, 1–1 to 1–10		13.00	[3]July 1, 1984
1, 1–11 to Appendix, 2 (2 Reserved)		13.00	[3]July 1, 1984
3–6		14.00	[3]July 1, 1984
7		6.00	[3]July 1, 1984
8		4.50	[3]July 1, 1984
9		13.00	[3]July 1, 1984
10–17		9.50	[3]July 1, 1984
18, Vol. I, Parts 1–5		13.00	[3]July 1, 1984
18, Vol. II, Parts 6–19		13.00	[3]July 1, 1984
18, Vol. III, Parts 20–52		13.00	[3]July 1, 1984
19–100		13.00	[3]July 1, 1984
1–100	(869–052–00167–8)	24.00	July 1, 2004
101	(869–052–00168–6)	21.00	July 1, 2004
102–200	(869–052–00169–4)	56.00	July 1, 2004
201–End	(869–052–00170–8)	24.00	July 1, 2004
42 Parts:			
1–399	(869–050–00169–1)	60.00	Oct. 1, 2003
400–429	(869–050–00170–5)	62.00	Oct. 1, 2003
430–End	(869–050–00171–3)	64.00	Oct. 1, 2003
43 Parts:			
1–999	(869–050–00172–1)	55.00	Oct. 1, 2003
1000–end	(869–050–00173–0)	62.00	Oct. 1, 2003
44	(869–050–00174–8)	50.00	Oct. 1, 2003
45 Parts:			
1–199	(869–050–00175–6)	60.00	Oct. 1, 2003
200–499	(869–050–00176–4)	33.00	Oct. 1, 2003
500–1199	(869–050–00177–2)	50.00	Oct. 1, 2003
1200–End	(869–050–00178–1)	60.00	Oct. 1, 2003
46 Parts:			
1–40	(869–050–00179–9)	46.00	Oct. 1, 2003
41–69	(869–050–00180–2)	39.00	Oct. 1, 2003
70–89	(869–050–00181–1)	14.00	Oct. 1, 2003
90–139	(869–050–00182–9)	44.00	Oct. 1, 2003
140–155	(869–050–00183–7)	25.00	Oct. 1, 2003
156–165	(869–050–00184–5)	34.00	Oct. 1, 2003
166–199	(869–050–00185–3)	46.00	Oct. 1, 2003
200–499	(869–050–00186–1)	39.00	Oct. 1, 2003
500–End	(869–050–00187–0)	25.00	Oct. 1, 2003
47 Parts:			
0–19	(869–050–00188–8)	61.00	Oct. 1, 2003
20–39	(869–050–00189–6)	45.00	Oct. 1, 2003
40–69	(869–050–00190–0)	39.00	Oct. 1, 2003
70–79	(869–050–00191–8)	61.00	Oct. 1, 2003
80–End	(869–050–00192–6)	61.00	Oct. 1, 2003
48 Chapters:			
1 (Parts 1–51)	(869–050–00193–4)	63.00	Oct. 1, 2003
1 (Parts 52–99)	(869–050–00194–2)	50.00	Oct. 1, 2003
2 (Parts 201–299)	(869–050–00195–1)	55.00	Oct. 1, 2003
3–6	(869–050–00196–9)	33.00	Oct. 1, 2003
7–14	(869–050–00197–7)	61.00	Oct. 1, 2003
15–28	(869–050–00198–5)	57.00	Oct. 1, 2003
29–End	(869–050–00199–3)	38.00	[9]Oct. 1, 2003
49 Parts:			
1–99	(869–050–00200–1)	60.00	Oct. 1, 2003

Title	Stock Number	Price	Revision Date
100–185	(869–050–00201–9)	63.00	Oct. 1, 2003
186–199	(869–050–00202–7)	20.00	Oct. 1, 2003
200–399	(869–050–00203–5)	64.00	Oct. 1, 2003
400–599	(869–050–00204–3)	63.00	Oct. 1, 2003
*600–999	(869–052–00207–1)	19.00	Oct. 1, 2004
1000–1199	(869–050–00206–0)	26.00	Oct. 1, 2003
1200–End	(869–048–00207–8)	33.00	Oct. 1, 2003
50 Parts:			
1–16	(869–050–00208–6)	11.00	Oct. 1, 2003
17.1–17.95	(869–050–00209–4)	62.00	Oct. 1, 2003
17.96–17.99(h)	(869–050–00210–8)	61.00	Oct. 1, 2003
17.99(i)–end	(869–050–00211–6)	50.00	Oct. 1, 2003
18–199	(869–050–00212–4)	42.00	Oct. 1, 2003
200–599	(869–050–00213–2)	44.00	Oct. 1, 2003
600–End	(869–050–00214–1)	61.00	Oct. 1, 2003
CFR Index and Findings Aids	(869–052–00049–3)	62.00	Jan. 1, 2004
Complete 2004 CFR set		1,342.00	2004
Microfiche CFR Edition:			
Subscription (mailed as issued)		325.00	2004
Individual copies		2.00	2004
Complete set (one-time mailing)		298.00	2003
Complete set (one-time mailing)		298.00	2002

[1] Because Title 3 is an annual compilation, this volume and all previous volumes should be retained as a permanent reference source.

[2] The July 1, 1985 edition of 32 CFR Parts 1–189 contains a note only for Parts 1–39 inclusive. For the full text of the Defense Acquisition Regulations in Parts 1–39, consult the three CFR volumes issued as of July 1, 1984, containing those parts.

[3] The July 1, 1985 edition of 41 CFR Chapters 1–100 contains a note only for Chapters 1 to 49 inclusive. For the full text of procurement regulations in Chapters 1 to 49, consult the eleven CFR volumes issued as of July 1, 1984 containing those chapters.

[4] No amendments to this volume were promulgated during the period January 1, 2003, through January 1, 2004. The CFR volume issued as of January 1, 2002 should be retained.

[5] No amendments to this volume were promulgated during the period April 1, 2000, through April 1, 2004. The CFR volume issued as of April 1, 2000 should be retained.

[6] No amendments to this volume were promulgated during the period July 1, 2000, through July 1, 2004. The CFR volume issued as of July 1, 2000 should be retained.

[7] No amendments to this volume were promulgated during the period July 1, 2002, through July 1, 2004. The CFR volume issued as of July 1, 2002 should be retained.

[8] No amendments to this volume were promulgated during the period July 1, 2003, through July 1, 2004. The CFR volume issued as of July 1, 2003 should be retained.

[9] No amendments to this volume were promulgated during the period October 1, 2001, through October 1, 2003. The CFR volume issued as of October 1, 2001 should be retained.